

# MDS 3.0: Updates for Quality of Care and Beyond

# Presented by: HARMONY UNIVERSITY

*The Provider Unit of* Harmony Healthcare International, Inc.

\*PPS & Case Mix Onsite Chart Audits \*MMQ Audits \*Seminars \*Consulting \*Program Development \*Mock Survey \*Sample RAC Reviews \*JCAHO \*5 Star Rating Analysis

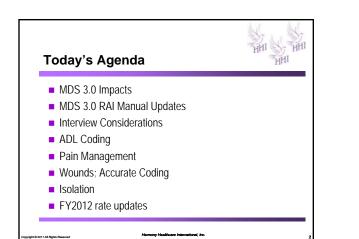
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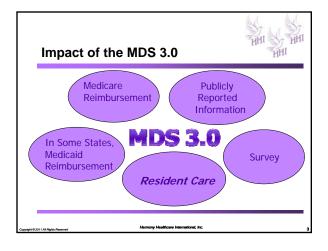


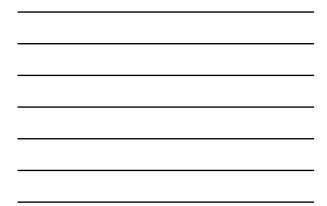


# MDS 3.0: Updates for Quality of Care and Beyond

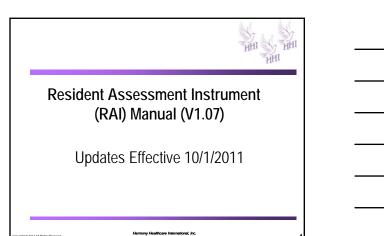
Sponsored by: Wyoming Department of Health, Aging Division Healthcare Licensing and Surveys and Mountain Pacific Quality Health Presented by: Elisa Bovee Harmony Healthcare International, Inc.











# Background

Chapter 1

- CMS released the RAI User's Manual (V1.07) on August 31, 2011
- Updates become effective October 1, 2011.
- Until October 1, 2011, clinicians must continue to use the RAI User's Manual (V1.05) from May 2011

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- Minor edits and formatting changes made
- CMS also reiterates the regulatory requirements related to MDS and reminds facility staff of the multiple regulatory requirements addressing the RAI process.

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### **Regulations require:**

- The assessment accurately reflects the resident's status;
- A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; and
- The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

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# Nursing homes are left to determine...



- Who should participate in the assessment process;
- How the assessment process is completed; and
- How the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within the RAI User's Manual.

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# Chapter 2



CMS clarifies that when retaining 15 months of RAIs in the active medical record, the exception is that demographic information (Items A0500-A1600) from the most recent admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated.

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# Chapter 2



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# Regarding setting the ARD:

- ◆ CMS stressed (in accordance with what was previously stated in the 2009 Final Rule) that the facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment.
- ◆ On the 9/1/2011 Open Door Forum (ODF), CMS stated further clarification regarding this is forthcoming.

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- Additional examples have been provided regarding OBRA scheduling and timing, including regarding significant change examples.
- Multiple updates and clarifications have been made to the PPS Scheduling information according to the Final Rule.

Changes to MDS 3.0 Assessment Schedule & HI Strike Other Medicare-Required Assessments

• The combination of the current grace period allowance and observation period could cause MDS assessments to be performed in such a way that some of the information coded on a subsequent assessment is duplicative of the previous assessment.

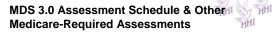


# Changes to MDS 3.0 Assessment Schedule & Other Medicare-Required Assessments

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- Because the observation periods overlap so closely, changes in the patient's status are not reflected as originally intended.
- CMS will modify the current Medicare-required assessment schedule (table A) to incorporate new assessment windows and grace days, as indicated in (table B), with appropriate changes to be made in the RAI Manual.

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Current MDS 3.0 Assessment Schedule

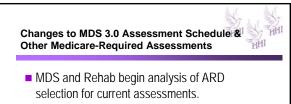
MDS Assessment/Type	Assessment Reference Date	Grace Days	Reason for Assessment (A0310B code)	Medicare Payment Days
5 Day /Return	1-5	6-8	01	1-14
14 Day	11-14	15-19	02	15-30
30 Day Full	21-29	30-34	03	31-60
60 Day Full	50-59	60-64	04	61-90
90 Day Full	80-89	90-94	05	91-100

	1				1
MDS Assessment/Type	Assessment Reference Date	Grace Days	# of Eliminated Days	Reason for Assessment (A0310B code)	Medica Paymer Days
5 Day /Return	1-5	6-8	0	01	1-14
14 Day	13-14	15-18	3	02	15-30
30 Day Full	27-29	30-33	7	03	31-60
60 Day Full	57-59	60-63	7	04	61-90
90 Day Full	87-89	90-93	7	05	91-100



# Changes to MDS 3.0 Assessment Schedule & HHI Other Medicare-Required Assessments

- Improve patient and provider satisfaction and care quality.
- Not necessary to repeat interview questions and assessment items required on the MDS assessments within such a short period of time.



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Case manage toward new schedule.

## **Assessment Combination**

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- A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window—the two assessments must be combined with an ARD appropriate to the unscheduled assessment.

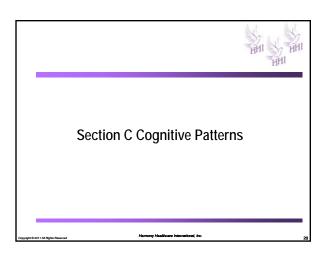


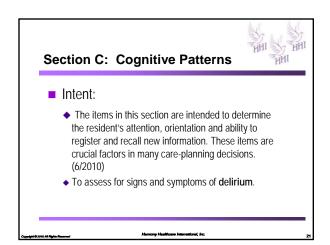
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# Assessment Combination

If a scheduled assessment has been completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment.

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Brief Interview for Mental Status (BIMS).

Section C: New Additions

- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
- Confusion Assessment Method (CAM) to identify signs and symptoms of delirium.



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# C0500: Summary Score

- Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:
  - 13-15: Cognitively intact
  - 8-12: Moderately impaired
  - 0-7: Severe impairment

# MDS 3.0 FAQs **Section C: Cognitive Patterns**

- HHI HHI HHI
- **Question:** Can the BIMS replace the Mini Mental Status Exam (MMSE), or should both be administered?
- Answer: The BIMS can replace the MMSE. If a facility chooses to have both assessments administered be aware of inconsistencies.

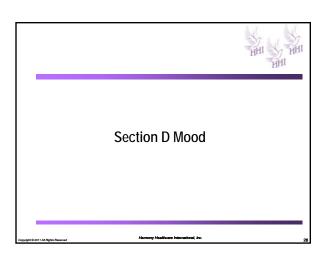


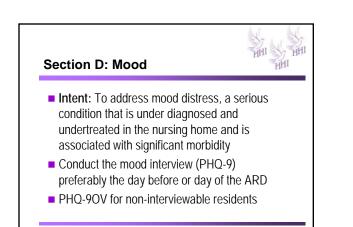
# RAI Manual Update: Chapter 3 – Section C



- CMS clarified that while conducting the Brief Interview for Mental Status (BIMS):
  - Interviewers need to use the words and related category cues as indicated.
  - If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.

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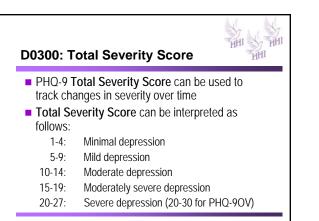




# A Key Point from the RAI Manual

- ...the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder
- Assessors do not make or assign a diagnosis in Section D, they simply record the presence or absence of specific clinical mood indicators

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# D0200: Mood Interview (PHQ-9)

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- Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood
- Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician



# Practice/Policy Implications and and and and **Potential Staff Education Needs**



- Provider notification of PHQ-9 changes
- Investigation of actual mood issue and root causes
- PHQ-9 is a single point in time interview
- PHQ-9OV should include information from all shifts and disciplines
- The primary CNA should not be the only source of information - let's talk about why!

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■ Follow up plan for D02001 = 1



# D0200: Mood Interview (PHQ-9)

Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

# D0500: Staff Assessment of **Resident Mood (PHQ-9-OV)**



- Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
- Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.
- If frequency cannot be coded because the resident has been in the facility for less than 14 days, talk to family or significant other and review transfer records to inform the selection of a frequency code.





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### Section D: Mood (PHQ-9)

- Accuracy in coding will reflect the additional care required for patients suffering from mood disorders.
- Compare PHQ-9 scores from assessment to assessment.
- 5, 14 and 30-Day assessments; investigate variances in scores in Section D.

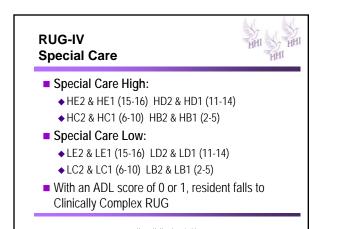
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# RUG-IV Depression End Splits

- Depression End Splits: Signs and symptoms of depression are used as a third-level split for the Special Care and Clinically Complex categories
  - D0300 PHQ-9 Total Severity Score is greater than or equal to 10 but not 99
  - or • D0600 PHQ-9OV Total Severity Score is greater

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than or equal to 10





# ADL Coding and Scoring



# **Section G: Functional Status**

### Intent:

- To assess the need for assistance with activities of daily living, altered gait and balance, and decreased range of motion
- Upon admission, assess the rehabilitation potential of the patient
- Added newly detailed balance assessment designed to guide staff in identifying parts of gait and transition that relate to fall risk

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# Section G: Coding Changes from MDS 2.0

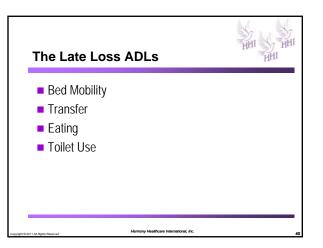


- A new coding level of "7" "Activity occurred only once or twice" added
- Added new language to "0" "Independent"
- Assistance can be provided by facility staff only

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No look-back into the hospital





# The Late Loss ADLs Defined

 Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

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 Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)

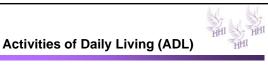
# The Late Loss ADLs Defined

- pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)
- Toilet use how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag



# HHI HHI Activities of Daily Living (ADL) HHI Activity occurred three or more times:

- 0. Independent: No help or staff oversight for the entire observation period 1. Supervision: Oversight, encouragement or cueing
- 2. Limited Assistance: Resident highly involved in activity; staff provide guided maneuvering of limbs or other non-
- weight bearing assistance 3. Extensive Assistance: Resident involved in activity, staff provide weight-bearing support
- 4. Total Dependence: Full staff performance every time
- during entire 7 day period Harmony Healthcare Inte



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Activity Occurred 2 or Fewer Times

7. Activity occurred only once or twice activity did occur but only once or twice

8. Activity did not occur - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7 day period

# HHI HHI Activities of Daily Living (ADL) HHI ADL Support Provided: Code for most support provided over all shifts; code regardless of resident's self-performance classification Coding: 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist

