SECTION S: STATE-SPECIFIC ITEMS (New York)

Intent: The intent of this section is to support the semi-annual determination of each RHCF's Medicaid payment rate.

Effective: The version of Section S to use for an assessment is determined by the *assessment date.* The *assessment date* is one of three dates in Section A. The specific date used is based on the Entry/Discharge Reporting code (A0310F).

If the Entry/Discharge Reporting (A0310F) is coded:

- [**01**] (entry), then the *assessment date* is equal to **A1600** (entry date).
- [**10**, **11**, or **12**] (discharge or death in facility), then the *assessment date* is equal to **A2000** (discharge date).
- [**99**] (not entry/discharge), then the *assessment date* is equal to **A2300** (assessment reference date).

After determining the *assessment date* as described above, select from the table below the correct version of Section S to use for the assessment.

Section S Version	Effective for ***Assessments Dated*** (A1600 or A2000 or A2300)	
	Start Date	**End Date**
10/01/2018	10/01/2018	09/30/2019
10/01/2019	10/01/2019	none

Instructions:

- Complete Section S for all nursing home assessments, except the Tracking (NT) Item Set:
  - NC Nursing Home Comprehensive
  - NQ Nursing Home Quarterly
  - NP Nursing Home PPS
  - ND Nursing Home Discharge
  - NOD Nursing Home OMRA Other – Discharge
  - NSD Nursing Home OMRA – Start of Therapy and Discharge
  - NO Nursing Home OMRA Other
  - NS Nursing Home OMRA – Start of Therapy

- Section S is not required for swing-bed program assessments.

S0160. Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions

S0160.	**Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions**
Enter Code ☐	**01** Discrete AIDS Unit
	02 Ventilator Dependent Unit
	03 Traumatic Brain Injury (TBI) Unit
	04 Behavioral Intervention Unit
	05 Behavioral Intervention Step-Down Unit
	06 Pediatric Specialty Unit/Facility
	07 AIDS Scatter Beds
	08 Traumatic Brain (TBI) Extended Care
	09 Neurodegenerative Unit
	99 None of the Above

Item Rationale:

- To identify whether the resident:
  - resides in a discrete specialty unit or facility that is eligible for a discrete specialty Medicaid reimbursement rate in accordance with the applicable regulation or statute,

  OR
  - is eligible for enhanced Medicaid reimbursement (Add-On) for an approved specialty program in accordance with the applicable regulation or statute.

Definitions and Coding Instructions:

Enter the single code that applies.

To be eligible for a discrete specialty unit/facility rate the resident must reside in a unit or facility that is approved by the Commissioner of Health in accordance with the cited regulation(s) and/or statute(s).

- **Code 01, Discrete AIDS Unit/Facility -** Approved pursuant to 10 NYCRR Part 86-2.10 (p) and Part 710 or any successor regulation and/or statute.

- **Code 02, Ventilator Dependent Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (q) and Section 415.38 or any successor regulation and/or statute.

- **Code 03, Traumatic Brain-Injury (TBI) Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (n) and Section 415.36 or any successor regulation and/or statute.

- **Code 04, Behavioral Intervention Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (w) and Section 415.39 or any successor regulation and/or statute.

- **Code 05, Behavioral Intervention Step-Down Unit** – This code does not apply to any NY facilities.

- **Code 06, Pediatric Specialty Unit / Facility** – Approved pursuant to 10 NYCRR Part 86-2.10 (i) or any successor regulation and/or statute. Department of Health policy ONLY recognizes pediatric residents up to age 21 for purposes of specialty reimbursement.

- **Code 09, Neurodegenerative Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (x) and Section 415.41 or any successor regulation and/or statute.

OR

To be eligible for an enhanced Medicaid reimbursement rate (Add-On) the resident must be enrolled in a specialty program that is approved by the Commissioner of Health in accordance with the regulation(s) and/or statute(s) cited below.

- **Code 07, AIDS Scatter Beds** - Approved pursuant to 10 NYCRR Part 86-2.10 (p) (3) and Part 710 or any successor regulation and/or statute.

- **Code 08, Traumatic Brain-Injury (TBI) Extended Care** - Approved pursuant to 10 NYCRR Part 86-2.10 (v) and Section 415.40 or any successor regulation and/or statute.

OR

- **Code 99, None of the Above** - if the resident does not reside in a unit or facility that is approved by the Commissioner of Health in accordance with the above-cited regulation(s) and/or statute(s), and the resident is not enrolled in a specialty program that is approved by the Commissioner of Health in accordance with the above-cited regulation(s) and/or statute(s).

S0170. Advanced directive

S0170. Advanced Directive - check all that apply

☐	A. Guardian
☐	B. DPOA-HC
☐	C. Living Will
☐	D. Do not Resuscitate
☐	E. Do not Hospitalize
☐	F. Do not Intubate
☐	G. Feeding Restrictions
☐	H. Other Treatment Restrictions
☐	Z. None of the above

Item Rationale:

- To document who has responsibility for making decisions regarding resident's health care and treatment options. This decision can be made by the resident or a legal proxy.
- More information about Advanced directive can be found at https://www.health.ny.gov/publications/1503/.

