

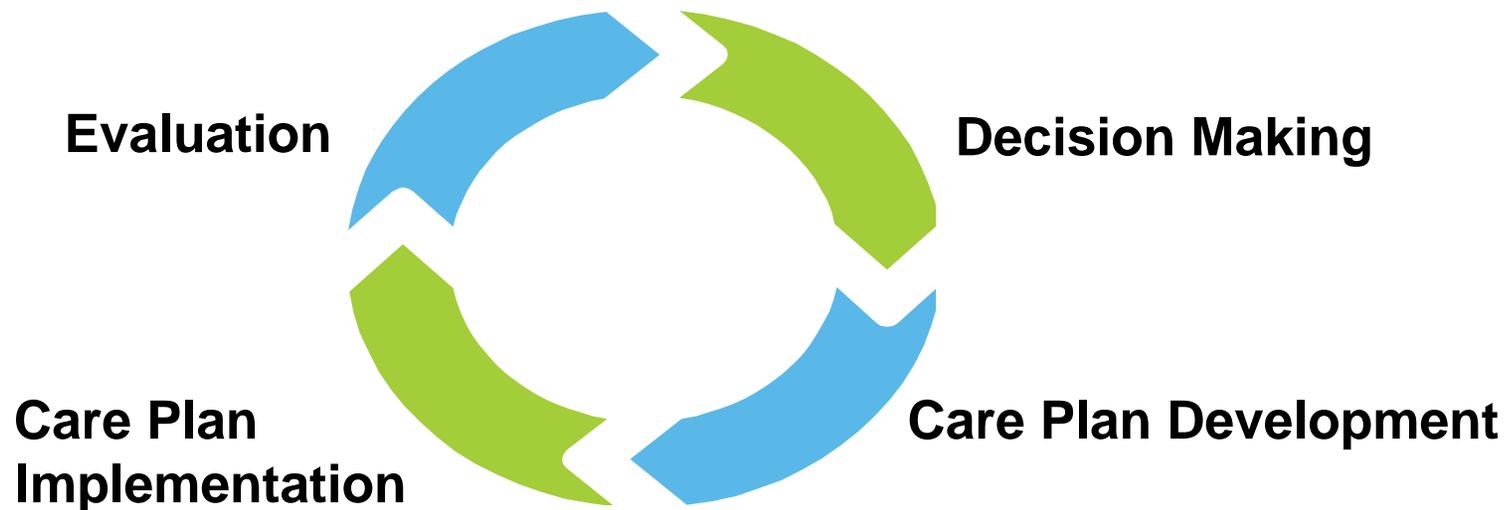
CHAPTER 4

CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING



OVERVIEW OF THE RAI AND CARE AREA ASSESSMENTS (CAAs)

MDS Assessment



■ CAA PROCESS FRAMEWORK

- ✓ **Guides review of triggered areas**
- ✓ **Clarifies functional status and related causes of impairments**
- ✓ **Assessment of causes and contributing factors provides IDT additional information**
- ✓ **Should help staff:**
 - **Consider each resident as a whole**
 - **Identify areas of concern**
 - **Develop to extent possible, interventions to help improve, stabilize, or prevent declines**
 - **Address need and desire for other considerations such as palliative care**



■ WHAT ARE THE CARE AREA ASSESSMENTS (CAAs)

- ✓ Triggered responses to items on the MDS specific to a resident's problems, needs, or strengths
- ✓ CAAs reflect conditions, symptoms, other concern common in nursing home residents
- ✓ Commonly identified or suggested by MDS findings
- ✓ CAAs are not required for Medicare PPS assessments
- ✓ When a PPS is combined with a OBRA comprehensive; the CAA process must be completed

■ WHAT ARE THE CARE AREA ASSESSMENTS (CAAs)

- ✓ **The MDS information and the CAA process provide the foundation upon which the individualized care plan is formulated**
- ✓ **No specific tool mandated**
- ✓ **No specific guidance on how to understand or interpret triggered areas**
- ✓ **Facilities are to identify and use tools that are current and grounded in current clinical standards of practice**
- ✓ **Use sound clinical problem solving and decision making skills**
- ✓ **Only required for OBRA comprehensive assessments**