- 3. Two+ persons physical assist
- 8. ADL activity itself did not occur during entire period



## Section G: HHI HHI Principles of Accurate Assessment

- 7-day look-back period
- Assess
- Observe
- Consult with all interdisciplinary team across all shifts for accurate assist levels provided

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- Ask probing questions, beginning with the general and proceeding to the more specific
- Consider subtasks

# Practice/Policy Implications and Potential Staff Education Needs

- Documentation to support coding is a must
- Focus on four late loss ADLs
- Accuracy begins at the bedside with the C.N.A. – don't forget the night C.N.A.
- Always double check Bed Mobility with a score of less than 3/3 and when Toilet Use is coded less than Transfer

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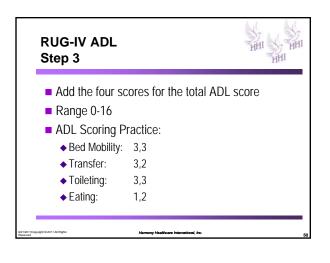
-	RUG-IV ADL Step 1		HHI	HHI
ł	To calculate the ADL scc mobility (G0110A), tra (G0110I).			
	Self-Performance Column 1	Support Column 2	ADL Score	
	-,0,1,7 or 8	Any number	0	
	2	Any number	1	
	3	-,0-2	2	
	4	-,0-2	3	
	3 or 4	3	4	
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	IG-IV ADL ep 2		HHI	НН
	o calculate the ADL sco Illowing chart.	re for <b>eating (G011</b>	<b>0H)</b> , use the	
Se	elf-Performance Column 1	Support Column 2	ADL Score	
	-,0,1,2, 7 or 8	-,0, 1,8	0	
	-,0,1,2, 7 or 8	2 or 3	2	
	3 or 4	-,0, 1	2	
	3	2 or 3	3	
	4	2 or 3	4	



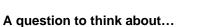


ADL Scoring A	Answers	HHI
ADL Scoring A	nswers:	
Bed Mobility:	3,3 = 4	
♦ Transfer:	3,2 = 2	
♦ Toileting:	3,3 = 4	
Eating:	<u>1,2 = 2</u>	
Total	12	
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# Section J Health Conditions





What is the number one reason for suboptimal pain management by healthcare professionals?

# Other Barriers to Pain Assessment Handlor Management

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- Resident-centered
- Concerned about addiction
- Beliefs that pain means disease is worsening
- Not wanted to bother staff
   Fear of analgesia side effects
- Family-centered
   Concerns that pain meds
- cause drowsiness ◆ Lack of education
- regarding disease processes/pain
- Speaks for a loved-one rather than allowing the resident to answer regarding pain

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and/or Management Staff-centered Inadequate knowledge of pain assessment and management Lack of time to conduct assessment Lack of communication among health care	<ul> <li>Staff-centered (continued)</li> <li>Concern about causing addiction or physical dependence</li> <li>PRNs not given unless resident asks</li> <li>Failure to recognize pain in</li> </ul>
providers Fear of analgesia side effects (i.e., respiratory depression) Failure to coordinate care around pain regimen	cognitively and/or communicatively impaired resident Failure to educate frontline staff regarding pain

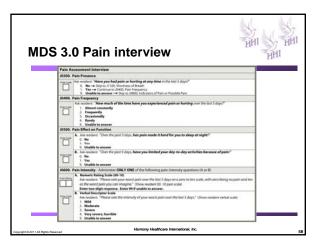


# The RAI Manual Definition of Pain

- Any type of physical pain or discomfort in any part of the body.
- It may be localized to one area or may be more generalized.
- It may be acute or chronic, continuous or intermittent, or occur at rest or with movement.
- Pain is very subjective: *pain is whatever the experiencing person says it is* and exists whenever he or she says it does.

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# J0300-J0600: Pain Assessment

- It is preferable to conduct the interview the day of or day before ARD
- Five day look-back
- Stop interview and go to staff assessment if the resident is unable to answer J0300, Pain Presence or J0400, Pain Frequency
- If J0300 = 0 (No), the pain interview is done.
- If the resident successfully answers J0300 and J0400, the interview is done (but all questions should be attempted).

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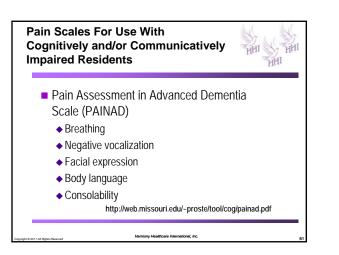
# Staff Assessment for Pain

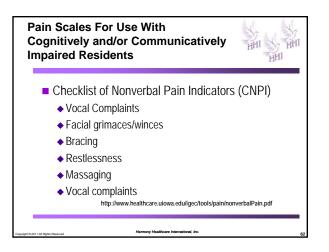


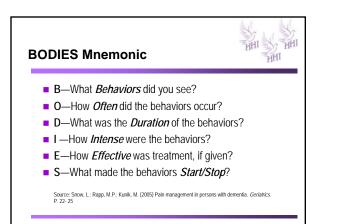
- Note any indicators of pain present in the last five days in J0800
- In J0850, note the number of days the indicators have been present
- To complete the assessment: review the record, interview staff and observe the resident

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# **Policy Considerations**



- Pain assessment
- Positioning issues always consider pain
- Pre-medications for potentially painful treatments

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- Frontline staff reporting process
- Family/resident education
- TEAM approach
- Non-medication interventions
- MDDs



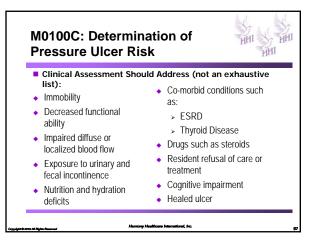
# Section M: Skin Conditions

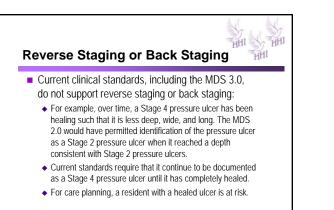
### Then.

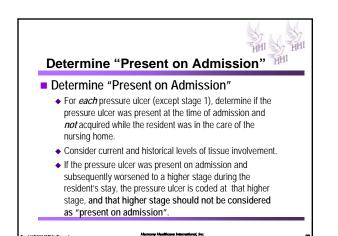
- To document the risk, presence, appearance, and change of pressure ulcers.
- This section notes other skin ulcers, wounds, or lesions.
- Also includes information to capture some treatment categories related to skin injury and avoiding injury.

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# Determine "Present on Admission"

- Determining "Present on Admission" (cont.)
  - If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer *should not be coded as "present on admission"* because it was present at the residential facility prior to the hospitalization.
  - If a current pressure ulcer worsens to a higher stage during hospitalization, it is coded at the higher stage upon reentry and should be coded as "present on admission."

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# Pressure Ulcer Stages

- Stages 1-4
- Unstageable due to a non-removable dressing
- Unstageable due to slough and/or eschar
- Unstageable due to suspected deep tissue injury (sDTI)

# Pressure Ulcer Staging: Unstageable



Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and stage cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

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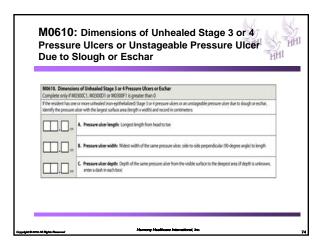


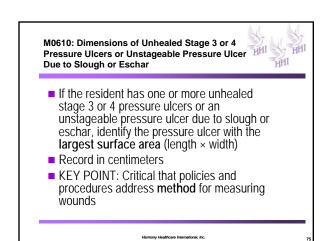
# Skin Definitions

Deep Tissue Injury: Purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue. The adjacent or surrounding areas may be painful, firm, mushy, boggy, warm or cool. DTI may be difficult to detect in dark skinned tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

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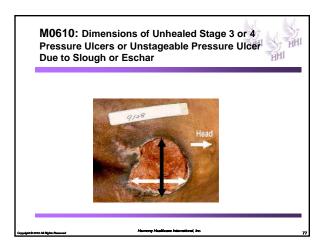


### M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar

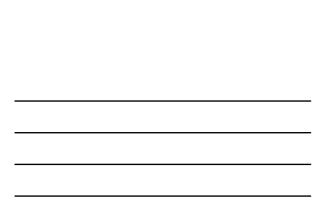
### Coding Instructions:

- M0610A: Enter the current longest length (head to toe measurement) of the <u>largest</u> Stage 3 or 4 or unstageable pressure ulcer due to slough or eschar in <u>centimeters</u> to one decimal point (e.g., 2.3cm.).
- M0610B: Measure the <u>widest width</u> (hip to hip) of the largest Stage 3 or 4 or unstageable pressure ulcer due to slough or eschar in <u>centimeters</u> to one decimal point (e.g., 2.3cm.).

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<b>M</b> 1	200: Skin and Ulcer Treatments
	Skin and Ulcer Treatments
+ 1	Check all that apply
Ц	A. Pressure reducing device for chair
0	B. Pressure reducing device for bed
	C. Turning/repositioning program
	D. Nutrition or hydration intervention to manage skin problems
	E. Ulcer care
	F. Surgical wound care
	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
	H. Applications of elements/medications other than to feet
	1. Application of dressings to feet (with or without topical medications)
	Z. None of the above were provided





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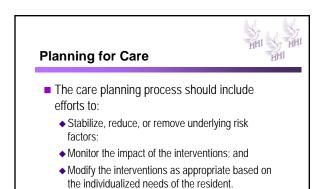
### M1200: Skin and Ulcer Treatments

Chapter 3 – Section M

- When coding M1200G Application of Non-Surgical Dressings, do not include Band-Aids
- Much clarifying information has been added to directions for coding M1200D Nutrition or Hydration Intervention to Manage Skin Problems including that determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment

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• Examples added to clarify coding for M1200



# Providing Care to Prevent and Treat Pressure Ulcers



- The facility should have a system/procedure to assure:
  - Assessments are timely and appropriate;
  - Interventions are implemented, monitored, and revised as appropriate; and
  - Changes in condition are recognized, evaluated, reported to the practitioner, and addressed.



# Section O Isolation

## O0100: Special Treatments and Procedures

- O0100M: Isolation or quarantine for active infectious disease does not include standard body/fluid precautions
  - Code only when the resident requires strict isolation or quarantine in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease in an attempt to prevent spread of illness.

# O0100: Special Treatments and Procedures



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O0100M: Isolation or quarantine (cont.)

- Do not code this item if the resident only has a history of infectious disease (e.g., MRSA or C-Diff with no active symptoms), but facility policy requires cohorting of similar infectious disease conditions.
- Do not code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone.