S0170A. Advanced directive: Guardian

Definitions and Coding Instructions:

- Someone who has been appointed after a court hearing and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian.

- Under Article 29-CC of the New York Public Health Law, the Family Health Care Decisions Act enables a surrogate to make health care decisions on behalf of the patient in the absence of a health care proxy. Surrogates (e.g., legal guardians) under Article 29-CC should be considered when completing item S0170A.

- More information about health care agents and surrogates (e.g., legal guardians) can be found at https://www.health.ny.gov/publications/1503/.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have a Guardian.
- **Checked 1, Yes** - the resident has a Guardian.

S0170B. Advanced directive: DPOA-HC (Durable Power of Attorney – Health Care)

Definitions and Coding Instructions:

- Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have a DPOA-HC.
- **Checked 1, Yes** - the resident has a DPOA-HC.

S0170C. Advanced directive: Living Will

Definitions and Coding Instructions:

- Documentation specifying wishes of a resident regarding actions that should be taken for their health in a situation that a resident can no longer make decisions.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have a Living Will.
- **Checked 1, Yes** - the resident has a Living Will.

S0170D. Advanced directive: Do Not Resuscitate

Definitions and Coding Instructions:

- Documentation specifying that in the event of respiratory or cardiac failure, no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have documentation saying, 'Do not Resuscitate'.

- **Checked 1, Yes** - the resident has documentation saying, 'Do not Resuscitate'.

S0170E. Advanced directive: Do Not Hospitalize

Definitions and Coding Instructions:

- Documentation specifying that the resident should not be sent to hospital even after developing a medical condition that usually requires hospitalization.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have documentation saying, 'Do Not Hospitalize'.

- **Checked 1, Yes** - the resident has documentation saying, 'Do Not Hospitalize'.

S0170F. Advanced directive: Do Not Intubate

Definitions and Coding Instructions:

- Document specifying not to have a tube inserted to facilitate breathing by artificial means, if the resident is unable to breath independently.

Check the box as it applies.

- **Not checked 0, No** - the resident does not have documentation saying, 'Do Not Intubate'.

- **Checked 1, Yes** - the resident has documentation saying, 'Do Not Intubate'.

S0170G. Advanced directive: Feeding Restrictions

Definitions and Coding Instructions:

- Documentation specifying not to feed the resident by artificial means (e.g., intravenous nutrition, tube) if the resident is unable to be nourished by oral means.

Check the box as it applies.

- **Not checked, No** - the resident does not have documentation specifying feeding restrictions.

- **Checked 1, Yes** - the resident has documentation specifying feeding restrictions.

S0170H. Advanced directive: Other Treatment Restrictions

Definitions and Coding Instructions:

- Documentation specifying that the resident does not wish to receive certain medical treatments. Examples include, but not limited to, tracheotomy, blood transfusion, invasive procedures, medications, etc.,

Check the box as it applies.

- **Not checked 0, No** - the resident does not have documentation specifying treatment restrictions.

- **Checked 1, Yes** - the resident has documentation specifying treatment restrictions.

S0170Z. Advanced directive: None of the above

Coding Instructions:

If no options apply for items S0170A - S0170H, check item S0170Z

S0171. Health Care Proxy

S0171A. Resident healthcare proxy exists (Does the resident have a healthcare proxy?)

Item Rationale:

To document who has responsibility for making decisions regarding the resident's health care and treatment.

Definitions and Coding Instructions:

- Documentation specifying that the resident named someone to make health care decisions on their behalf if the resident becomes unable to make such decisions.

Enter the single code that applies.

- **Code 0, No** – the resident does not have healthcare proxy.
- **Code 1, Yes** – the resident has health care proxy

S0171B. Resident healthcare proxy invoked (Has healthcare proxy been invoked?)

Item Rationale:

Documentation that the resident's attending physician has determined to invoke (to put into effect or activate) the health care proxy. Health care proxy's authority becomes effective if the resident's attending physician documents, in writing, that the resident does not have the capacity to make heath care decisions.

Definitions and Coding Instructions:

- Documentation specifying that the resident's health care proxy is invoked.

Enter the single code that applies.

- **Code 0, No** - the resident does not have healthcare proxy or the resident does not have documentation that the health care proxy is invoked.
- **Code 1, Yes** - the resident has documentation that the health care proxy is invoked.

S0185. Discharge to Hospital: Health Care Proxy Involvement

Item Rationale:

- To identify residents who are sent to the hospital at the request of someone who has authority to make health care decisions for the resident, although the facility staff do not believe the hospitalization to be medically necessary.

Definitions and Coding Instructions:

Enter the single code that applies.

Under Article 29-CC of the New York Public Health Law, the Family Health Care Decisions Act enables a surrogate to make health care decisions on behalf of the patient in the absence of a health care proxy. Surrogates (e.g., legal guardians) under Article 29-CC should be considered when completing item S0185.

More information about health care agents and surrogates (e.g., legal guardians) can be found at https://www.health.ny.gov/publications/1503/.

