Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter NF-53
May 2009

TO: Nursing Facilities Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Nursing Facility Manual* (Revised Appendices D and E)

This letter transmits revised Appendices D and E for the *Nursing Facility Manual*. Appendix D contains specifications for submitting Management Minutes Questionnaires (MMQs). Appendix E contains instructions for completing MMQs. These revised specifications and instructions are effective May 26, 2009. MMQs submitted on or after May 8, 2009, must be submitted using the following attached instructions. This effective date is necessary to support MassHealth's implementation schedule for NewMMIS.

With the implementation of NewMMIS, there will be a change in the media type and submission methods for MMQs. MassHealth will no longer accept MMQs submitted on hard media (discs) or on paper. The last day MassHealth Customer Service will process MMQs via hard media will be May 8, 2009. Effective May 26, 2009, facilities must submit MMQs online, through the Provider Online Service Center, using direct data entry (DDE) or batch submission.

The MMQ software application developed by the Commonwealth has been upgraded to allow nursing facilities to create and submit MMQ information via the Provider Online Service Center. Facilities must check the MassHealth Web site and download the latest version of the application so that you are prepared to submit MMQs in the new format beginning in May 2009. This will enable you to use NewMMIS from the date of implementation.

To learn more about these upgrades, take the e-Learning or online training courses available on the NewMMIS Web site at http://masshealthnewmmisprovidertraining.ehs.state.ma.us/.

The following trainings are available.

- NewMMIS Provider Online Service Center - Provider Overview
- NewMMIS Provider Online Service Center - Provider Overview Job Aid
- Submitting MMQs

There are no changes to the time frames for preparation, submission, or the cycles by which nursing facilities must submit MMQ data. MassHealth will continue to perform audits of medical records to ensure that management minutes categories (MMCs) have been properly assigned and that MMQs have been properly prepared.

If you have any questions about this transmittal letter, please contact the MassHealth Customer Service at 1-800-841-2900.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Nursing Facility Manual

Pages D-1 through D-28 and E-1 through E-16

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Nursing Facility Manual

Pages D-1 through D-10 and E-1 through E-20 – transmitted by Transmittal Letter NF-50

Specifications for Electronic Submittal of the Management Minutes Questionnaires (MMQs) by Nursing Facilities

MassHealth has developed new specifications for the electronic submission of initial and semiannual MMQs.

General Instructions

- All MMQ data submitted electronically must conform, in all aspects, to the requirements in Appendix E of the *Nursing Facility Manual*.
- All MMQ data and documentation must be available on paper as requested by MassHealth for audits.
- The nursing facility is responsible for ensuring that the MMQ data is accurate, complete, and in compliance with all pertinent regulations and requirements.
- Providers are required to submit a signed certification form with their first electronic submission. The certification forms are not required for subsequent submissions. See form MMQ Cert-1, Electronic MMQ Submission Agreement and Certification Statement, attached to Nursing Facility Bulletin 119.

  To access bulletins, go to www.mass.gov/masshealth and click on MassHealth Regulations and Other Publications. Click on Provider Library and then on Provider Bulletins.
- MMQ information, except for submission purposes, must be sent to the following address.
  MassHealth
  Casemix Unit
  600 Washington Street, 5th Floor
  Boston, MA 02111
- MMQ information may be created using software provided by MassHealth. Providers can obtain the software by downloading it from MassHealth's Web site at www.mass.gov/mmq or by contacting MassHealth at the address given above.
- Providers or other entities authorized to use the MMQ batch submission function must log on to the NewMMIS Provider Online Service Center using a valid user ID and password.
- On the left side of the page under Provider Services, select the "Manage Members" hyperlink, select the "Long Term Care" link, and then select "Upload Batch MMQ Files," and follow the instructions on the Web page.
- Submitters will receive an acknowledgement from the Provider Online Service Center that their batch has been submitted successfully.
- Submitters must log on to the Provider Online Service Center on the following business day to receive responses to their MMQ submission. The response will include the total number of MMQ records that were processed by NewMMIS and the number of MMQ records that were accepted, rejected, or pended. If a record is rejected or pended, detailed information will be provided in the response to identify the MMQ records and the reasons why the records were rejected or pended.

Time Frames

- Initial MMQs must be submitted for each new MassHealth member within 30 days from the date of admission or conversion from private or Medicare coverage to MassHealth coverage.
- Semiannual MMQs must be submitted no later than the fifteenth of the month. For example: A nursing facility's semiannual submission date is January 1, 2009. The nursing facility must transmit the MMQTD submission no later than January 15, 2009.

Identifying Information for Patient

- Reason for Submission: Acceptable reason codes are 1, 2, 3, 4, 5, or D.
- Member ID must be 12 digits.

Service Information

The table below describes the fields on the questionnaire, and what each code and score mean.

Item	Code	Score	Description/Comments
1. Dispense Medications and Chart	Always 1	Always 30	-
2. Skilled Observations	1 2	0 15	-
3. Personal Hygiene	1 2 3	0 18 20	Score equals higher of bathing or grooming.
4. Dressing	1 2 3 4 5	0 30 30 0 0	-
5. Mobility	1 2 3 4 5	0 0 32 32 0	-
6. Eating	1 2 3 4 5 6 7 8	0 20 45 90 90 110 135 135	-
7. Continence/Catheter	1 2 3 4 5 6	0 0 48 48 20 (Bladder only) 18	Score equals higher of bladder or bowel code, unless bladder is code 5 and bowel is code 3 or 4, in which case the score = 38.

Service Information (cont.)

8. Bladder/Bowel Retraining	1 2 3 4	0 50 18 68	If bladder code in 7 equals 3, 4, or 5, and the code in 8 equals 2 or 4, the default in 8 is: code = 1, score = 0. If bowel code in 7 equals 3, 4, or 6, and the code in 8 equals 3 or 4, the default in 8 is: code = 1, score = 0.
9. Positioning	1 2	0 36	-
10. Pressure Ulcer Prevention	1 2	0 10	-
11. Skilled Procedure Daily/Pressure Ulcer	0 1-9	0 10 times the frequency; maximum of 90	-
12. Skilled Procedure Daily/Other	0 01-14	0 10 times the frequency; maximum of 90	If the frequency code is 1-9, there must be an entry in the procedure type. If only one procedure type is listed, and it is 02, 07, 10, or 12, the frequency code cannot exceed 3.
13. Special Attention	A = 0, 1 B = 0, 1 C = 0-3 D = 0, 1		If A-D contains all zeros: score = 0. If A-D contains at least one 1: score = 10% (x) subtotal.
14. Restorative Nursing	0 1-7	0 30 (See comment in next column)	Code 1-7: Score = 30 except as follows. If 3 (personal hygiene) is coded 2 or 3, code 2 for this service must default to 0. If 4 (dressing) is coded 2 or 3, code 1 for this service must default to 0. If 5 (mobility) is coded 3 or 4, code 6 for this service must default to 0. If 6 (Eating) is coded 2-8, code 3 for this service must default to 0. A maximum of 30 can be coded.
Grand Total - Total of scores for services 1-14. This number should be left justified.			