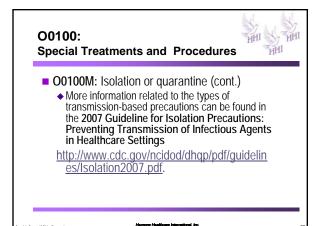


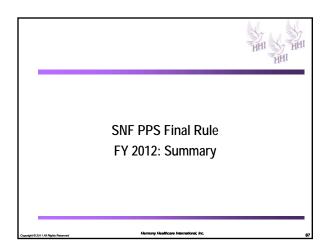
### O0100: Special Treatments and Procedures



Code this item only if a resident is in a room alone <u>because of active infection and cannot</u> <u>have a roommate.</u>

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# SNF PPS Final Rule FY 2012: Summary



- FY2012 Rate Updates
- Group Therapy
- End of Therapy (EOT) OMRA; Definition
- End of Therapy-Resumption (EOT-R)
- Change in Therapy (COT) OMRA
- Therapy Documentation
- Therapy Students

# SNF PPS Final Rule FY 2012: Summary



 SNF PPS Proposed Rule was posted by CMS on May 6, 2011

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- The Final Rule was posted on July 29, 2011
- Effective October 1, 2011 (FY 2012)

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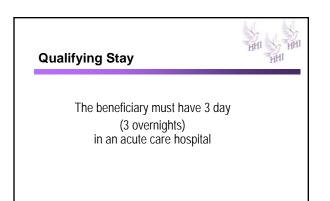
# **Medicare Eligibility**

Treated for a condition which was treated during a qualified stay...or... which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital.

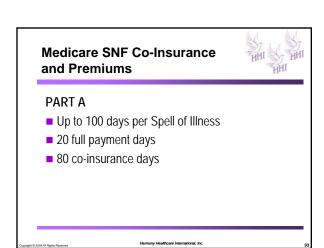
# For Example:

Fractured hip develops pneumonia secondary to immobility

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# **SNF Prospective Payment**



- What is skilled care?
- Nature of service requires the skills of RN, LPN
- Care rendered by a licensed person federal regulation define licensed person as physician, nurse and or therapist
- Provided directly by or under general supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result

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# Transmittal 262

- Skilled Nursing or skilled rehabilitation services
- On a daily basis
- Services rendered are reasonable and necessary
- MD ordered

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## Medicare Nursing Documentation

- Goal: Skilled nursing documentation should clearly delineate the medical complexity of the patient and skilled nursing services provided.
- The key to documenting skilled services is understanding the Medicare requirements for coverage requirements.

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### Medicare Coverage/Skilled Care

Q: Does Medicare require specific forms or documentation to prove a patient is receiving daily skilled care?

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A: No, CMS requires that the daily documentation supports that the patient requires nursing provide observation, assessment and treatment on a daily basis based on the patient's medical complexities.

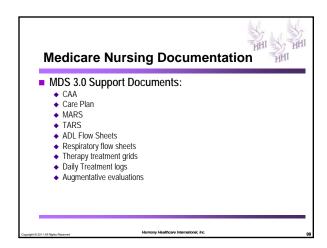
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### HII W HII **Medicare Nursing Documentation**

- Does the chart need to support the MDS?
  - For interview items, the interview can be conducted on the MDS itself and the actual date of completion should be reflected
  - ◆ For all items that affect revenue: YES!
  - Select sections of the MDS has specific sources that should be considered as demonstrated on the next slide.

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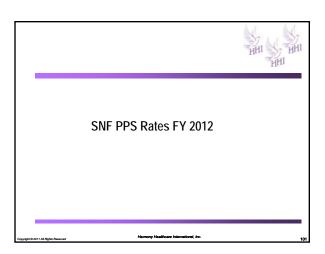
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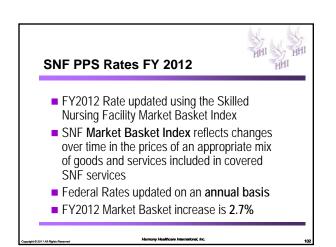
### **MDS Completion**

- CMS does not dictate which interdisciplinary professional complete each section of the MDS.
- The RN coordinator must sign that the assessment is complete.
- Federally an LPN has the authority to collect data and assist with coding the MDS. Confirm with state Nursing practice act.
- The involvement of an LPN is very state specific.

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Ex: RN must conduct all assessments in NY





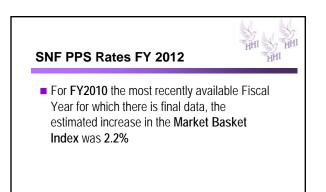


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# SNF PPS Rates FY 2012

- Market Basket Increase 2.7% less 1.0% productivity adjustment = net 1.7%
- \$600 million increase
- \$4.47 billion reduction from the recalibration of the case-mix adjustment
- Net decrease of \$3.87 billion in payments to SNFs or 11.1%

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# SNF PPS Rates FY 2012

- нні нні
- The temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA, remains in effect
- Diagnosis Code 042 (Human Immunodeficiency Virus (HIV) Infection)
  - ◆ Example: Urban HC2 \$401.48 adjusts to \$915.37
  - ◆ 2009 3,500 Medicare Part A residents coded



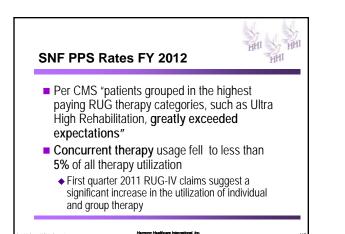
Rate Component	Nursing Case Mix	Therapy Case Mix	Therapy Non-Case Mix	Non- Case Mix
U <b>rban</b> Per Diem Amount	\$160.62	\$120.99	\$15.94	\$81.97
<b>Rural</b> Per Diem Amount	\$153.46	\$139.51	\$17.02	\$83.49

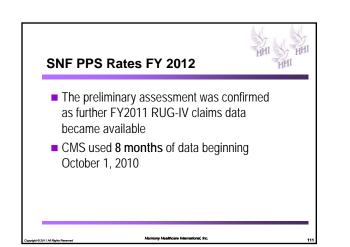
FY 20 <sup>2</sup>	12 Adjust	ed Fe	deral	Rates	нні нні
	RUG-IV Category	FY2012 Total Rate	FY2011 Total Rate	Variance	
	RUX	\$737.08	\$869.42	(\$132.34)	
	RUL	\$721.01	\$847.33	(\$126.32)	
	RUC	\$558.79	\$634.27	(\$75.48)	
	RUB	\$558.79	\$634.27	(\$75.48)	
	RUA	\$467.23	\$512.75	(\$45.52)	
	RVC	\$479.38	\$551.51	(\$72.13)	
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FY 201	2 Adjus	sted F	eder	al Rate	HHI HHI
	RUG-IV	FY2012	FY2011		1
	Category	Total Rate	Total Rate	Variance	
	HE1	\$377.39	\$370.81	\$6.58	
	HD1	\$354.90	\$348.71	\$6.19	
	LE1	\$345.26	\$339.24	\$6.02	
	CE1	\$338.84	\$332.93	\$5.91	
	CB1	\$261.74	\$257.18	\$4.56	
	PA1	\$184.64	\$181.42	\$3.22	
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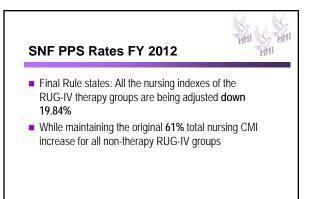
				San King
FY 2012 Adjus	sted Fe	deral	Rates	HHI
RUG-IV	FY2012	FY2010		1
Category	y Total Rate	Total Rate	Variance	
RUC	\$558.79	\$528.59	\$30.20	1
RVC	\$479.38	\$421.05	\$58.33	
RHC	\$417.71	\$364.54	\$53.17	1
RMC	\$366.95	\$335.36	\$31.59	1
HE1	\$377.39	\$257.61	\$119.78	1
PA1	\$184.64	\$166.03	\$18.61	1
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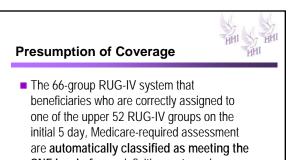




# SNF PPS Rates FY 2012 Note appropriate to achieve budget neutrality between the RUG-53 and RUG-IV systems by maintaining the 61 percent parity adjustment to the nursing CMIs for the RUG-IV non-therapy groups, and reducing the 61 percent parity adjustment as it applied to the nursing CMIs for the RUG-IV therapy groups



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**SNF level of care** definition up to and including the assessment reference date on the 5 day Medicare-required assessment



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#### **Presumption of Coverage**

This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 52 RUG-IV groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 14 RUG-IV groups

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#### **Presumption of Coverage**

This administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the beneficiary's assignment to one of the upper 52 RUG-IV groups

#### Totality

While it is true that dialysis is one of the discrete indicators for assignment to a RUG within the Special Care Low category – a category to which the level of care presumption applies for a short period of time at the start of a SNF stay – it is the totality of items and services included within a given RUG, not any one specific coded service, that actually serves to justify the presumption



# Changes to MDS 3.0 Assessment Schedule & Other Medicare-Required Assessments

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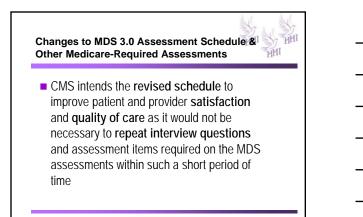
- CMS: Because the observation periods overlap so closely, changes in the patient's status are not reflected as originally intended
- CMS will modify the current Medicare-required assessment schedule (table A) to incorporate new assessment windows and grace days, as indicated in (table B), with appropriate changes to be made in the RAI Manual

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#### Changes to MDS 3.0 Assessment Schedule & Other Medicare-Required HHI Assessments

**NEW MDS 3.0 Assessment Schedule** 

MDS Assessment/Type	Assessment Reference Date	Grace Days	# of Eliminated Days	Reason for Assessment (A0310B code)	Medicare Payment Days
5 Day /Return	1-5	6-8	0	01	1-14
14 Day	13-14	15-18	3	02	15-30
30 Day Full	27-29	30-33	7	03	31-60
60 Day Full	57-59	60-63	7	04	61-90
90 Day Full	87-89	90-93	7	05	91-100





#### Final Rule FY 2012: Group Therapy



- Defines group therapy as therapy provided simultaneously to four patients who are performing similar therapy activities
- Allocating group therapy minutes among the four group therapy participants best captures the resource utilization associated with providing a maximally beneficial group therapy intervention.

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• The full time spent by the therapist with these patients would be **divided by 4** 

#### Final Rule FY 2012: Group Therapy



- If one or more of the four group therapy participants are unexpectedly absent from a session or cannot finish participating in the group, CMS deems the session as still meeting the definition for group as long as it was originally planned for four participants
- Minutes continue to be allocated as though four participants attended

#### Final Rule FY 2012: Group Therapy



- This total time would be allocated (that is, divided) among the four group therapy participants to determine the appropriate number of RTM
- The 25 percent cap on group therapy minutes, as defined in the July 30, 1999 final rule (64 FR 41662) will remain in effect
- Group therapy should serve only as an adjunct to individual therapy
- Supervising therapist may not be supervising any individuals other than the four individuals who are in the group



#### Final Rule 2012: Therapy Documentation

- Clarified expectations regarding the clinical documentation needed to support each patient's plan of care
  - SNFs are currently required to prescribe the type, amount, frequency, and duration of physical therapy, occupational therapy, and speech-language pathology services in a patient's plan of care
    - The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed

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- Additional clinical documentation needed to support each patient's plan of care
  - SNFs must indicate "the diagnosis and anticipated goals" associated with the therapy services prescribed.