■ CARE AREA ASSESSMENTS 1 – 10

1 - Delirium

2 - Cognitive Loss/Dementia

3 - Visual Function

4 - Communication

5 - ADL Functional/Rehabilitation Potential

6 - Urinary Incontinence and Indwelling Catheter

7 - Psychosocial Well-Being

8 - Mood State

9 - Behavioral Symptoms

10 - Activities

■ CARE AREA ASSESSMENTS 11 – 20

11 - Falls

12 - Nutritional Status

13 - Feeding Tube

14 - Dehydration/Fluid Maintenance

15 - Dental Care

16 - Pressure Ulcer

17 - Psychotropic Drug Use

18 - Physical Restraints

19 - Pain

20 - Return to Community Referral

■ WHAT THE CAA PROCESS INVOLVES

- ✓ **CAA process refers to identifying and clarifying areas of concern that are triggered based on specific MDS item responses**
- ✓ **Focuses on evaluating these triggered care areas**
- ✓ **Does not provide exact detail on how to select pertinent interventions for care planning**
- ✓ **Interventions must be individualized and based on effective problem solving and decision making approaches**

■ WHAT THE CAA PROCESS INVOLVES

✓ Care Area Triggers (CATs):

- Identify conditions that may require further evaluation
- Each triggered item must be assessed through the CAA process but may or may not be addressed in care plan
- Provides a “flag” for IDT, indicating need for assessment prior to care plan decision
- May identify causes, risk factors and complications associated with the care area condition
- Care plan then addresses these factors with goal of promoting resident’s highest practicable level of functioning



■ WHAT THE CAA PROCESS INVOLVES

✓ **A risk factor increases chance of a negative outcome or complication:**

- **Example:**

- **Impaired bed mobility may increase risk of a pressure ulcer:**

- **Impaired bed mobility is the risk factor**

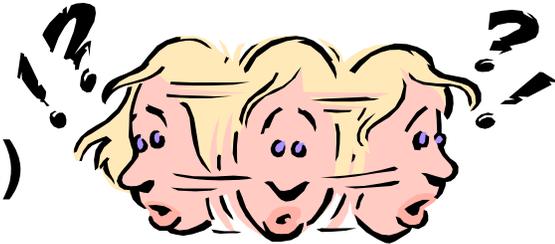
- **Unrelieved pressure is the effect**

- **Potential pressure ulcer is the complication**

■ WHAT THE CAA PROCESS INVOLVES

✓ A care area issue/condition (e.g., falls) may result from:

- A single underlying cause (new medication that causes dizziness)
- A combination of factors (new medication, forgot walker, bed too high or too low)



✓ There may be a single cause of multiple triggers and impairments:

✓ Example:

- Hypothyroidism is a common, potentially reversible medical condition that can have physical, functional and psychosocial complications:
 - It may trigger as many as 15 CAAs

■ WHAT THE CAA PROCESS INVOLVES

- ✓ **Recognizing connection among symptoms and treating underlying cause(s) to extent possible:**
 - **Can help address complications**
 - **Can improve outcome**
- ✓ **Failing to recognize links and instead trying to address the triggers in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood**

■ WHAT THE CAA PROCESS INVOLVES

- ✓ The RAI is not intended to:
 - Provide diagnostic advice
 - Specify which triggered areas may be related to one another
 - How those problems relate to underlying causes
- ✓ The IDT, including resident's MD, should determine these connections and underlying causes as they assess the triggered care areas
- ✓ Not all triggers identify deficits or problems
- ✓ Some triggers indicate areas of strengths

■ WHAT THE CAA PROCESS INVOLVES

- ✓ **The CAA process may help the IDT to:**
 - **Identify and address associated causes and effects**
 - **Determine whether and how multiple triggered conditions are related**
 - **Identify need to obtain additional information**
 - **Identify whether and how a triggered condition actually affects resident's function and quality of life or if resident is at risk**

■ WHAT THE CAA PROCESS INVOLVES

- ✓ **The CAA process may help the IDT to:**
 - **Review resident's condition with health care practitioner**
 - **Identify links**
 - **Pertinent tests**
 - **Consultations**
 - **Interventions**
 - **Determine if resident could potentially benefit from rehabilitation interventions**
 - **Develop individualized care plan**