Range of minutes for MMQ categories (Effective January 1, 2000)	
H	30
J	30.1 – 85.0
K	85.1 – 110.0
L	110.1 – 140.0
M	140.1 – 170.0

Service Information (cont.)

Item	Code	Score	Description/Comments
Range of minutes for MMQ categories (Effective January 1, 2000)			
N	170.1 – 200.0		
P	200.1 – 225.0		
R	225.1 – 245.0		
S	245.1 – 270.0		
T	270.1 +		
15. Toilet Use	Must be 1, 2, 3, or 4	N/A	-
16. Transfer	Must be 1, 2, 3, or 4	N/A	-
17. Mental Status	Must be 1, 2, or 3	N/A	-
18. Restraint	Must be 1, 2, or 3	N/A	-
19. Activities Participation	Must be 1, 2, 3, or 8	N/A	-
20. Consultations	00-12 88	N/A	Code 00 enter Type = 00, Freq = 0 Code 88 enter: Type = 88, Freq = 0 Otherwise: Type = 01-12, Freq = 1-6
21. Medications	Codes 0-8; Frequency: 0-3	N/A	-
22. Accidents/Contracture/Weight Change	1 or 2	N/A	Make entries for all three fields A, C, and WC.
23. Primary Diagnosis	Use ICD-9 codes	N/A	Must be left justified; Length may be 3-5 bytes.
24. Secondary Diagnosis(es)	Use ICD-9 codes	N/A	Must be left justified.
25. RN Evaluator	N/A	N/A	Name of the evaluator
26. Eval Date	N/A	N/A	Date the MMQ is completed
27. Name of Administrator	N/A	N/A	Name of the administrator
28. Affiliation	1 2 3	N/A	Code 1 = Nursing facility staff Code 2 = MassHealth staff Code 3 = RN contractor
29. Discharge Code – if applicable	01 to 14	N/A	-
30. Discharge Date – if applicable	N/A	N/A	Date the resident is discharged

MMQ Batch Submission Requirements

The schema developed to process MMQ data is used by both the Direct Data Entry (DDE) function and the MMQ batch function on the Provider Online Service Center. Batch submitters should be aware that some attributes in the schema that are populated by the DDE function are not required to be submitted in an MMQ batch.

Please note the following.

- The submission data must be encoded in Extensible Markup Language (XML) and conform to the detailed specifications that appear on the following pages.
- Attributes used by the DDE function that are not required for batch submissions are identified in the detailed specifications below.
- An XML Schema Definition (XSD) document for batch MMQ submissions will be made available upon request.
- A sample of an MMQ XML batch submission is provided at the end of this section.
- All MMQ batch submissions must include the following wrapper node: submitMemberMMQRequests.
- The MMQ_ACTION_IND for all MMQ submissions must be "PROC_MMQ."
- All dates must be in YYYYMMDD format.
- If there is no data in the Secondary Diagnosis field, do not send the node for that field.

Note: If you have any questions about the information in this appendix, please contact MassHealth Customer Service at 1-800-841-2900 or by e-mail at providersupport@mahealth.net.

MMQ Batch Input File Specifications

When the vendor submits MMQ data to MassHealth, it must be submitted in the following format.

MMQ Action Indicator – Required Segment

Detail Field	Required?	Description
MMQ_ACTION_IND	Y	Must equal "PROC_MMQ" for batch submission.

Personal Information – Required Segment

This segment will contain all the personal information for the MMQ submitted by the provider for the member. The key elements are provider ID/service location and member ID.

Only one personal information segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
PROVIDER ID	String	9	Y	The provider ID submitting the MMQ.
SERVICE_LOCATION	String	1	Y	The service location for the provider ID submitting the MMQ.
MEMBER ID	String	12	Y	This is the member ID for the MMQ being submitted by the provider.
FACILITY NAME	-	-	-	***Field should be empty for batch submission.***
DTE_ADMIT	Date	8	Y	This is the date the member was admitted. Date format is YYYYMMDD.
LAST_NAME	String	20	Y	This is the member's last name on the MMQ submitted by the provider.
FIRST_NAME	String	15	Y	This is the member's first name on the MMQ submitted by the provider. At least the first initial of the first name must be populated.
BIRTH_DTE	Date	8	Y	This is the member's date of birth on the MMQ. Date format is YYYYMMDD.
GENDER	-	-	-	***Field should be empty for batch submission.***
RACE	-	-	-	***Field should be empty for batch submission.***
DTE_EFF	Date	8	Y	This is the effective date of the MMQ. Date format is YYYYMMDD.
SUBMIT_REASON	String	1	Y	The reason for submitting the MMQ. Valid values are: 1 = Admission 2 = Conversion 3 = Semiannual or significant change 4 = Semiannual category and score change 5 = Semiannual no change D = Discharge

Service Section 1 – Required Segment

This segment contains all of Service Section 1 information (Questions 1-12) for the MMQ submitted by the provider for the member. Only one Service Section 1 segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
DISP_MED_SCORE	-	-	-	***Field should be empty for batch submission.***
SKILLED_OBSERV_DAILIY_CODE	String	1	Y	Service code for the skilled observation daily service. Valid values are: 1 = No observation 2 = Daily observation
SKILLED_OBSERV_DAILIY_SCORE	-	-	-	***Field should be empty for batch submission.***
PERS_HYG_BATH_CODE	String	1	Y	Service code for bathing service. Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent
PERS_HYG_BATH_SCORE	-	-	-	***Field should be empty for batch submission.***
PERS_HYG_GROOM_CODE	String	1	Y	Service code for grooming service. Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent
PERS_HYG_GROOM_SCORE	-	-	-	***Field should be empty for batch submission.***
DRESSING_CODE	String	1	Y	Service code for the dressing service. Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent 4 = Socks and shoes only 5 = Not Dressed
DRESSING_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MOBILITY_CODE	String	1	Y	Service code for the mobility service. Valid values are: 1 = Independent/restorative program 2 = Independent w/wheelchair 3 = Walks with assist 4 = Wheelchair with assist 5 = Nonambulatory
MOBILITY_SCORE	-	-	-	***Field should be empty for batch submission.***
EATING_CODE	String	1	Y	Service code for the eating service. Valid values are: 1 = Independent/restorative program 2 = Assist 3 = Totally dependent 4 = Tube fed 5 = I.V. 6 = Tube fed and assist 7 = Tube fed and totally dependent 8 = Tube fed and I.V.
EATING_SCORE	-	-	-	***Field should be empty for batch submission.***
CONT_CATH_BLAD_CODE	String	1	Y	Service code for the continence/catheter - bladder service. Valid values are: 1 = Continent 2 = Incontinent occasionally 3 = Incontinent and toileted 4 = Incontinent 5 = Indwelling catheter 6 = Bowel incontinent and bladder training
CONT_CATH_BLAD_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONT_CATH_BOWEL_CODE	String	1	Y	Service code for the continence / catheter – bowel service. Valid values are: 1 = Continent 2 = Incontinent occasionally 3 = Incontinent and toileted 4 = Incontinent 6 = Bowel incontinent and bladder training
CONT_CATH_BOWEL_SCORE	-	-	-	***Field should be empty for batch submission***
BLAD_BOWEL_RETRAIN_CODE	String	1	Y	Service code for the bladder / bowel retraining service. Valid values are: 1 = No retraining received 2 = Bladder retraining 3 = Bowel retraining 4 = Bladder and bowel retraining
BLAD_BOWEL_RETRAIN_SCORE	-	-	-	***Field should be empty for batch submission.***
POSITIONING_CODE	String	1	Y	Service code for the positioning service. Valid values are: 1 = Independent 2 = Assist
POSITIONING_SCORE	-	-	-	***Field should be empty for batch submission.***
PRES_ULCER_PREV_CODE	String	1	Y	Service code for the pressure ulcer prevention service. Valid values are: 1 = No preventive measures 2 = Preventive measures
PRES_ULCER_PREV_SCORE	-	-	-	***Field should be empty for batch submission.***
SPROC_DAILY_PRES_ULCER_FREQ	String	1	Y	Frequency for the skilled procedure daily/pressure ulcer services. Valid values are “0” through “9.”
SPROC_DAILY_PRES_ULCER_SCORE	-	-	-	***Field should be empty for batch submission.***