- **Code 0, No** - the resident is not being discharged to an acute hospital against the opinion of the nursing home.
- **Code 1, Yes** - the resident is being discharged to an acute hospital against the opinion of the nursing home.
- For non-discharge assessment and/or the resident is not being discharged to an acute hospital, the facility should use a dash to indicate that the question is not applicable.
- S0185 only needs to be present on ND, NOD, and NSD assessments.

S6500. Comfort Care Provided in the Last 14 Days

Item Rationale:

- To identify residents who are receiving comfort care without curative intent. These residents are those who are not receiving care from a state-licensed and/or Medicare-certified hospice provider as defined in MDS Item O0100K. To meet the criteria of this item, the primary goal of comfort care must be to reduce suffering.

Definitions and Coding Instructions:

Enter the single code that applies.

- **Code 0, No** - the resident has not received comfort care in the last 14 days.
- **Code 1, Yes** - the resident has received comfort care in the last 14 days.

S7000. Dental Care

Item Rationale:

- To capture the type and frequency of dental care provided to residents.

Definitions and Coding Instructions:

Enter the single code that applies.

Routine dental care is planned or scheduled care. Emergent dental care is unplanned or unscheduled care provided for the purposes described in 10 NYCRR Section 415.17 and any successor regulation.

- **Code 1, Routine dental care since last assessment** - the resident received planned or scheduled dental care.
- **Code 2, Emergent dental care since last assessment** - the resident received unplanned or unscheduled dental care.
- **Code 9, None of the above** - the resident did not receive routine or emergent dental care since the last assessment.

S8015. MMIS Identification Number

Item Rationale*:*

- To identify the Managed Long-Term Care (MLTC) or Medicaid Managed Care ("Mainstream") plan the resident is enrolled in at the time of assessment.

Definitions and Coding Instructions:

Enter the Medicaid Management Information System (MMIS) identification number for the Managed Long-Term Care or Mainstream Medicaid Managed Care plan in which the resident was enrolled for this assessment, regardless of whether the plan is also the primary payor at the time of assessment (Question S8055). Please click on link below for Managed Care Information. If the resident was not enrolled in either type of managed care plan, enter a dash in the first box.

A listing of current MMIS identification numbers for Managed Long-Term Care and Mainstream Medicaid Managed Care plans can be found at:
https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf
Please note that the MMIS identification number for a managed care plan is its 8-digit plan identification number. MMIS identification numbers (i.e., plan ID numbers) may also be obtained directly from managed care plan representatives.

S8055. Primary Payor

S8055. Primary Payor	
Enter Code	**1** Medicare
	2 Medicaid
	3 Medicaid Pending
	4 Medicaid Managed Care
	5 Managed Long-term Care
	9 None of the Above

Item Rationale*:*

- To determine the primary payment source as of the MDS Assessment Reference Date (A2300).

Steps for Assessment:

- Check with the billing office to review current payment source(s). Do not rely exclusively on information recorded in the resident's clinical record.

Definitions and Coding Instructions:

Enter the Code of the **one** source of coverage that has primary responsibility for and pays for most of the resident's current nursing home stay on the Assessment Reference Date (A2300).

- **Code 1. Medicare** – Medicare Part A (traditional) or Medicare Part C (Medicare Choice/HMO) is the primary payor. Medicaid may pay for the Medicare co-insurance and/or deductibles.

- **Code 2. Medicaid*** – Medicaid fee-for-service is the primary payor. Residents with Medicaid coverage supplemented by Medicare Part B should be recorded as Medicaid payor.

- **Code 3. Medicaid Pending*** - There is no other primary third-party coverage being used for the resident's present stay, **and** the facility has sought, or intends to seek, establishment of Medicaid eligibility for coverage as of the Assessment Reference Date (A2300).

- **Code 4. Medicaid Managed Care*** - A Medicaid managed care program is the primary payor. Medicaid Managed Care ("Mainstream" managed care) covers acute, primary, specialty, long term care and behavioral health through managed care organizations (MCOs) for residents who are not Medicare eligible.

- **Code 5. Managed Long-Term Care*** - A Medicaid Managed Long Term Care (MLTC) plan is the primary payor. MLTC assists chronically ill or disabled individuals who require health and long-term care services. Full Medicaid eligibility and most often but not always Medicare eligible. MLTC plan types include FIDA, Partial Capitation Plans, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus and Medicaid Advantage.

- **Code 9. None of the Above** - The primary third-party payor is not Medicare Part A or Medicaid, and Medicaid is not pending. A resident who pays privately, or has long-term care insurance or Veteran's Administration benefits, or one who receives charity care.

***Payor category is included in the nursing home Medicaid-Only CMI.**

For Further Information

- For questions on Items S0170A-S0170Z, S0171A-S0171B, S0185, S6500 and S7000 please send an email to: nhqp@health.ny.gov.
- For questions on Item S8015 please send an email to: doh.sm.MLTC.System.issues@health.ny.gov.
- For questions on Items S0160 or S8055 please send an email to: PRImail@health.ny.gov.