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

- ✓ **Assigning responsibility for completing the MDS and CAAs:**
 - **Per OBRA statute, the resident assessment must be conducted or coordinated by a RN**
 - **Appropriate participation of health professionals**
 - **Common practice for a facility to assign specific MDS items and CAAs associated with those items to various disciplines**
 - **More than one discipline may need to be involved**
 - **Facility's responsibility to obtain input needed for clinical decision making consistent with relevant clinical standards of practice**

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

- ✓ **Identifying policies and practices related to the assessment and care planning processes:**
 - **Per OBRA, medical director is responsible for overseeing “implementation of resident care policies” and “coordination of medical care in the facility”**
 - **IDT members should collaborate with the medical director**
 - **Identify current evidence-based or expert-endorsed resources and standards of practice**
 - **Be ready to provide state surveyors resources used in CAA process**

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

✓ CAA documentation:

- Relevant documentation for each triggered CAA describes causes and contributing factors
- Nature of issue or condition
 - What is the issue or condition for resident
 - Why is it an issue or problem
- Complications affecting or caused by the care area
- Risk factors affecting care planning decision
- Factors to be considered in developing individualized care plan interventions:
 - To care plan or not to care plan

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

✓ CAA documentation:

- **Need for additional evaluation by other health professionals**
- **Resources or assessment tools used for decision making**
- **Conclusions from performing the CAA**
- **Completion of Section V (CAA Summary) of the MDS**



■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

✓ CAA documentation:

- **Written documentation of CAA findings and decision making process may appear anywhere in the resident's record:**
 - **Discipline-specific flow sheets**
 - **Progress notes**
 - **Care plan summary notes**
 - **CAA summary narrative**
- **Use the “Location and Date of CAA Documentation” column on CAA Summary (Section V of MDS)**
- **Indicate in “Care Planning Decision” if triggered area is addressed in care plan**



■ WHEN IS THE RAI NOT ENOUGH?

- ✓ **Limitations of the RAI-related instruments:**
 - **MDS may not trigger every relevant issue**
 - **Not all triggers are clinically significant**
 - **MDS is not a diagnostic tool or treatment selection guide**
 - **MDS does not identify causation or history of problems**
 - **Facilities are responsible for assessing and addressing all relevant care issues, whether or not covered by the RAI, including monitoring condition and appropriate interventions**

■ THE RAI AND CARE PLANNING

- ✓ **Per 42 CFR 483.25, the comprehensive care plan:**
 - **Is an interdisciplinary communication tool**
 - **Must include measurable objectives and time frames**
 - **Must describe services to be furnished to attain or maintain resident's highest practicable physical, mental and psychosocial well-being**
 - **Must be reviewed and revised periodically**
 - **Services provided or arranged must be consistent with written plan of care**
 - **Must maintain assessments completed in the previous 15 months in the active record**

■ THE RAI AND CARE PLANNING

- ✓ **A well-developed and executed assessment care plan:**
 - **Looks at resident as a whole human being with unique characteristics and strengths**
 - **Views the resident in distinct functional areas (MDS)**
 - **Gives the IDT a common understanding of the resident**
 - **Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers)**

■ THE RAI AND CARE PLANNING

- ✓ **A well-developed and executed assessment care plan:**
 - **Provides additional clarity of potential issues and/or conditions (CAA process)**
 - **Develops and implements an interdisciplinary care plan with necessary monitoring and follow-up**
 - **Reflects the resident/resident representative input and goals for health care**

■ THE RAI AND CARE PLANNING

- ✓ **A well-developed and executed assessment and care plan:**
 - **Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning)**
 - **Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using RAI and then modifies the individualized care plan as appropriate and necessary**
 - **Communicate with resident/family/representative regarding resident's care plan and wishes**

■ THE OVERALL CARE PLAN

- ✓ **The overall care plan should be oriented towards:**
 - **Preventing avoidable declines in functioning if possible**
 - **Managing risk factors to the extent possible**
 - **Addressing ways to try to preserve and build upon resident strengths**
 - **Assessing and planning for care to meet medical, nursing, mental and psychosocial needs**
 - **Applying current standards of practice**
 - **Evaluating treatment for measurable objectives, timetables and outcomes of care**