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SPD_PU_STG1_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 1 service. Valid values are "0" through "9."
SPD_PU_STG2_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 2 service. Valid values are "0" through "9."
SPD_PU_STG3_CODE	String	1	Y	Service code for the skilled procedure daily/pressure ulcer, stage 3 service. Valid values are "0" through "9."
SPD_PU_STG4_CODE	String	1	Y	Service code for the skilled procedure daily / pressure ulcer, stage 4 service. Valid values are "0" through "9."
SPTD_OTHER_FREQ	String	1	Y	Frequency for the skilled procedure type daily/other services. Valid values are "0" through "9."
SPTD_OTHER_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC1_CODE	String	2	Y	Service code for the skilled procedure type daily/other, procedure 1 service. Valid values are as follows. 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 = Other

Service Section 1 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SPTD_OTHER_PROC1_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC2_CODE	String	2	Y	Service code for the skilled procedure type daily / other - procedure 2 service. Valid values are as follows. 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 =Other
SPTD_OTHER_PROC2_SCORE	-	-	-	***Field should be empty for batch submission.***
SPTD_OTHER_PROC3_CODE	String	1	Y	Service code for the skilled procedure type daily/other, procedure 3 service. Valid values are as follows. 00 = None 01 = Dressing change 02 = Catheter irrigation 03 = Intermittent catheterization 04 = Eye irrigation 05 = Ear irrigation 06 = Care of heparin locks 07 = Oxygen therapy 08 = Tracheotomy care 09 = Sterile dressing 10 = Suctioning 11 = Not in use at this time 12 = Respiratory therapy 13 = New colostomy care 14 = Other
SPTD_OTHER_PROC3_SCORE	-	-	-	***Field should be empty for batch submission.***
SUBTOTAL	-	-	-	***Field should be empty for batch submission.***

Service Section 2 – Required Segment

This segment will contain all the Service Section 2 information (Questions 13 and 14) for the MMQ submitted by the provider for the member. Only one Service Section 2 segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
SPEC_ATT_IMMOBIL_CODE	String	1	Y	Service code for the special attention (code A) immobility service. Valid values are "0" and "1."
SPEC_ATT_SEV_SPASTIC_CODE	String	1	Y	Service code for the special attention (code B) severe spasticity/rigidity service. Valid values are "0" and "1."
SPEC_ATT_BEH_PROB_CODE	String	1	Y	Service code for the special attention (code C) behavioral problems service. Valid values are 0, 1, 2, and 3.
SPEC_ATT_ISOLATION_CODE	String	1	Y	Service code for the special attention (code D) isolation service. Valid values are "0" and "1."
SPEC_ATT_SCORE	-	-	-	***Field should be empty for batch submission.***
REST_NRSNG_TYPE1_CODE	String	1	Y	Service code for the restorative nursing/type 2 service. Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion

Service Section 2 – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
REST_NRSNG_TYPE2_CODE	String	1	Y	Service code for the restorative nursing/type 2 service. Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion
REST_NRSNG_TYPE3_CODE	String	1	Y	Service code for the restorative nursing/type 3 service. Valid values are: 0 = None 1 = Dressing 2 = Personal hygiene 3 = Eating 4 = Ostomy teaching 5 = Diabetic teaching 6 = Ambulation 7 = Range of motion
REST_NRSNG_TYPE3_CODE	-	-	-	***Field should be empty for batch submission.***
GRAND_TOTAL	-	-	-	***Field should be empty for batch submission.***
CATEGORY	-	-	-	***Field should be empty for batch submission.***

Extra Questions – Required Segment

This segment will contain all the additional information (Questions 15-30) for the MMQ submitted by the provider for the member. Only one additional questions segment can be sent per member.

Detail Field	Data Type	Length	Required?	Description
TOILET_USE	String	1	Y	Code classification for toilet use. Valid values are: 1 = Independent 2 = Assist 3 = Totally dependent 4 = Not toileted
TRANSFER	String	1	Y	Code classification for transfer. Valid values are: 1 = Independent 2 = Assist 3 = Totally dependent 4 = Bedbound
MENTAL_STAT	String	1	Y	Code classification for mental status. Valid values are: 1 = Oriented 2 = Disoriented 3 = Not yet determined
RESTRAINT	String	1	Y	Code classification for restraint. Valid values are: 1 = Not ordered 2 = Ordered not used 3 = Ordered and used daily
ACTIVITY_PART	String	1	Y	Code classification for activities participation. Valid values are: 1 = Always active 2 = Occasionally active 3 = Rarely active or not active 8 = Not yet determined

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONSULTATION1_FREQ	String	1	Y	Frequency of consultation. Valid values are: 0 = None 1 = Daily 2 = 2 – 3 times per week 3 = Weekly 4 = 2 – 3 times monthly 5 = Monthly 6 = One time only (PRN)
CONSULTATION1_TYPE	String	2	Y	Type of consultation. Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined
CONSULTATION2_FREQ	String	1	Y	Frequency of consultation. Valid values are: 0= None 1 = Daily 2 =2–3 times per week 3 = Weekly 4 =2–3 times monthly 5 = Monthly 6 = One time only (PRN)