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#### Final Rule 2012: Therapy Documentation

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- New: SNFs should include in the patient's plan of care an explicit justification for the use of group, rather than individual or concurrent
- Description should include:
  - Specific benefits to that particular patient
  - Documented type and amount of group therapy
  - How the prescribed type and amount of group therapy
  - will meet the patient's needs and assist the patient in reaching the documented goals



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#### End of Therapy OMRA

- End of Therapy (EOT) OMRA must be set 1 to 3 days after the discontinuation of all therapies (speech-language pathology services and occupational and physical therapies)
- Based on this policy, the EOT OMRA must be completed, at the latest, when a patient has not received therapy for three consecutive days

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#### End of Therapy OMRA

- Two types of discontinuation of therapy services
   "Unplanned" discontinuation of services
  - "Planned" discontinuation
- The ARD for the EOT OMRA must be set for day 1 to 3 after the discontinuation, planned or unplanned, of all therapy services
- Regardless of the reason for the discontinuation of therapy

# End of Therapy OMRA Eliminated the distinction between 5 day and 7 day facilities for purposes of setting the ARD for the EOT OMRA October 1, 2011, an EOT OMRA for a patient classified in a RUG-IV therapy group would be required if that patient goes three consecutive calendar days without being furnished any therapy services regardless of whether the facility is a 5 day or 7 day facility or the reason for the discontinuation in therapy services

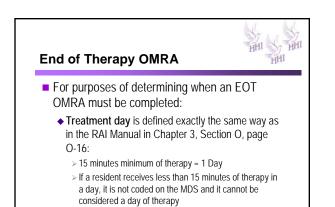


#### End of Therapy OMRA: Rehab Low



CMS requires that an EOT OMRA also be completed for residents who are in the Rehabilitation Low RUG groups, when therapy services have been discontinued for 3 consecutive calendar days

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# End of Therapy Resumption OMRA



Where an EOT OMRA has been completed and therapy resumes shortly thereafter, a SOT OMRA may not be necessary to establish the patient's clinical condition, specifically where the RUG-IV classification level has not changed

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# End of Therapy Resumption OMRA

- Where an EOT OMRA has been completed and therapy subsequently resumes:
  - SNFs may complete an End of Therapy Resumption (EOT-R) OMRA, rather than an SOT OMRA if:
    - Therapy services have ceased for a period of no more than 5 consecutive calendar days AND
    - > Resumed at the same RUG-IV classification level

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# End of Therapy Resumption OMRA

- When therapy resumes in such a short period of time at the same RUG-IV classification level, a new therapy evaluation and SOT OMRA would not be necessary to reclassify the patient back into a RUG-IV therapy classification
  - Resumption date may be no more than 5 consecutive calendar days after the date of the last therapy service furnished prior to the temporary discontinuation of therapy service reported on the EOT OMRA

# End of Therapy Resumption OMRA

- When therapy resumes more than five consecutive calendar days from the discontinuation of therapy service, likely that the patient's clinical condition needs to be evaluated to identify changes in clinical and/or therapy needs
- SNF could either perform an optional SOT OMRA to classify the patient into a RUG-IV therapy group, or wait until the completion of the next regularly scheduled PPS assessment
- Therapist would be required to conduct a therapy evaluation and establish a new therapy care plan



#### Change of Therapy OMRA

Effective October 1, 2011, Change of Therapy (COT) OMRA, for patients classified into a RUG-IV therapy group, whenever the intensity of therapy (that is, the total RTM delivered) changes to such a degree it no longer reflects the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment

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#### **Change of Therapy OMRA**

- If a therapy discipline is discontinued and this results in a patient no longer meeting the required number of therapy disciplines for the patient's current RUG category then a COT OMRA would be required
- In addition, if a patient fails to receive the requisite number of days of therapy required for classification into the RUG category, then a COT OMRA would be required to change the patients' RUG category as appropriate

#### . . . . . . . . .



#### Change of Therapy OMRA

- The ARD for the COT OMRA would be set for day 7 of a COT observation period
- Rolling 7 day window
  - Beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment OR
  - The day therapy resumes in cases where an EOT-R OMRA is completed
- Ends each 7th calendar day thereafter



#### Change of Therapy OMRA

- SNFs are required to complete a COT OMRA only if a patient's total RTM changes to such an extent that the patient's RUG classification, based on their last PPS assessment, is no longer an accurate representation of their current clinical condition
- Evaluation of the necessity for a COT OMRA must be completed every seven calendar days starting from the day following the ARD set for the most recent scheduled or unscheduled PPS assessment

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#### **Change of Therapy OMRA**

- Payment begins the day after the ARD of the beginning of the look back period
- RUG remains in effect until the end of the payment window for the assessment) or until a new unscheduled assessment (an OMRA, SCSA, or SCPA) is completed

#### 

- Utilization of PPS Tracker
- Daily Minute Management Meeting with MDS and Rehab
- Create "check book" debits of missed days and minutes
- Monitor for lower as well as higher classifications

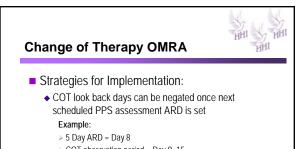


#### **Change of Therapy OMRA**

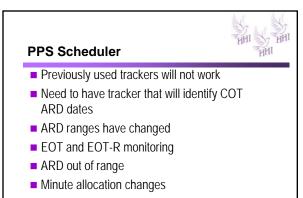


- Strategies for Implementation: ◆ Mark "Check Points" on PPS Tracker
  - Education and training for every therapist to monitor level of care weekly
  - ◆ Post and highlight chosen ARD for each patient on weekly billing log

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- > COT observation period = Day 9 -15
- > 14 Day ARD = Day 13
- > COT Observation period Day 14 20
- > COT observation for 5 day is shortened to 9-12



Harmony has developed this tool



# Strategies for Success



- ARD coordination and selection
- ADL coding/capturing (Section G)

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- Accurate MDS coding
- Rehab case management
  - $\blacklozenge$  New admissions
  - Groups
  - ◆ Concurrent therapy
- Education



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# MDS 3.0 Updates for Quality of Care and Beyond Wyoming Department of Health September 28, 2011

#### HANDOUT TABLE OF CONTENTS

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- All

# NEW MDS 3.0 ASSESSMENT SCHEDULE

PAYMENT DAYS	1-14	15-30	31-60	61-90	91-100
REASON FOR ASSESSMENT (A0310B CODE)	01	02	03	04	05
# OF DAYS Eliminated	0	3	7	٢	7
GRACE DAYS	6-8	15-18	30-33	60-63	90-93
ASSESSMENT Reference Date	1-5	13-14	27-29	57-59	87-89
MDS ASSESSMENT/TYPE	5 Day /Return	14 Day	30 Day Full	60 Day Full	90 Day Full

Effective October 1, 2011

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HARMONY HEALTHCARE INTERNATIONAL, INC. 430 Boston Street, Suite 104, Topsfield, MA 01983 + Tel: 978-887-8919 + Fax: 978-887-3738 www.harmony-healthcare.com Seminars: Handouts: 2011: Final Rule1



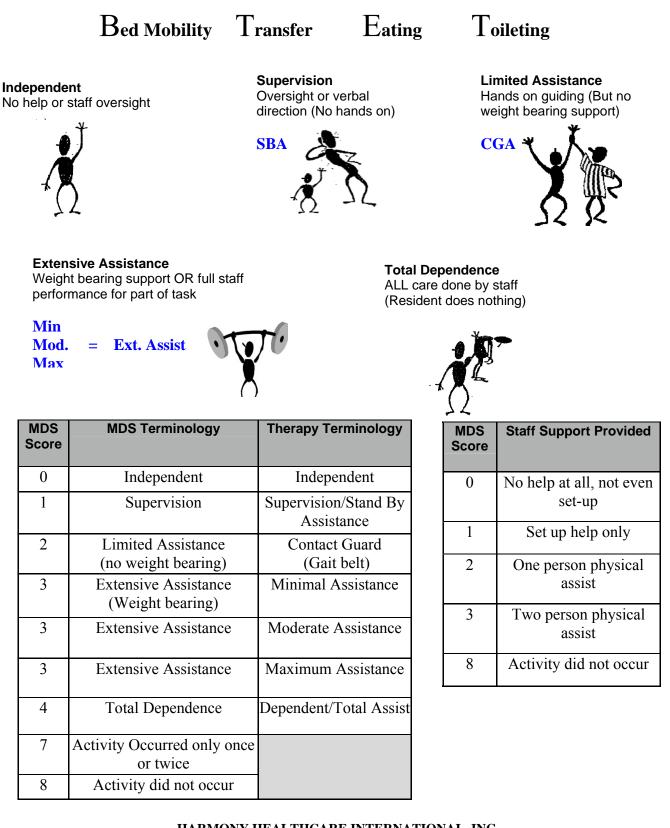
# **ADL CONVERSION SHEET** (RUG-IV GROUPER)

#### BENEFICIARY NAME \_\_\_\_\_\_FACILITY NAME \_\_\_\_\_

	MDS ADL	ADL GROUPER SUM	
Category	Self Performance	Support	Total
	8	0-8	0
TRANSFER	7	0-8	0
	4	3	4
	4	0-2	3
	3	3	4
	3	0-2	2
	2	0-8	1
	1	0-8	0
	0	0-8	Ő
	8	0-8	0
BED	8 7	0-8	0
MOBILITY	4	3	4
	4	0-2	4 3
	4 3	0-2	5
	3	0-2	2
	2	0-8	1
	1	0-8	0
	0	0-8	0
TOILET USE	8	0-8	0
IOILEI OSE	7	0-8	0
	4	3	4
	4	0-2	3
	3	3	4
	3	0-2	2
	2	0-8	1
	1	0-8	0
	0	0-8	0
	8	0, 1, 8	0
EATING	8	2, 3	2
	7	0, 1, 8	0
	7	2, 3	2
	4	0, 1	2
	4	2, 3	$\frac{2}{4}$
	3	0, 1	2
		2, 1	
	2	2, 3 0, 1, 8	3 0
	3 2 2	$\begin{array}{c} 0, 1, 0 \\ 2 \end{array}$	2
	ے 1	2, 3	
	1	0, 1, 8 2, 3	0
	1	2, 3	0 2 0 2
	0	0, 1, 8	0
	0	2, 3	2

TOTAL\_\_\_\_\_





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# ADLs: Unlock the Secrets

ADL DEFINITIONS

#### Independent: NO TALK NO TOUCH

Staff does not assist, instruct, or cue. Resident does all of activity ALONE. No monitoring, **no** hands on assistance.