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
CONSULTATION2_TYPE	String	2	Y	Type of consultation. Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined
CONSULTATION3_FREQ	String	1	Y	Frequency of consultation. Valid values are: 0 = None 1 = Daily 2 =2–3 times per week 3 = Weekly 4 =2–3 times monthly 5 = Monthly 6 = One time only (PRN)
CONSULTATION3_TYPE	String	2	Y	Type of consultation. Valid values are: 00 = None 01 = Physician 02 = Psychiatrist 03 = Dentist 04 = Podiatrist 05 = Physical therapist 06 = Psychologist 07 = Dietician 08 = Social services 09 = Occupational therapist 10 = Audiologist 11 = Speech therapist 12 = Other 88 = Not determined

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MED1_MED	String	1	Y	Type of medication. Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED1_FREQ	String	1	Y	Frequency of medication. Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only
MED2_MED	String	1	Y	Type of medication. Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED2_FREQ	String	1	Y	Frequency of medication. Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only

Detail Field	Data Type	Length	Required?	Description
MED3_MED	String	1	Y	Type of medication. Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED3_FREQ	String	1	Y	Frequency of medication. Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
MED4_MED	String	1	Y	Type of medication. Valid values are: 0 = None 1 = Tranquilizers 2 = Sedatives/hypnotics 3 = Anti-hypertensive 4 = Narcotics 5 = Pain relievers (non-narcotic) 6 = Anti-psychotics 7 = Antibiotics 8 = Antidepressants
MED4_FREQ	String	1	Y	Frequency that medication is taken. Valid values are: 0 = None 1 = Regularly 2 = PRN 3 = One time only
ACW_ACCIDENT	String	1	Y	Service code for accidents. Valid values are: 1 = Yes 2 = No
ACW_CONTRACTURE	String	1	Y	Service code for contracture. Valid values are: 1 = Yes 2 = No
ACW_WEIGHT_CHG	String	1	Y	Service code for weight change. Valid values are: 1 = Yes 2 = No
PRIM_DIAGNOSIS	Numeric	5	Y	The primary diagnosis coded on the MMQ.
SEC_DIAGNOSIS1	Numeric	5	N	The first secondary diagnosis coded on the MMQ. **For batch submission** If there is no data in this field, do not send this node.

Extra Questions – Required Segment (cont.)

Detail Field	Data Type	Length	Required?	Description
SEC_DIAGNOSIS2	Numeric	5	N	The second secondary diagnosis coded on the MMQ. **For batch submission** If there is no data in this field, do not send this node.
SEC_DIAGNOSIS3	Numeric	5	N	The third secondary diagnosis coded on the MMQ. **For batch submission** If there is no data in this field, do not send this node.

Certification Statement – Required Segment

Detail Field	Data Type	Length	Required?	Description
RN_EVAL	String	35	Y	The name of the registered nurse that conducted the evaluation.
EVAL_DTE	Date	8	Y	The date the MMQ is completed. Date format is YYYYMMDD.
ADMINISTRATOR	String	35	Y	The name of the administrator of the facility.
AFFILIATION	String	1	Y	Enter the appropriate code for the person completing the MMQ. 1 = Nursing facility staff 2 = MassHealth 3 = RN Contractor

Certification Statement – Required Segment (cont.)

DISCHARGE_REASON	String	50	N	The reason for the member's discharge. Discharge reason codes are: 01 = Acute hospital 02 = Chronic hospital 03 = Mental hospital 04 = Another nursing home 05 = Rest home 06 = Private residence w/HM-HHA 07 = Private residence w/o HM-HHA 08 = Private residence w/HHA 09 = Private residence w/o HHA 10 = Other 11 = Deceased 12 = Discharged to unknown sight 13 = Private patient 14 = Medicare patient.
DISCHARGE_DATE	Date	8	N	The date the member was discharged. Date format is YYYYMMDD.

Sample MMQ Batch Submission

The following is a sample of an MMQ batch submission with two MMQ records.

Sample of MMQ Batch Submission (with two MMQ Records)

<submitMemberMMQRequests> **< ---- This is the wrapper node.**
<submitMemberMMQRequest> **< ---- This is the first member MMQ.**
<MEMBER_SUBMIT>
<MMQ_ACTION_IND>PROC_MMQ</MMQ_ACTION_IND>
<PERSONAL_INFO>
<PROVIDER_ID>110000014</PROVIDER_ID>
<SERVICE_LOCATION>A</SERVICE_LOCATION>
<MEMBER_ID>123456789012</MEMBER_ID>
<FACILITY_NAME/>
<DTE_ADMIT>20071001</DTE_ADMIT>
<LAST_NAME>LINCOLN</LAST_NAME>
<FIRST_NAME>TED</FIRST_NAME>
<BIRTH_DTE>19131125</BIRTH_DTE>
<DTE_EFF>20071001</DTE_EFF>
<SUBMIT_REASON>1</SUBMIT_REASON>
</PERSONAL_INFO>
<SERVICE_SECTION_1>
<DISP_MEDS_SCORE/>
<SKILLED_OBSERV_DAILIY_CODE>1</SKILLED_OBSERV_DAILIY_CODE>
<SKILLED_OBSERV_DAILIY_SCORE/>
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Instructions for Completing Initial and Semiannual Management Minutes Questionnaires (MMQs)

General Instructions

- An initial Management Minutes Questionnaire (MMQ) must be submitted for each new MassHealth member at the end of 30 days from the admission date, or at the end of 30 days from the conversion date from private or Medicare coverage to MassHealth coverage. An MMQ must also be submitted semiannually for all MassHealth members who are residents of a nursing facility.
- For new members, codes must reflect the care provided on the effective date forward for 30 days. For established residents, codes must reflect the care provided during the previous month. A temporary condition may not be claimed. A temporary condition is one that requires service for less than 50 percent of the month. All services claimed must be medically necessary.
- The medical record is the source for information to complete the MMQ. Documentation must be complete, accurate, dated, and signed by the person performing the care. The licensed nursing summary, daily licensed nursing notes, physician's orders and progress notes, ADL flow sheets, medication administration records, treatment records, and care plans should all be reviewed to complete the MMQ. Documentation for assistance with activities of daily living must be associated with resident dysfunction, and the reason given for assistance must relate to this dysfunction as described in the medical plan.
- The following terms should not be used in documentation, as they are not specific: frequently, almost always, often mostly dependent, and almost total assist.
- If a member has been in the facility for less than a month, the score is based on 50 percent of the days the resident has been in the facility.
- Initial MMQs and semiannual MMQs must be signed by a registered nurse. Clinical records must document this activity before the information is forwarded to the nursing facility staff who are responsible for preparing the electronic submission of MMQ data.

Medicare

When a member's stay is covered by Medicare, the facility does not need to complete an MMQ.

When Medicare coverage ends, the member is eligible for conversion to MassHealth. The facility must submit an MMQ (Reason Code 2 for conversion) with an effective date of the first day of MassHealth eligibility. Submit the MMQ at the end of the month following the issuance of the member’s 12-digit member identification number.

Completing the Semiannual MMQ

- The semiannual MMQ must be submitted for every MassHealth member who is a resident of the facility on the first day of the reporting period.
- The semiannual MMQ must be completed from documentation for the previous month. It is essential to obtain semiannual MMQ information at the same time for each reporting period.