#### Supervision: TALK $\rightarrow$ NO TOUCH

Staff provides instructions or cueing, Oversight and cuing.But does **not** provide physical (hands on) assistance.(Do not touch) Staff uses mouth/voice only.NO HANDS

#### Limited Assist: TALK & TOUCH

Staff talks to give instruction or cues and touches resident to assist. Example: Putting your hand on resident's back or holding his/her elbow while he/she walks. Open hand touching only, no close hand lifting. Staff does not lift any part of the resident.

#### Extensive Assist: TALK, TOUCH, & LIFT

Staff uses muscle power to lift, move, or "shift" resident.

Lifting legs into bed, "scooting" buttocks into position in bed, lifting arm to assist in self feeding.

Lifted part of or entire resident and/or completed almost the entire task. Closed hand lifting/Weight bearing assistance.

#### Total Dependence: ALL ACTION BY STAFF

Resident does not participate at all in any part of the activity being done for him/her. Staff performs the entire task.

#### IF STAFF MEMBER HAS TOUCHED THE RESIDENT AT ALL, CODE AT LEAST LIMITED ASSIST.

#### **Support Codes**

8 = Activity did not occur	1 = Set up help only
3 = 2 + person physical assist	0 = No set up or physical help from staff
2 = 1 person physical assist	7= Activity occurred only once or twice

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#### **COVERAGE OF SERVICES THERAPY**

#### 214. Covered Level of Care – General

Care in a SNF is covered if all of the following three factors are met:

- The patient requires skilled nursing services <u>or</u> skilled rehabilitation services i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§214.1 214.3);
- The patient requires these skilled services on a daily basis (see §214.5);
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF (see §214.6).

If any one of these three factors is not met, a stay in an SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care <u>could not be made</u> if a patient needs an <u>intermittent</u> rather than daily skilled service.

In determining whether the level of care requirements are met, the first consideration should be whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements do not have to be addressed.

In addition, the services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

**EXAMPLE 1:** Even though the irrigation of a catheter may be a skilled nursing service, daily irrigations may not be "reasonable and necessary" for the treatment of a patient's illness or injury.

#### 214.1 Skilled Nursing and Skilled Rehabilitation Services

A. <u>Skilled Services – Defined.</u> Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.



**NOTE:** "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Assume that skilled services provided by a participating SNF are furnished by or under the general supervision of the appropriate skilled nursing or skilled rehabilitation personnel.

- B. Principles for Determining Whether a Service is Skilled
  - If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled services; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of catheters; and ultrasound, shortwave, and microwave therapy treatments.
  - The nature of the service and the skills required for safe and effective delivery of that service are considered in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.
- **EXAMPLE:** Even where a patient's full or partial recovery is not possible, a skilled service still could be needed to <u>prevent deterioration</u> or <u>to maintain current capabilities</u>. A cancer patient, for instance, whose prognosis is terminal may require skilled services at various stages of his illness in connection with periodic "tapping" to relieve fluid accumulation and nursing assessment and intervention to alleviate pain or prevent deterioration. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel (see §214.3.A).

- A service that is ordinarily considered non-skilled could be considered skilled service in cases in which, because of special medical complications, skilled nurses or skilled rehabilitation personnel are required to perform or supervise it or to observe patient. In these cases, the complications and special services involved must be documented by physician's orders and nursing or therapy notes.
- **EXAMPLE:** The existence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, a patient with a preexisting acute skin problem, pre-existing peripheral vascular disease, or a need for special traction of the



injured extremity might need skilled nursing or skilled rehabilitation personnel to observe for complications or to adjust traction.

- **EXAMPLE:** Whirpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition was complicated by circulatory deficiency, areas of desensitization, or open wounds.
  - In determining whether services rendered in an SNF constitute covered care it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.
- **EXAMPLE:** An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered cerebrovascular accident, is incontinent and has a Grade 1 decubitus ulcer and is unable to communicate and make her needs known. Even though specific service provide is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, observe the patient's progress, and to evaluate the need for changes in the treatment plan.
  - The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.
- **EXAMPLE:** A primary need of a nonambulatory patient may be frequent changes in position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service even though such services are obviously necessary.

The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to <u>avoid contractures</u> and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

#### C. Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

1. <u>Management and Evaluation of a Patient Care Plan</u>. The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery,



and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. Skilled management would be required where the sum total of unskilled services which are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety.

- **EXAMPLE 1:** An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and not require skilled nursing personnel.
- **EXAMPLE 2:** An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

2. <u>Observation and Assessment of Patient's Condition</u>. Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.

**EXAMPLE 1:** A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from



prescribed medication. Skilled observation is needed to determine when the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized.

- **EXAMPLE 2:** A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin of the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required.
- **EXAMPLE 3:** A patient has undergone hip surgery and has been transferred to a Skilled Nursing Facility. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, breakdown, or need for the administration of subcutaneous Heparin, both reasonable and necessary.
- **EXAMLE 4:** A patient has been hospitalized following a heart attack. Following treatment but before mobilization, he is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated and continued until the patient's treatment regimen is essentially stabilized.
- **EXAMPLE 5:** A frail 85-year-old man was hospitalized for pneumonia. The infection resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake and the assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration.
- EXAMPLE 6: A patient/resident left the acute hospital on a high dosage of Coumadin with daily clotting time studies. Coumadin is reimbursable until a maintenance dosage is attained and the patient/resident shows no adverse symptoms. DO NOT DENY IF THE DOSAGE IS NOT REGULATED ON A DAILY BASIS. Regulation is an integral part of this patient/resident's coverage. Ongoing observation and assessment, notifying the physician and multiple changes in the plan of care, are also skilled in nature.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was reasonable probability for such a complication or further acute episode "Reasonable probability" means that a potential complication or further acute episode a likely possibility.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to the physical problems, have



a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders precluded by law from participating in Medicare.) Therefore, these cases must carefully be documented.

3. <u>Teaching and Training Activities</u>. Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

D. <u>Questionable Situations</u>. There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

- The primary service needed is oral medication; or
- The patient is capable of independent ambulation, dressing, feeding, and hygiene.

# **214.2 Direct Skilled Nursing Services to Patients.** Some examples of direct skilled nursing services are:

- Intravenous and intramuscular injections;
- Intravenous feedings;
- Nasogastric tube, gastrostomy, and jejunostomy feedings;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of catheters; care of suprapubic catheter and, in selected patients, urethral catheter (the mere presence of urethral catheter, particularly



one placed for convenience or the control of incontinence does not justify a need for skilled nursing care. On the other hand, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for urethral catheter must be justified and documented in the patient's medical record; i.e., must be established that it is reasonable and necessary for the treatment of the patients condition);

- Application of dressings involving prescription medications and aseptic techniques (see §214.4 for exception);
- Treatment of decubitus ulcers, of a severity rated at Grade 3 or worse, or widespread skin disorder (see §214.4 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress (see §214.4 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early postoperative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

#### 214.3 Direct Skilled Rehabilitation Services to Patients

#### A. <u>Skilled Physical Therapy</u>

1. <u>General</u>. Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified physical therapist;
- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;
- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and



- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.
- **EXAMPLE 1:** An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.
- **EXAMPLE 2:** A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

If the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results, the physical therapy would not be reasonable and necessary, and thus would not be covered skilled physical therapy services.

Many SNF inpatients do not require skilled physical therapy services but do require services which are routine in nature. Those services can be performed by supportive personnel; e.g., aides or nursing personnel, without the supervision of a physical therapist. Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

2. <u>Application of Guidelines</u>. Some of the more common physical therapy modalities and procedures are:

a. <u>Assessment</u>. The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measures of range of motion, strength, balance, coordination, endurance, and functional ability.

b. <u>Therapeutic Exercises</u>. Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

c. <u>Gait Training</u>. Gait evaluation and training furnished a patient when ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a



qualified physical therapist and constitute skilled physical therapy they reasonably can be expected to improve significantly the patient's ability to walk.

Repetitious exercises to improve gait, or to maintain strength and endurance, assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

d. <u>Range of Motion</u>. Only the qualified physical therapist may perform range of motion tests and, therefore, such <u>tests</u> are skilled physical therapy. Range of motion <u>exercises</u> constitute skilled physical therapy only if they are part of actual treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost to the degree to be restored).

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises maintain range of motion in paralyzed extremities that can be carried out by aides nursing personnel would not be considered skilled care.

e. <u>Maintenance Therapy</u>. The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services (see §214.1.B). The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

**EXAMPLE:** A Parkinson's patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine which type of exercises are required for the maintenance of his present level of function. The initial evaluation of the patient's needs, the designing of the maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, and such infrequent reevaluations as may be required, would constitute skilled physical therapy.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last restorative session, the physical therapist will have already designed the maintenance



program required and instructed the patient or support personnel in the carrying out of the program.

f. <u>Ultrasound, Shortwave and Microwave Diathermy Treatments</u>. The modalities must always be performed by or under the supervision of qualified physical therapist and are skilled physical therapy.

g. <u>Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths</u>. Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case e.g., where the patient's condition is complicated by circulatory deficiency, areas desensitization, open wounds, fractures or other complications.

B. <u>Speech Pathology</u> – See §230.3.B

C. Occupational Therapy – See §230.3.C

**214.4** Nonskilled Supporting or Personal Care Services. The following services are not skilled services unless rendered under circumstances detailed in §214.1.B:

- Administration of routine oral medications, eye drops, and ointments. The fact that a patient cannot be relied upon to take such medications himself or that State law requires all medications to be dispensed by a nurse to institutional patients would not change their service to a skilled service);
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying containers and cleaning them and clamp tubing);
- Changes of dressings for noninfected postoperative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application creams, or treatment of minor skin problems;
- Routine care of the incontinent patient, including use of diapers and protective sheets;
- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin circulatory condition or needs to have traction adjusted);
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and



• General supervision of exercises which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking) (see §230.3.A.2(d)).

**214.5 Daily Skilled Services** – **Defined.** Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis", i.e., on essentially a 7-day-a-week basis. However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when he needs and receives those services on at least 5 days a week. Accordingly, if a facility provides physical therapy on only 5 days a week and a patient in the facility requires and receives physical therapy on each of those days, the requirement that skilled rehabilitation services be provided on a daily basis is meet. (If the services are available less than 5 days a week, though, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

**EXAMPLE:** A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

**214.6** Services Provided on an Inpatient Basis as a "Practical Matter". In determining whether the daily skilled care needed by an individual can, as a "practical matter", only be provided in an SNF on an inpatient basis, the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services are considered.

As a "practical matter", daily skilled services can be provided only in an SNF if they are not available on an outpatient basis in the area in which the individual resides and transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting



The availability at home of capable and willing family or the feasibility of obtaining other assistance for the patient should be considered. Even though needed daily skilled service might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

**EXAMPLE:** A patient undergoing restorative physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk of further injury from falling, of dehydration or of malnutrition because insufficient supervision or assistance could be arranged for the patient in his home. Under these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

A. <u>The Availability of Alternative Facilities or Services</u>. Alternative facilities or services may be available to a patient if health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

**EXAMPLE:** Where the residents of a rural community general utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage and noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that such care cannot be covered by Medicare is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from independently practicing physical therapist. However, the fact that Medicare reimbursement could not be made for the services because the \$500 expense limitation applicable to the services of an independent physical therapist had been exceeded because the patient was not enrolled in Part B, would not be a basis for determining that as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternative services is not a factor to be considered.



B. <u>Whether Available Alternatives are More Economical in the Individual Case</u>. If a generally more economical care alternative is available to provide the needed care, whether the use of the alternative actually would be more economical in the individual case is considered.

- **EXAMPLE 1:** If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.
- **EXAMPLE 2:** If needed care could be provided in the home, but the patient's residence so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

C. <u>Whether the Patient's Physical Condition Would Permit Him to Utilize an Available More</u> <u>Economical Care Alternative</u>. In determining the practicality of using more economical care alternatives, the patient's medical condition should be considered. If the use of those alternatives would adversely affect the patient's medical condition then as a practical matter the daily skilled services can only be provided by an SNF on an inpatient basis.

If the use of a care alternative involves transportation of the individual on a daily basis whether daily transportation would cause excessive physical hardship is considered. Determinations on whether a patient's condition would be adversely affected if available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely affected by daily transportation to a care facility, even though he is able to ambulate to some extent.

**EXAMPLE:** A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs with safety. The patient lives alone in a second floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are only available in a CORF one mile away from her apartment. However, because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SNF.

The "practical matter" criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring an SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF for the receipt of his or her required skilled care. Very often special arrangements, not feasible on a daily basis, have had to be made to allow the absence from the



facility. Where frequent or prolonged periods away from the SNF become possible, however, then questions as to whether the patient's care can, as a practical matter, only be furnished on an inpatient basis in an SNF may be raised. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences. (see §242.3) for counting inpatient days during a leave of absence).

A conservative approach to retain the presumption for waiver of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If an SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not. (see §356.2, Improper SNF Coverage Decisions).

HHI

#### CLASSIFICATION GRID RUG-IV

	ADL		
RUGs Level	Score	Requirements	MDS 3.0 Section
	RF	EHABILITATION/EXTENSIVE SERVICES	
ULTRA HIGH RUX RUL	11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services.         • Rx 720 minutes/week minimum AND         • At least 1 discipline 5 days/week AND         • A second discipline at least 3 days/week AND         • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND         • ADL score > =2	O, A,B,C, 1,2,3,4
		See updated Extensive Services Category*     Residents needing both extensive medical services and	
VERY HIGH RVX RVL	11-16 2-10	<ul> <li>physical or occupational therapy or speech-language pathology services.</li> <li>Rx 500 minutes/week minimum AND</li> <li>One discipline at least 5 days/week AND</li> <li>Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND</li> <li>ADL score &gt; =2</li> </ul>	O, A,B,C, 1,2,3,4
		See updated Extensive Services Category	
HIGH RHX RHL	11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services.	
		<ul> <li>Rx 325 minutes/week minimum AND</li> <li>One discipline 5 days/week AND</li> <li>Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND</li> <li>ADL score &gt; =2</li> <li>See updated Extensive Services Category*</li> </ul>	O, A,B,C, 1,2,3,4



RUG-IV					
RUGs Level	ADL Score	Requirements	MDS 3.0 Section		
	REHABI	LITATION/EXTENSIVE SERVICES (Continu	ed)		
MEDIUM		<i>Residents needing both extensive medical services and PT, OT or SLP services.</i>			
RMX RML	11-16 2-10	<ul> <li>Rx 150 minutes/week minimum AND</li> <li>5 days/week across 3 disciplines AND</li> <li>Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND</li> <li>ADL score&gt; =2</li> <li>See updated Extensive Services Category*</li> </ul>	O, A,B,C, 1,2,3,4		
LOW		Residents needing both extensive medical services and			
LOW RLX Extensive Services quali		physical or occupational therapy or speech-language pathology services. AND <ul> <li>3 days any combo of 3 disciplines AND</li> <li>Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services) AND</li> <li>Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND</li> <li>ADL score &gt; =2</li> <li>See updated Extensive Services Category*</li> <li>*Updated Extensive Services: ADL Sum &gt; 2 and one of the following services:</li> </ul>	O, A,B,C, 1,2,3,4		
	Respirator OR active infectious di	sease while a resident			
		REHABILITATION			
ULTRA HIGH		In last 7 days: • Received 720 minutes/week minimum AND	O, A,B,C, 1,2,3,4		
RUC RUB RUA	11-16 6-10 0-5	<ul> <li>At least 1 discipline 5 days/week AND</li> <li>2<sup>nd</sup> for at least 3 days/week</li> </ul>			
VERY HIGH RVC RVB RVA	11-16 6-10 0-5	In last 7 days: • Received 500 minutes/week minimum AND • At least 1 discipline 5 days/week	O, A,B,C, 1,2,3,4		



RUGs Level	ADL Score	Requirements	MDS 3.0 Section
	S	SPECIAL REHABILITATION (Continued)	
HIGH RHC RHB RHA	11-16 6-10 0-5	<ul> <li>In last 7 days:</li> <li>Received 325 minutes/week minimum AND</li> <li>At least 1 discipline -5 days/week</li> </ul>	O, A,B,C, 1,2,3,4
MEDIUM RMC RMB RMA	11-16 6-10 0-5	In last 7 days: • Received 150 minutes/week minimum AND • 5 days, any combo 3 disciplines	O, A,B,C, 1,2,3,4
LOW RLB RLA	11-16 0-10	<ul> <li>In last 7 days:</li> <li>Received 45 minutes/week minimum AND</li> <li>3 days, any combo 3 disciplines AND</li> <li>Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services)</li> </ul>	O, A,B,C, 1,2,3,4
		EXTENSIVE SERVICES	
		<ul> <li>Residents receiving the following complex clinical care:</li> <li>Tracheostomy Care OR</li> <li>Ventilator / Respirator</li> </ul>	O0100E2 O0100F2
		OR <ul> <li>Isolation for active infectious disease while a resident         AND <li>ADL score &gt;=2</li> </li></ul>	O0100M2
ES3	2-16	<ul> <li>Notes: Qualifiers count for end splits</li> <li>Tracheostomy care (while a resident) AND</li> <li>Ventilator / Respirator (while a resident)</li> </ul>	O0100E2 O0100F2
ES2	2-16	Ventrator / Respirator (while a resident)     Tracheostomy care (while a resident)     OR	O0100F2 O0100E2
		• Ventilator / Respirator (while a resident)	O0100E2
ES1	2-16	• Isolation for active infectious disease (while a resident)	O0100M2



RUGs Level		ADL Score	Requirements	MDS 3.0 Section
			SPECIAL CARE HIGH	
HE2 HE1	Yes No	15-16 15-16	<ul> <li><i>Residents receiving the following complex clinical care or with a following medical condition:</i></li> <li>Comatose and completely ADL dependent</li> </ul>	B, B0100
HD2 HD1 HC2 HC1 HB2 HB1	Yes No Yes No	11-14 11-14 6-10 6-10 2-5 2-5	<ul> <li>Septicemia</li> <li>Diabetes with daily injections requiring physician order changes on 2 or more days</li> <li>Quadriplegia and ADL score &gt; = 5</li> <li>Chronic obstructive pulmonary disease and shortness of breath when lying flat</li> <li>Fever with <ul> <li>Pneumonia</li> <li>Vomiting</li> <li>Feeding tube</li> <li>Weight loss</li> </ul> </li> <li>Parenteral/IV feedings <ul> <li>Respiratory therapy for 7 days AND</li> <li>ADL score &gt; =2</li> </ul> </li> </ul>	I, I2100 I, I2900; Section N, N0350,A I, I5100 I, I6200 J, J1550,A I, I2000 J, J1550,B K, K0500,B K, K0500,A O, O0400,D
			Notes: Signs of depression used for end splits; PHQ score         =>10         SPECIAL CARE LOW         Residents receiving the following complex clinical care or	
LE2 LE1	Yes No	15-16 15-16	<ul> <li>with a following medical condition:</li> <li>Cerebral palsy and ADL score &gt;=5</li> <li>Multiple sclerosis and ADL score &gt;=5</li> </ul>	I, 14400 I, 15200
LD2 LD1	Yes No	11-14 11-14	<ul> <li>Multiple sclerosis and ADL score &gt;=5</li> <li>Parkinson's disease and ADL score &gt;=5</li> <li>Feeding tube (calories ≥ 51% or calories = 26-50% and fluid ≥ 501 cc)</li> </ul>	I, 15300 K, K0700,A,B,
LC2 LC1	Yes No	6-10 6-10	<ul> <li>Ulcers with 2 or more skin treatments</li> <li>2 or more stage II</li> <li>1 or more stage III or IV pressure ulcers</li> <li>Unstageable secondary to slough/eschar</li> </ul>	M M, M0800,A M, M0800,B,C M, M1030
LB2 LB1	Yes No	2-5 2-5	<ul> <li>2 or more venous/arterial ulcers OR         <ul> <li>1 stage II pressure ulcer AND</li> <li>1 venous/arterial ulcer</li> </ul> </li> <li>Foot infection, diabetic foot ulcer or open lesions on the foot with treatment</li> <li>Radiation therapy while a resident</li> <li>Respiratory failure and oxygen therapy while a resident</li> <li>Dialysis while a resident             <ul> <li>ADL score &gt;=2</li> </ul> </li> <li>Notes: Signs of depression used for end splits; PHQ score =&gt;10</li> </ul>	M, M-0800,A M, M1030 M, M1040,A,C O, O0100,B,2 I, I6300 O,O0100C O, O0100,J,2



RUGs Level		ADL Score	Requirements	MDS 3.0 Section		
The do Letter	CLINICALLY COMPLEX					
CE2 CE1	Yes No	15-16 15-16	Residents with Extensive Services, Special Care High or Special Care Low qualifier. AND • ADL score = 0-1			
CD2 CD1	Yes No	11-14 11-14	OR Residents with any one of the following clinically complex qualifiers: • Pneumonia	I, I2000 I, I4900		
CC2 CC1	Yes No	6-10 6-10	<ul> <li>Hemiplegia and ADL score &gt;=5</li> <li>Surgical wounds or open lesions with treatment</li> <li>Burns</li> </ul>	M, M1040,E		
CB2 CB1	Yes No	2-5 2-5	<ul> <li>Chemotherapy while a resident</li> <li>Oxygen while a resident</li> <li>IV medications while a resident</li> <li>Transfusions while a resident</li> </ul>	M, M1040,F O, O0100,A,2 O, O0100,C,2 O, O0100,H,2		
CA2 CA1	Yes No	0-1 0-1	Notes: Signs of depression used for end splits: PHQ score =>10	O, O0100,I,2		
		BEH	IAVIORAL SYMPTOMS AND COGNITIVE	-		
BB2 BB1	*	2-5 2-5	Residents having cognitive impairment BIMS score<=9 or CPS >=3 OR • Hallucinations or delusions	C E0100A E0100B		
BA2	*	0-1	OR Residents displaying any of the following on 4 or more days over last 7 days:			
BA1	<ul> <li>**</li> <li>* 2 or more Restorative Services 6+ days</li> <li>** Less Restorative Nursing</li> </ul>	0-1	<ul> <li>Physical or verbal behavioral symptoms toward others</li> <li>Other behavioral symptoms</li> <li>Rejection of care</li> <li>Wandering         <ul> <li>AND</li> </ul> </li> <li>ADL score &lt;=5</li> <li>Notes: Restorative nursing used for end splits. See Reduced Physical Function for restorative nursing services count</li> </ul>	E, E0200,A,B,C E, E0300,1 E, E0900		