With each semiannual MMQ, indicate the discharge of a resident who is no longer a MassHealth member as of the first day of the current reporting period. For example, if the effective date of the semiannual MMQ period is July 1, 2009, do not enter a discharge that occurred on July 3, 2009.

Item-by-Item Instructions for Completing the MMQ

Item/Field	Description
Last Name, First, MI	Enter last name, first name, and then middle initial (if no middle initial, leave MI field blank).
MassHealth ID	Use the 12-digit member ID.
Submission Reason Code 1: Admission	The resident is a new MassHealth admission to the facility. Submit the MMQ at the end of 30 days from the admission date following the issuance of the member's 12-digit member ID.
Code 2: Conversion	The resident is a new conversion to MassHealth. Submit the MMQ at the end of 30 days from the date of conversion following the issuance of the member's 12-digit member ID.
Code 3: Category Change	The member's category has changed from the last semiannual assessment. Indicate the changes on an MMQ and submit. For significant change, the nursing facility must have submitted an MDS 2.0. Significant changes include improvement and deterioration. Indicate changes on an MMQ and submit the MMQ with an effective date of the first of the month following the event. There must be at least 15 days of documented changes during the previous month to warrant a significant change submission.
Code 4: Code/Score Change	The scoring or coding for this member changed since the last assessment but the change did not result in a change in category. Indicate changes on the MMQ and submit upon semiannual review.
Code 5	No codes or scores changed for this member since last assessment. Indicate Reason Code 5 on the MMQ and submit upon semiannual review.
Code D: Discharge	The member has been discharged from the facility.
Admission Date	This is the date of admission to the facility.
Effective Date	Start date for the category. Enter the month, day, and year for the date that applies as follows: a. New MassHealth admission: the date of admission to the facility b. Conversion: the first date of MassHealth eligibility c. Semiannual update: the first date of the new period d. Significant change: the first of the month following the significant change.
Date of Birth	The member's date of birth.

Clinical Instructions for the Initial and Semiannual MMQ

To justify the member's casemix score and category, the member's condition and care requirements must be documented for at least 15 days of the month during which the MMQ assessment takes place. If the individual has been a MassHealth member in the facility for less than a month, the score is based on 50 percent of the MassHealth eligible days the member has been in the facility.

In completing the MMQ, information from the physician's orders, monthly nursing summary, nursing progress and daily notes, MDS, care plan, ADL flow sheets, medication record, treatment record, and all pertinent documentation must be reviewed. A licensed nursing summary must be completed monthly (or no later than five days after the end of the month), summarizing all of the care provided to the member.

All documentation must be complete, accurate, dated, and signed by the person performing the care. Prompting, white-out, write-overs, recreating flow sheets, or predetermining documentation is unacceptable. For example, licensed nurses may not indicate how nurse's aides are to complete an ADL flow sheet by highlighting, circling, or otherwise marking items. Only the original writer who made the original entry may change that entry. Late entries, corrections, and addendums must be made within 15 days of the original entry or before the MMQ is submitted, whichever is sooner. To correct an error, draw a single line through the error, leaving the original entry legible, then initial and date the entry.

All MMQs claims must be medically necessary. The member's score and category are based upon the services provided and recorded through the nurse's and nurse's aide's documentation. When conflicting documentation exists, the lower score will be applied.

Justification for assistance with activities of daily living and special attention must be associated with the member's clinical and functional status as documented by the licensed nurse according to the member's care plan.

A service may be claimed as either an intermittent PRN service or a continuous service and only as ordered by the physician and documented in the clinical record. For example, oxygen PRN may be claimed under Item 2 (Skilled Observation Daily), or continuous or daily oxygen may be claimed under Item 12 (Skilled Procedure Daily/Other). Both items cannot be claimed on the same MMQ.

To ensure accuracy and objectivity, the monthly nursing summary must be completed by a licensed nurse who provided direct member care or was directly responsible for the care provided. The licensed nurse who completes the monthly nursing summary cannot complete the MMQs. The MMQ must be completed by a different licensed nurse (RN, LPN) and must be signed by a registered nurse.

Field Descriptions

All fields on the questionnaire are described in detail in this section.

1. Dispense Medications and Chart (includes all routine documentation)

Code 1, Score 30 for all residents

Pouring, delivering, and charting all medications, including psychoactives (see exclusion under Skilled Observation), intermittent I.V. antibiotics, routine injections, PRN medications, eye drops, eye ointments, inhalation aerosols, topical medications, suppositories, miscellaneous brief services such as vital signs that must be taken in conjunction with various medications, routine vital signs, and routine sugar and acetone.

All residents receive 30 points since it reflects the necessary presence of a licensed nurse on duty at the nursing unit. The Code and Score data fields are pre-filled on the data-entry screen.

2. Skilled Observation Daily

No documented observations required - Code 1, Score 0

Daily skilled observations - Code 2, Score 15

A skilled observation must be specifically ordered with parameters in writing by a physician, performed by a licensed nurse, and recorded at least **daily** (for example, neurological signs, B/P, and TPR) over and above any vital signs that must be taken and recorded as a prerequisite for the administration of certain medications.

This also includes any nonroutine measurement of a resident's condition, such as the need for suctioning a resident with a tracheostomy, observation of the edema and/or congestion in a resident with congestive heart failure, the need for oxygen, and blood tests for insulin administration.

This may include the introduction and/or titration of a psychoactive medication for a resident with a diagnosis of a major mental disorder that is defined as one or more of the following:

- schizophrenia;
- major affective disorder;
- atypical psychosis;
- schizoaffective disorder;
- bipolar depression;
- unipolar depression; or
- organic mental syndrome with associated psychotic and/or agitated behavior;

specifically to:

- titrate the dose for maximum effectiveness;
- manage unexpected harmful behaviors that cannot be managed without a psychoactive medication

  Note: The resident's condition must indicate the clinical complexity and justify the need for skilled observation, with documentation of a current or recent episode within the past 60 days. Document the date and type of episode.

Field Descriptions (cont.)

Documentation: Daily licensed nursing documentation must be specific to the observation, including the nursing action and effect. Specific observations must be noted daily on a treatment sheet. Each episode must be documented and dated.

Exclusions:

- routine PRN use or tapering of psychoactive medications;
- aspiration precautions (except in clinically complex situations); and
- monitoring of temperature and signs and symptoms of infection while on antibiotic therapy.

3. Personal Hygiene

Independent - Code 1, Score 0

The resident is independent, assisted only for weekly bath/shower or on a restorative bathing/grooming program. Score 0 if both bathing and grooming are Code 1.

Assist - Code 2, Score 18 (See Note below.)

Nursing procedures by staff to maintain personal cleanliness and good grooming including attending and/or assisting with bathing, shaving, and brushing teeth. Attending means continual supervision while the resident performs the personal hygiene task to ensure completion of the task. Includes routine skin care and the use of all bathing products.