## MDS 3.0 CLASSIFICATION GRID (CONT.) RUG-IV

RUGs Level	Restorative Nursing	ADL Score	Requirements	MDS 3.0 Section
			REDUCED PHYSICAL FUNCTIONING	
PE2 PE1	* **	15-16 15-16	<i>Residents whose needs are primarily for activities of daily living and general supervision.</i>	
PD2 PD1	* **	11-14 11-14	<ul> <li>Residents not qualifying for other categories</li> <li>Restorative nursing services:</li> <li>Urinary and/or bowel training program</li> </ul>	O, 0500,A-J H, H0200/H0500
PC2 PC1	* **	6-10 6-10	<ul><li>Passive and/or active ROM</li><li>Amputation/prosthesis care training</li><li>Splint or brace assistance</li></ul>	
PB2 PB1	* **	2-5 2-5	<ul><li>Dressing or grooming training</li><li>Eating or swallowing training</li><li>Transfer training</li></ul>	
PA2 PA1	* **	0-1 0-1	<ul><li>Bed mobility and/or walking training</li><li>Communication training</li></ul>	
	*2 or more Restorative Services 6+ days			
	**Less Restorative Nursing		Notes: No clinical variables used	



PAIN CAA SAMPLE

#### **Review of Indicators of Pain**

<b></b>	T	Quere estima Deserve tation
		Supporting Documentation (Basis/reason for checking the item,
	Diseases and conditions that may cause pain	including the location, date, and source (if
	(diagnosis OR signs/symptoms present)	applicable) of that information)
X	Cancer (10100)	11/1/2010 Admission MD Note
	Circulatory/heart	Dx: Metastatic Lungconcer
	Atherosclerotic Heart Disease (ASHD)	(mets to bone)
	(10400)	
	— Deep Vein Thrombosis (I0500)	
	- Peripheral Vascular Disease (10900)	
X	Skin/Wound	II/1/2010 NURSING Admit Note: Stage I pressure ulcer on
	Pressure ulcer (section M)	STRAP T pressure ulcer on
1	Other ulcers, wounds, incision, skin	Convine pressed of the
	problems (M1040)	Cociyx
	Infections	
	Urinary tract infection (I2300)	
	Pneumonia (12000)	
	Neurological	
	<ul> <li>Head trauma (from clinical record)</li> </ul>	
	Headache	
	Neuropathy	
	Post-stroke syndrome	
X	Gastrointestinal	
	Gastroesophageal Reflux Disease/Ulcer	
	(11200)	
	Disease/Inflammatory Bowel Disease (I1300)	
1	Constipation (H0600, and from clinical	Hx of constinution due to
	record, resident interview)	narcotics (per nursing
	Hospice care (O0100K)	Hx of constipation due to narcotics (per nursing admission note 11/1/2010)
A	Musculoskeletal	
$  \uparrow \rangle$	Arthritis (13700)	
	Osteoporosis (13800)	
1	Hip fracture (13900)	
1	-Other fracture (14000)	
1	-Back problems	
	Amputation (O0500)	
	— Other	Bone nets - see above note
	Dental problems (section L)	



		Supporting Documentation
		(Basis/reason for checking the item,
		including the location, date, and source (if
1	Characteristics of the pain	applicable) of that information)
X	• Location Ge	peralized pain
	<ul> <li>Type (constant, intermittent, varies over</li> </ul>	Per Paranti Per
	time, etc.)	(Fentanyi parch, prinkovanoi) meducation
X	What makes it better	(Fentenyi patch, pm Roxanoi) per st, narcotic pain meds Record
X	What makes it worse	venent / and nursing
X	• Words that describe it (for example aching	
	soreness, dull, throbbing, crushing)	r perident interview today,
	- Burning, pins and needles, shooting,	r resident interview today, two bbing "describes constant pain but break through cidents of severe painare scribed as "like a knife stokbing"
1	numbness (neuropathic)	onin, but break through
1	<ul> <li>— Cramping, crushing, throbbing, stabbing</li> </ul>	Lidente de servere paintere
	(musculoskeletal)	hen bed as "like a knife stabling"
	- Cramping, tightness (visceral)	pourous as are and and and a
		·
	Frequency and intensity of the pain (J0400,	
14	J0600, J0850)	La bar that the that have been been been been been been been be
X	How often it occurs	stant (level up to 4 or 5) Break
X	Time or situation of onset	franklin price of relev
X	· How long it lasts Constraint, L	ength of severe episodes vary
	Non-verbal indicators of pain (particularly	
12	important if resident is stoic)	
13	<ul> <li>Facial expression (frowning, grimacing,</li> </ul>	pain, tearful @ trees
	etc.) (J0800A, J0800C)	pain, rear fuil conned
R	<ul> <li>Vocal behaviors (signing, moaning,</li> </ul>	moans@times
	groaning, crying, etc.) (J0800A, J0800B)	Thours Gonnoce
ষ্	<ul> <li>Body position (guarding, distorted posture,</li> </ul>	Becomes tense with break-
	restricted limb movement, etc.) (J0800D)	Becomes tense with break- through pain.
	Restlessness	
1	Pain effect on function	
	<ul> <li>Disturbs sleep (J0500A)</li> </ul>	
শ	Decreases appetite (from clinical record)	Apperite since admission (per mean flow sheets) ranges from poor to excellent)
	<ul> <li>Adversely affects mood (D0200, D0500,</li> </ul>	near flow sheets) ranges
	and from clinical record)	prompoor to excellent)
X	Limits day-to-day activities (J0500B) (social	Dreferstarran in Ded except
	events, eating in dining room, etc.) +	o go to coffee hour with husband
X		
		of staff for ADL care
	except v	vulfeed self until she
	tires H	re staff assists as needed

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~	Associated signs and symptoms	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)	
	<ul> <li>Bedfast (G0800)</li> </ul>		
	<ul> <li>Agitation or new or increased behavior problems (E0200)</li> </ul>		
	Delirium (C1600)		
X	· Withdrawal Perachvities, de	clined all programs exce	$p \neq$
	Coffee hour.	clined all programs exce	•
1	Other Considerations		
	<ul> <li>Improper positioning</li> </ul>		
	Contractures (G0400)		
X	Immobility	ependent in others for move	ment
	Use of restraints (P0100)	Hover lift for transfer due t	0
×	<ul> <li>Recent change in pain (characteristics, frequency, intensity, etc.) (J0400, J0600) Ro</li> </ul>	Ependent on others for move Hoyer lift for transfer due t pathalogical fracturerisk, orts increase in at rest pain over last 24-48 hours,	lovel
Ø	<ul> <li>Insufficient pain relief (from resident/staff interview, clinical record, direct observation)</li> </ul>	over last 24-48hours. Is Roxanol helpful but "not o ood as it used to be "	as
	<ul> <li>Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain</li> </ul>		

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

States pain level 2-3 is tolerable. Does express desire for routine medication prior to Am and PM care/in addition to prior to pressure ulcer R which is already being provided). It is very important to her to continue to participate in self-feeding.

Analysis of Findings		Care Plan Considerations
Review indicators and supporting	Care	Document reason(s) care plan will/ will
documentation, and draw conclusions.	Plan	not be developed.
Document:	Y/N	
<ul> <li>Description of the problem;</li> </ul>		
<ul> <li>Causes and contributing factors; and</li> </ul>		
<ul> <li>Risk factors related to the care area.</li> </ul>		
Paun level 4-5, breakthrough		be enhanced to include
to level 10. Terminal Lungca		be enhanced to include
w bone mets. Hx of constration		the fellowing:
	r i	preprician revaluation!
due to pour meds: at rist for this with increase of meds.		-painmeds (dose and scheduling) - constpation prevention
		scheduling)
Has stage I pressure ulcer:		- constration prevention
at risk for worsening in		Social work/chaptain/
pressure ulce status due to		activities supportive
immobility. Pain contributes.		Visits to resident/husband
to poor appetite and decreased		Dietary referral: - constration
ability to participate in		prevention
ability to participate in self feeding. Atrisk for mood		- consider several small
alteration/further isolation		meals / day
due to pain.		OT- energy conservation
Hospice consult offered		PT- seating (officialing)
11/2/10 - declined by		Nonpharmacological pain
Hospice consult offered 11/2/10 - declined by resident. Team will		approaches: rest breaks durin
repher on 11/9/10 as		Nonpharmacological paun approaches: rest breaksduring ADL care, dim lights in room;
reaffer on 11/9/10 as resident requested		Soft music.
		OFFER pet visits

Referral(s) to another discipline(s) is warranted (to whom and why): See above Mganding referrals)

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):  $\searrow$  Yes  $\Box$  No

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#### FY 2012 RUG-IV FEDERAL RATES URBAN **HIGHEST TO LOWEST** CASE MIX INDEX MAXIMIZING