Note: Any degree of resident involvement is considered an assist.

Totally dependent - Code 3, Score 20 (See Note below.)

Bathing and/or grooming completed entirely by nursing staff without assistance from the resident. Bath may take place at bedside, or in a bathing system, shower, or regular tub.

Note: Score is based on the highest level of need in either grooming or bathing.

Example: If the resident is independent in grooming but needs daily assistance in bathing, the codes are Bathing - 2, Grooming - 1, and the score is 18.

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for bathing or grooming, points may not be scored under restorative bathing or grooming program.

4. Dressing

Independent - Code 1, Score 0

This item includes setting out the resident's clothes. Code 1 if the resident is on a restorative dressing program.

Assist - Code 2, Score 30 (See Note below.)

The resident cannot dress and undress without direct physical, or continual instructional, or continual motivational assistance. This item includes application of all splints (for example, Multipodus or L'nard boots), braces, binders, anti-embolism stockings, and cervical collars. Assistance only with socks and shoes may not be claimed.

Field Descriptions (cont.)

Note: Any degree of resident involvement is considered an assist.

Totally dependent - Code 3, Score 30

The resident cannot dress and undress.

Socks and shoes only - Code 4, Score 0

The resident needs assistance with socks, shoes, buttons, bra hooks, or zippers only.

Not dressed - Code 5, Score 0

The resident wearing night clothes only is "not dressed."

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for dressing, points may not be scored under "Restorative Dressing" program.

5. Mobility

Mobility describes how the resident walks indoors, once in a standing position, or wheels once in a wheelchair. Transfer (Item 16) describes how the resident gets to the standing or sitting position.

Independent - Code 1, Score 0

The resident is independent if no staff intervention is necessary. This includes the resident who walks with the assistance of equipment (e.g., uses a walker or a cane or wears a wanderguard). Code 1 if the resident is on a "Restorative Ambulation" program.

Independent with wheelchair - Code 2, Score 0

Walks with assist - Code 3, Score 32

The resident can bear own weight but must be physically steadied (one on one) or guided (standby guard) in ambulation by nursing staff, or the resident must be continually monitored, supervised, and given verbal instructions.

Wheelchair with assist - Code 4, Score 32

Wheelchair resident who cannot move or propel alone, or appropriately, because of mental or physical state, or the resident must be continually monitored, supervised, and given verbal instructions.

Nonambulatory/bedbound - Code 5, Score 0

The resident does not move out of his or her bed (nonmobile, bedbound, or bed-to-chair only).

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

Note: If points are scored for mobility/ambulation, points may not be scored under "Restorative Ambulation" program.

Field Descriptions (cont.)

6. Eating

Independent - Code 1, Score 0

A resident requiring standard tray preparation (uncover all items on tray, open milk carton) but needs no help eating, is independent. Cutting up meat is considered standard tray preparation. Code 1 if the resident is on "Restorative Feeding" program.

Assist - Code 2, Score 20 (See Note below.)

The resident can bring food to mouth. The resident requires intervention by caregiver, including direct physical assistance, or continual individual or small-group supervision (at a ratio no greater than one staff to eight residents) during the entire mealtime.

Note: Any degree of resident involvement is considered an assist.

Totally dependent - Code 3, Score 45

The resident is fed by the nursing staff. This item includes syringe feeding when approved in writing by the physician.

Tube fed - Code 4, Score 90

This applies to the resident who is being tube fed only.

I.V. - Code 5, Score 90

This applies to the resident receiving I.V. therapy, or TPN for total nutrition and hydration. I.V. may be scored if required for more than five days of the month.

Tube fed and assist - Code 6, Score 110

In those documented instances where a resident is tube fed and needs assistance with eating.

Tube fed and totally dependent - Code 7, Score 135

In those documented instances where a resident is tube fed and is totally dependent in eating.

Tube fed and I.V. - Code 8, Score 135

This covers the rare instance of a resident receiving both tube feeding and an I.V. (Do not also take points as a "Skilled Procedure," Item 12.)

I.V. therapy refers to nutrition and hydration.

Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident and the amount of supervision required.

Note: If points are scored for feeding, points may not be scored under "Restorative Feeding" program.

7. Continence/Catheter

Continent - Code 1, Score 0

The resident is continent or able to request assistance with toileting. Includes the resident who is dependent for transfers but is able to request assistance in advance of need.

Incontinent occasionally - Code 2, Score 0

"Occasionally" is defined as less than 15 days of the month. Use this code for the residents on bowel and bladder retraining.

Field Descriptions (cont.)

Incontinent and toileted - Code 3, Score 48

This applies to the resident whose continence is maintained only through regular staff assistance in advance of need. The resident is not able to request assistance but is toileted at least every two hours, or three to four times per shift. Includes incontinent care.

Incontinent - Code 4, Score 48

This applies to regular incontinence due to the resident's inability to control micturition or bowels, or to notify staff of need, and includes incontinent care. (Cannot claim bladder incontinence if the resident is on a bladder-retraining program. Cannot claim bowel incontinence if the resident is on a bowel-retraining program). This service may be claimed if the resident is regularly incontinent at any time during the 24-hour period or requires routine colostomy, ileostomy, or urostomy care.

Indwelling catheter - Code 5, Score 20

Prescribed by a physician. Includes insertion, maintenance, catheter care, and cystostomy care and irrigation, if less than daily. (Cannot claim if the resident is on bladder-retraining program, Item 8).

Please note that when catheter is irrigated at least daily the service may be claimed as a "Skilled Procedure" in Item 12.

Bowel incontinent and bladder retraining - Score 18

Enter Code 2 for bladder and Code 6 for bowel. Points for Bladder Retraining should be taken in Item 8.

Documentation: The licensed nursing summary must verify ADL status at least monthly. The ADL flow sheet must document daily functional status of the resident.

Score for continence is based on the highest level of need in either Bladder or Bowel.

Example: If Bladder is Code 4, Incontinent, and Bowel is Code 2, Incontinent occasionally, Score 48.

Exception: If Bladder is Code 5, Indwelling catheter, and Bowel is Code 3, Incontinent and toileted, or Code 4, Incontinent, Score 38.

8. Bladder/Bowel Retraining

No retraining received - Code 1, Score 0

Bladder retraining - Code 2, Score 50

A planned and documented program designed to reduce incontinence of urine. Include intermittent catheterization or clamping procedure for bladder retraining here, not to exceed 90 days. Routine toileting to prevent incontinence does not constitute a retraining program. Cannot claim in combination with "Bladder Incontinence," Item 7.

Bowel retraining - Code 3, Score 18

A planned and documented program designed to reduce incontinence of feces, not to exceed 90 days. Cannot be claimed in combination with "Bowel Incontinence," Item 7.

Bladder and bowel retraining - Code 4, Score 68

Residents on both a bladder and bowel retraining program must meet the requirements listed above.

Documentation: The monthly licensed nursing summary must verify the start date, the goal of the program, the resident's progress or lack thereof, and any revisions to the plan of care. The ADL flow sheet must document the daily functional status of the resident.

Note: The clinical record must contain evidence that the resident has the capacity to comprehend and to participate in a program of bladder and bowel retraining.

Field Descriptions (cont.)

9. Positioning

Independent - Code 1, Score 0

Assist - Code 2, Score 36

The resident is essentially helpless to assist himself or herself and must be positioned every two hours while in bed or chair. Adjustment of restraints and routine skin care are provided in conjunction with position change.

Documentation: The Licensed Nursing Summary must specify the resident's functional status and frequency of positioning and must indicate a reason for the assistance. Daily documentation must specify frequency and position on a positioning sheet or a restraint sheet.

10. Pressure Ulcer Prevention

No preventive measures - Code 1, Score 0

Preventive measures - Code 2, Score 10

Pressure ulcer prevention includes routine diabetic foot care or the use of elbow or heel protectors or handrolls. It may include the use of over-the-counter (nonprescription) creams such as: Desitin, Eucerin, A&D, Vaseline, Aloe Vesta, and Sween Cream, which are used to provide an extra increment of care. There must be documentation of a previous pressure ulcer and/or a current risk assessment using the Braden or Norton scale to indicate moderate or high risk of skin breakdown.

Note:

1. Points cannot be taken for the use of an air/water mattress, egg-crate pad, sheepskin, or foot cradles.
2. Incontinent treatment does not necessitate the need for preventive measures, unless the resident has had documented previous skin breakdown.
3. This item is concerned solely with preventive measures. The following item applies to the treatment of an existing condition.

Documentation: The daily nursing documentation must be specific to indicate the type of care, frequency, and site of application. The monthly licensed nursing summary must specify the reason for preventive measures (previous skin breakdown or current risk assessment). Only the Braden or Norton scale, which must have been completed within the previous 90 days, will be accepted, or the skin breakdown must have been documented within the previous 90 days.

11. Skilled Procedure Daily/Pressure Ulcer

Code the daily frequency of procedures administered (maximum of nine). Enter 0 if no treatments are ordered.

Procedures must be specifically ordered by a physician in writing and must be performed by a licensed nurse. Multiple pressure ulcers at the same or different locations are considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing.

Multiply daily frequency of each procedure by 10 and enter the total score.

Field Descriptions (cont.)

Note: In rare situations, different treatments may be ordered for multiple pressure ulcers in different locations. This may be claimed as more than one treatment.

Identify the number of pressure ulcers in each stage (maximum of nine).

Documentation: Daily licensed nursing documentation must be recorded on the treatment sheet. At least weekly, the licensed nurse must record description, size, stage, treatment, and progress of pressure ulcer or ulcers on the treatment sheet.

Clinical stages are described as follows:

Stage 1 Pre-Ulcer: Characterized by unbroken skin surface. An area of induration, erythema, or blue/black discoloration of the skin that does not fade within 30 minutes after pressure has been removed.

Stage 2 Ulcer: Moist, irregular, partial-thickness ulceration limited to the superficial epidermal and dermal layers.

Stage 3 Ulcer: Full thickness extending into the subcutaneous adipose tissue.

Stage 4 Ulcer: Necrotic ulcer extending into muscle, bone, or joint structure.

12. Skilled Procedure Daily/Other

Skilled procedures are procedures or treatments, other than pressure ulcer treatment, specifically ordered by a physician in writing that must be performed by a licensed nurse. See list of procedures below.

Code the daily frequency of skilled procedures in the single box (maximum of 9). Code 0 if no skilled procedures are needed. If more than one procedure is done daily, add the daily frequency for each procedure and enter the code.

Example: If one procedure is done twice a day and another is done three times a day, the code is 5.

Multiply the sum of the daily frequency of each procedure or treatment by 10 and enter the total on the score line.

Respiratory therapy, continuous or daily oxygen, oxygen therapy, suctioning, and continuous bladder irrigation may be claimed for a maximum of one time per shift. The same treatment to different locations is considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing. Topical medications requiring a prescription may be scored for a maximum of 20 points for a dermatological condition involving epidermal and dermal layers of skin.

Documentation: Daily licensed nursing documentation must specify treatment, frequency, description, and outcome. Specific observations must be recorded daily on a treatment sheet.

Enter appropriate procedure code(s) in the double boxes provided:

00 - None

01 - Dressing change

02 - Catheter irrigation

03 - Intermittent catheterization

04 - Eye irrigation

05 - Ear irrigation

06 - Care of heparin locks

07 - Oxygen therapy (continuous or daily therapy)

Field Descriptions (cont.)

08 - Tracheostomy care

09 - Sterile dressing

10 - Suctioning

11 - Not in use at this time

12 - Respiratory therapy (includes the use of inhalation aerosols for the management of episodes of bronchospasm)

13 - New colostomy irrigation

14 - Other

13. Special Attention

Coding: A code must be entered for each box A through D. (See Note below for Box C.) Code 0 if not applicable. Code 1 if special attention was required for 15 days of the month reviewed (or 50 percent of the total days if less than a full month).

A. Immobility: Code 1 if the resident is so heavy, helpless, or combative that two or more people are needed to change position, transfer, or ambulate. This includes use of mechanical lifting devices, for example, a Hoyer lift. The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must record the daily functional status.

B. Severe spasticity or Rigidity: Code 1 if the problem is of such magnitude that it severely limits personal care or ambulation, requiring two or more people. The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must code the daily functional status.

C. Behavioral problems: Code 1, 2, or 3 may be used for behavioral problems. The disruptive behavior interferes with staff and/or other residents, causing the staff to stop or change what they are doing to control or alleviate the following disruptive behaviors:

i. Wandering - moves with no rational purpose, appears oblivious to needs or safety.

ii. Verbally abusive - threatens, screams, or curses.

iii. Physically abusive - hits, shoves, scratches, or sexually abuses others.

iv. Socially inappropriate or disruptive behavior - performs self-abusive acts, exhibits sexual behavior or disrobes in public, smears or throws food or feces, or rummages through others' belongings.

Note:

- Code 1 if behavior and intervention have been documented for 15-22 days.
- Code 2 if behavior and intervention have been documented for 23-29 days.
- Code 3 if behavior and intervention have been documented for 30 or 31 days.

Documentation: For Code 1, 2, or 3, a current active treatment plan for behavioral problems must be in the medical record.

For Code 1, the licensed nursing summary must verify and summarize the daily documented behavior(s), frequency, intervention(s), and the outcome of intervention(s).

For Code 2 or 3, the daily nursing documentation must specify behaviors, frequency, interventions, and outcome of interventions.

For Code 2 or 3, a psychiatric assessment must document the disruptive behavior.

Field Descriptions (cont.)

D. Isolation: Code 1 if gowns and gloves are required due to communicable infection or severely impaired immune status; must be over and above universal precautions.

14. Restorative Nursing

Restorative nursing refers to care procedures that may require relearning after an illness such as a fractured hip or CVA.