J	FY 2012 RUG-F	V	FY 2012 RUG-IV Rate I		
66 RUG-IV	Case Mix Index Urban	Rate	66 RUG-IV	Case Mix Index Urban	
RUX	66	\$737.08	RUX	66	
RUL	65	\$721.01	RUL	65	
RVX	63	\$656.06	ES3	64	
RVL	61	\$588.60	RVX	63	
RHX	62	\$594.39	RHX	62	
RHL	57	\$530.14	RVL	61	
RMX	58	\$545.24	RUC	60	
RML	55	\$500.27	RUB	59	
RLX	53	\$478.85	RMX	58	
RUC	60	\$558.79	RHL	57	
RUB	59	\$558.79	ES2	56	
RUA	51	\$467.23	RML	55	
RVC	54	\$479.38	RVC	54	
RVB	47	\$415.13	RLX	53	
RVA	46	\$413.52	ES1	52	
RHC	48	\$417.71	RUA	51	
RHB	40	\$375.95	HE2	50	
RHA	26	\$330.97	HD2	49	
RMC	38	\$366.95	RHC	48	
RMB	32	\$344.47	RVB	47	
RMA	18	\$283.43	RVA	46	
RLB	37	\$356.78	LE2	45	
RLA	7	\$229.89	HC2	44	
ES3	64	\$672.93	HB2	43	
ES2	56	\$526.77	LD2	42	
ES1	52	\$470.55	HE1	41	
HE2	50	\$454.49	RHB	40	
HE1	41	\$377.39	CE2	39	
HD2	49	\$425.57	RMC	38	
HD1	36	\$354.90	RLB	37	
HC2	44	\$401.48	HD1	36	
IC1	29	\$335.63	LC2	35	
IB2	43	\$396.66	CD2	34	
HB1	28	\$332.42	LE1	33	
.E2	45	\$412.73	RMB	32	
.E1	33	\$345.26	CE1	31	
.D2	42	\$396.66	PE2	30	
_D1	27	\$332.42	HC1	29	
_C2	35	\$348.48	HB1	28	
_C1	19	\$293.87	LD1	27	
_B2	25	\$330.81	RHA	26	
_B1	15	\$281.02	LB2	25	
CE2	39	\$367.75	PE1	24	
CE1	31	\$338.84	CD1	23	
CD2	34	\$348.48	PD2	22	
CD1	23	\$319.57	CC2	21	
CC2	21	\$305.11	PD1	20	
CC1	17	\$282.62	LC1	19	
CB2	16	\$282.62	RMA	18	
CB1	13	\$261.74	CC1	17	
CA2	9	\$239.26	CB2	16	
CA1	6	\$223.19	LB1	15	
BB2	11	\$253.71	PC2	14	
BB1	10	\$242.47	CB1	13	
BA2	4	\$210.34	PC1	12	
BA1	3	\$200.71	BB2	11	
PE2	30	\$338.84	BB1	10	
PE1	24	\$322.78	CA2	9	
PD2	22	\$319.57	PB2	8	
PD1	20	\$303.50	RLA	7	
PC2	14	\$274.59	CA1	6	
PC1	12	\$261.74	PB1	5	
PB2	8	\$232.83	BA2	4	
°B1	5	\$223.19	BA1	3	
PA2	2	\$192.68	PA2	2	
PA1	1	\$184.64	PA1	1	

ghest to Lowest	1	
	1	
Rate	1	
	1	
\$737.08		
\$721.01	-	Tracheostomy Care AND Ventilator while a
\$672.93		
\$656.06	1	
\$594.39		Tracheostomy Care OR Ventilator while a
\$588.60	i /	Hadheeddiniy eare <u>ere</u> ventilator white a
\$558.79		
\$558.79		
\$545.24	1//	Isolation for active infectious disease while a
\$530.14		
\$526.77	i /	
\$500.27		ADL score 15-16 with Comatose, Septicemia, Diabetes with
\$479.38		daily injections and 2 or more days of MD order changes,
\$478.85		Quadriplegia with ADL score greater than or equal to 5,
\$470.55		COPD and shortness of breath while lying flat, fever with
\$467.23		pneumonia or vomiting or feeding tube or weight loss,
\$454.49	/	Parenteral/IV feedings, Respiratory Therapy for 7 days. PHQ
\$425.57		
\$417.71	$\sim$	
\$415.13		Same as HE2 with ADL score 11-14, PHQ score greater than
\$413.52		or equal to 10.
\$412.73		ADL score 15-16 with CP, MS, Parkinson's disease, Feeding
\$401.48	i \	tube, Ulcers with 2 or more skin treatments, foot infection,
\$396.66	47	diabetic foot ulcer or open lesion on foot with treatments,
\$396.66	$\mathbb{N}$	Radiation therapy while a resident, Respiratory failure and O2
\$377.39	$    \setminus   $	therapy, Dialysis. PHQ score greater than or equal to 10.
\$375.95	$(\Lambda)$	
\$367.75	- 11 N	
\$366.95	· // `	Same as HE2 with ADL score 6-10, PHQ score greater than or
\$356.78		equal to 10.
\$354.90		
\$348.48	$1 \rightarrow 1$	Same as HE2 with ADL score 2-5, PHQ score greater than or
\$348.48		equal to 10.
\$345.26		
\$344.47	۱ I	
\$338.84	1	Same as LE2 with ADL score 11-14, PHQ score greater than
\$338.84		or equal to 10.
\$335.63		
\$332.42		
\$332.42		
\$330.97	ĺ	
\$330.81	i i i i i i i i i i i i i i i i i i i	
\$322.78	1	
\$319.57	1	
\$319.57	1	
\$305.11	1	
\$303.50		
\$293.87		
\$283.43	1	
\$282.62	1	
\$282.62		
\$281.02		
\$274.59		
\$261.74		
\$261.74	i i	
	r	
\$253.71	1	
\$242.47	1	
\$239.26	1	
\$232.83	1	
\$229.89	1	
\$223.19	1	
\$223.19	1	
\$210.34		

\$210.34

\$200.71

\$192.68

\$184.64



#### FY 2012 RUG-IV FEDERAL RATES RURAL HIGHEST TO LOWEST CASE MIX INDEX MAXIMIZING

FY 2012 RUG-IV			FY 2012 RUG-I		
66 RUG-IV	Case Mix Index Rural	Wage Adjusted Rate	66 RUG-IV	Case	
RUX	66	\$754.11	RUX		
RUL	65	\$738.76	RUL		
RVX	64	\$662.59	RVX		
RVL	62	\$598.14	ES3		
RHX	61	\$593.39	RVL		
RHL	57	\$532.01	RHX		
RMX	58	\$539.27	RUC		
RML	55	\$496.30	RUB		
RLX	52	\$469.37	RMX		
	60	\$583.77	RHL		
RUB RUA	59 54	\$583.77	ES2 RML		
RVC	53	\$496.30 \$493.78	RUA		
RVB	49	\$432.40	RVC		
RVA	48	\$430.87	RLX		
RHC	47	\$424.59	ES1		
RHB	41	\$384.69	HE2		
RHA	34	\$341.72	RVB		
RMC	40	\$368.93	RVA		
RMB	36	\$347.44	RHC		
RMA	19	\$289.13	HD2		
RLB	37	\$352.74	LE2		
RLA	8	\$231.51	HC2		
ES3	63	\$649.90	HB2		
S2	56	\$510.25	LD2		
<u>IS1</u>	51	\$456.54	RHB		
	50	\$441.19	RMC		
HE1 HD2	39 46	\$367.53 \$413.57	HE1 CE2		
1D2 1D1	35	\$346.05	RLB		
IC2	44	\$390.55	RMB		
IC1	28	\$327.63	HD1		
IB2	43	\$385.95	RHA		
IB1	27	\$324.56	LC2		
.E2	45	\$401.29	CD2		
.E1	31	\$336.84	LE1		
.D2	42	\$385.95	CE1		
D1	26	\$324.56	PE2		
. <u>C2</u>	33	\$339.91	HC1		
<u>.C1</u>	18	\$287.73	HB1		
.B2	25	\$323.03	LD1		
<u>.B1</u> CE2	15 38	\$275.45 \$358.32	LB2 PE1		
CE1	38	\$358.32 \$330.70	CD1	_	
DD2	30	\$339.91	PD2		
D1	23	\$312.28	CC2		
C2	21	\$298.47	PD1		
CC1	17	\$276.99	RMA		
CB2	16	\$276.99	LC1		
CB1	13	\$257.04	CC1		
CA2	9	\$235.55	CB2		
CA1	6	\$220.21	LB1		
3B2	11	\$249.37	PC2		
3B1	10	\$238.62	CB1		
3A2	4	\$207.93	PC1		
BA1	3	\$198.72	BB2		
PE2	29	\$330.70	BB1		
PE1	24	\$315.35	CA2		
PD2 PD1	22	\$312.28	RLA PB2		
PD1 PC2	20	\$296.94 \$269.32	PB2 CA1		
PC2	14 12	\$269.32 \$257.04	PB1		
PB2	7	\$237.04	BA2		
PB1	5	\$229.42	BA1		
PA2	2	\$191.05	PA2		
PA1	1	\$183.38	PA1	_	

2012 ]	RUG-IV Rate H	Highest to Lowest		
	Case Mix Index			
JG-IV	Rural	Wage Adjusted Rate		_
	66	\$754.11	/	Ti
	65	\$738.76		Т
	64	\$662.59		
	63	\$649.90	/	
	62 61	\$598.14 \$593.39	/	Is
	60	\$583.77		13
	59	\$583.77		_
	58	\$539.27	///	A
	57	\$532.01		da Q
	56	\$510.25	ľ //	ar
	55	\$496.30		or
	54	\$496.30	//	fe
	53	\$493.78	//	th
	52	\$469.37	//	_
	51	\$456.54	V	
	50 49	\$441.19 \$432.40	/	S
	49 48	\$430.87		
	40	\$424.59		_
	46	\$413.57	/ _	A
	45	\$401.29		tu
	44	\$390.55	k	di R
	43	\$385.95		th
	42	\$385.95	$\wedge \wedge$	
	41	\$384.69	$() \land$	_
	40	\$368.93	$\langle \rangle \rangle$	Sa
	39	\$367.53	$\langle \rangle \rangle$	ec
	38	\$358.32	$\langle \rangle \rangle$	_
	37 36	\$352.74 \$347.44		S
	35	\$346.05		ec
	34	\$341.72		
	33	\$339.91	۱ <i>۱</i>	S
	32	\$339.91		e
	31	\$336.84		
	30	\$330.70		
	29	\$330.70		
	28	\$327.63		
	27 26	\$324.56 \$324.56		
	25	\$323.03		
	24	\$315.35		
	23	\$312.28		
	22	\$312.28		
	21	\$298.47		
	20	\$296.94		
	19	\$289.13		
	18	\$287.73		
	17	\$276.99		
	16	\$276.99		
	15	\$275.45		
	14 13	\$269.32 \$257.04		
	13	\$257.04 \$257.04		
	12	\$249.37		
	10	\$238.62		
	9	\$235.55		
	8	\$231.51		
	7	\$229.42		
	6	\$220.21		
	5	\$220.21		
	4	\$207.93		
	3	\$198.72		
	2	\$101.05		

Tracheostomy Care <u>AND</u> Ventilator while a resident.

Tracheostomy Care <u>OR</u> Ventilator while a resident.

Isolation for active infectious disease while a resident.

ADL score 15-16 with Comatose, Septicemia, Diabetes with daily injections and 2 or more days of MD order changes, Quadriplegia with ADL score greater than or equal to 5, COPD and shortness of breath while lying flat, fever with pneumonia or vomiting or feeding tube or weight loss, Parenteral/IV feedings, Respiratory Therapy for 7 days. PHQ score greater than or equal to 10.

Same as HE2 with ADL score 11-14, PHQ score greater than or equal to 10.

ADL score 15-16 with CP, MS, Parkinson's disease, Feeding tube, Ulcers with 2 or more skin treatments, foot infection, diabetic foot ulcer or open lesion on foot with treatments, Radiation therapy while a resident, Respiratory failure and O2 therapy, Dialysis. PHQ score greater than or equal to 10.

Same as HE2 with ADL score 6-10, PHQ score greater than or equal to 10.

Same as HE2 with ADL score 2-5, PHQ score greater than or equal to 10.

Same as LE2 with ADL score 11-14, PHQ score greater than or equal to 10.

\$191.05

\$183.38