Implementation of specific types of resident reteaching conducted at least five times per week by nursing staff. Intervention and progress must be well documented daily, with time limits and goals clearly stated. This may only be claimed for a period not to exceed 90 days.

May claim points only for the limited time necessary to achieve the stated care plan objective or to prove it impractical, as shown by progress or lack of progress. Time limits for such services as ADL training, ostomy teaching, diabetic teaching, and restorative eating participation are those established during the resident-care planning process (maximum of 90 days).

Code - Enter procedure types in the boxes.

Note: The clinical record must contain evidence that the patient has the capacity to comprehend and to participate in the restorative program.

0 - None required

1 - Activities of daily living - dressing

2 - Activities of daily living - personal hygiene

3 - Activities of daily living - restorative eating

4 - Ostomy care/teaching

5 - Diabetic teaching

6 - Ambulation

7 - Range of motion

Score - Enter 30 if any restorative nursing procedures are administered. The maximum score for this item is 30, regardless of the number of programs implemented. Enter 0 if none was provided.

Documentation: The monthly licensed nursing summary must verify time limits, not to exceed 90 days, goals, progress, or lack of progress. The ADL flow sheet must document the daily functional status of the resident.

Note: No points are connected with the next 10 items. All items must have entries.

15. Toilet Use (use of toileting equipment)

Toilet use refers to how the resident uses the toilet, bedpan, urinal, or commode, including transferring, if necessary, or positioning a bedpan/urinal, cleansing after elimination, and adjusting clothes prior to and after using the toilet. The process involved in getting to the toilet may not be included here.

Code 1 - Independent

Code 2 - Assist

Code 3 - Totally dependent

Code 4 - Not toileted (includes residents who do not use toileting equipment because of incontinence or because they have a catheter)

Field Descriptions (cont.)

16. Transfer

Transfer refers to how the resident gets to the standing position or to sitting in a wheelchair. Mobility (Item 5) is how the resident walks indoors, once in a standing position, or wheels once in a wheelchair.

Code 1 - Independent

Code 2 - Assist

Code 3 - Totally dependent

Code 4 - Bedbound

17. Mental Status

Inability to remember dates or time, identify familiar locations or people, recall important aspects of recent events, or make straightforward judgments of such recent events, or make straightforward judgments of such a degree that the resident is impaired nearly every day in performance of basic activities of daily living, mobility, and adaptive tasks. Code as follows:

Code 1 - Resident is not disoriented or impaired in memory.

Code 2 - Resident is disoriented or impaired in memory daily.

Code 3 - Mental status is not determined (includes only new admissions and those residents unable to communicate).

18. Restraint

Code 1 - The resident does not have a written order for restraints.

Code 2 - Restraint is ordered but not used on a regular daily basis.

Code 3 - Restraint is ordered and used daily.

19. Activities Participation

Code 1 - Always active

Code 2 - Occasionally active

Code 3 - Rarely active or not active

Code 8 - Not yet determined

20. Consultations

Consultation is defined as a direct visit to a specific resident for reasons other than the required routine visit or admission screening.

Field Descriptions (cont.)

Type: Note which type of consultation occurred by entering the appropriate code in the column marked "Type." (If more than three types apply, list the three that are most frequent.) Enter 00 if none and 88 if not determined in the first set of boxes.

00 - None
01 - Physician
02 - Psychiatrist
03 - Dentist
04 - Podiatrist
05 - Physical therapist
06 - Psychologist
07 - Dietitian
08 - Social service
09 - Occupational therapist
10 - Audiologist
11 - Speech therapist
12 - Other
88 - Not determined

Frequency: Note the respective frequency of each consultation by entering the appropriate code(s) in the column marked "Freq.".

0 - None
1 - Daily
2 - 2-3 times per week
3 - Weekly
4 - 2-3 times monthly
5 – Monthly
6 - One time only (PRN)

21. Medications

If selected types of medications have been ordered and administered, indicate the type of medication in the row marked "Medications" using codes below. (Enter first code in the first box.) Enter 0 if none. Medications administered but that are not listed below should not be counted. Under each medication indicate the frequency using the codes below. Only codes listed in the instructions should be used. If more than four medications are administered, enter the ones administered most frequently.

Field Descriptions (cont.)

Medications (Prescription Only)	Frequency
0 - None	0 - None
1 - Tranquilizers	1 - Regularly
2 - Sedatives/Hypnotics	2 - PRN
3 - Antihypertensives	3 - One time only
4 - Narcotics	(includes 10-day order for antibiotics)
5 - Pain relievers (non-narcotics)	
6 - Antipsychotics	
7 - Antibiotics	
8 - Antidepressants	

22. Accidents/Contractures/Weight Change

Indicate whether or not the resident has experienced an accident (an accident or incident report was completed) or weight change during the month by entering the appropriate code in each box:

1 - Yes

2 - No

Note: A weight change is defined as an unplanned gain of eight or more pounds or loss of five or more pounds. (A weight change is considered planned when a resident is on a supplement diet, reduction diet, or diuretic program.)

Indicate whether the patient has any contractures by entering the following code in the box marked "C."

1 – Yes

2 – No

23. Primary Diagnosis

Use ICD-9-CM codes to indicate the diagnosis that is the principle reason for the resident's need for nursing facility services.

24. Secondary Diagnosis(es)

List up to three ICD-9-CM codes for the conditions that have a major relationship to the resident's activities of daily living (ADLs) or cognitive or behavioral status. Leave blank if no secondary diagnoses are present.

Note: ICD-9-CM code books are generally available at major booksellers.

25. Name of Registered Nurse Evaluator

"The undersigned certifies, under penalty of perjury, that the MMQ is a true and correct statement of the documented nursing services provided to the above named member."

The name of the facility's registered nurse completing the MMQ form certifies that the information on the questionnaire is complete, valid, and accurate.

Field Descriptions (cont.)

26. Evaluation Date

Enter the date the MMQ is completed

27. Name of Administrator

"The undersigned certifies, under penalty of perjury, that the MMQ is a true and correct statement of the documented nursing services provided to the above named member."

The name of the facility's administrator certifies that the information on the questionnaire is accurate, valid, and complete.

28. Affiliation

Enter the appropriate code for the person completing the MMQ.

Code 1 - Nursing facility staff
Code 2 - MassHealth
Code 3 - RN contractor

29. Discharge Reason

If the reason for submission is "D" (discharge) then enter the discharge reason. Discharge reason codes are as follows.

01 - Acute hospital
02 - Chronic hospital
03 - Mental hospital
04 - Another nursing home
05 - Rest home
06 - Private residence w/HM-HHA
07 - Private residence w/o HM-HHA
08 - Private residence w/HHA
09 - Private residence w/o HHA
10 - Other
11 - Deceased
12 - Discharged to unknown sight
13 - Private patient
14 - Medicare patient

30. Discharge Date

If the reason for submission is "D" (discharge) then enter the date of discharge.