■ THE OVERALL CARE PLAN

- ✓ **The overall care plan should be oriented towards:**
 - **Respecting the resident's right to decline treatment**
 - **Offering alternative treatments, as applicable**
 - **Using an appropriate interdisciplinary approach to improve the resident's functional abilities**
 - **Involving resident, resident's family/representatives as appropriate**
 - **Involving direct care staff**
 - **Addressing additional relevant care planning areas**

■ CAA TIPS AND CLARIFICATIONS

- ✓ **Care planning has several key steps that may occur at the same time or in sequence**
- ✓ **Goals should be measurable:**
 - **Lead to outcome objectives**
 - **Have a time frame for completion or evaluation**
- ✓ **Goal statements should include:**
 - **Subject (first or third person)**
 - **Verb**
 - **Modifiers**
 - **Time frame**
 - **Goals**



■ CAA TIPS AND CLARIFICATIONS

- ✓ **Clinical problem solving and decision making process, steps and objectives:**
 - **Recognition/Assessment**
 - **Problem definition**
 - **Diagnosis/Cause and effect analysis**
 - **Identify goals and objectives of care**
 - **Select interventions/planning care**
 - **Monitor progress**
 - **Modify goals and approaches as needed**

■ CAA TIPS AND CLARIFICATIONS

- ✓ **A separate care plan is not necessarily required for each triggered area:**
 - **A single trigger may have multiple causes and contributing factors**
 - **Multiple items may have a common cause or related factors**
 - **May be more appropriate to address multiple issues in one care plan**

■ USING THE CAA RESOURCES

- ✓ **Step 1 - Identification of triggered CAAs:**
 - Automated software
 - Manually
- ✓ **Step 2 - Analysis of triggered CAAs:**
 - Review items that caused CAA to trigger
 - In-depth, resident-specific assessment of potential need for care plan interventions
 - Consider any issues and/or conditions that may contribute but are not captured in MDS data
 - Identify areas of concern
 - Use this information to make a clear issue or problem statement that clearly identifies the situation
 - Determine extent of problem

■ USING THE CAA RESOURCES

- ✓ **Step 2 - Analysis of triggered CAAs (continued):**
 - **Identify links among triggers and their causes**
 - **Detailed history is essential**
 - **Refer to sources as needed to help with clinical decision making consistent with professional standards of practice**
 - **May need to involve physician**
- ✓ **Step 3 - Decision making:**
 - **Resident, family or resident's representative should be integral part of process**
 - **Staff who have participated in the assessment and provided pertinent information should be part of IDT that develops care plan**

■ USING THE CAA RESOURCES

✓ **Step 4 - CAA documentation:**

- **Information from assessment that led to care plan decision should be clearly documented**
- **Refer to CAT Logic tables within each CAA description (Chapter 4, section 4.10) and Appendix C in RAI Manual for detailed information on triggers**

✓ **Twenty Care Areas detail:**

- **Chapter 4, Pages 4-16 through 4-41**

■ POST TEST #6

- ✓ **What are Care Area Assessments (CAAs)?**
 - **Triggered responses to items on the MDS specific to a resident's problems, needs or strengths**
- ✓ **How many CAAs are there?**
 - **20**
- ✓ **Does each triggered CAA have to be assessed?**
 - **Yes**
- ✓ **Does each triggered CAA have to be care planned?**
 - **No**
- ✓ **How are the MDS, CAAs/CATs and care plan related?**
 - **The MDS provides a foundation for more thorough assessment through the CAAs/CATs which leads to development of individualized plan of care.**

"PSYCHOSOCIAL WELL-BEING" CARE PLAN EXERCISE



■ PSYCHOSOCIAL WELL-BEING CAA

- ✓ **This CAA is triggered when a resident exhibits minimal interest in social involvement**
- ✓ **Involvement in social relationships is vital**
- ✓ **Decreases in social relationships may affect:**
 - **Psychological well-being**
 - **Mood or behavior**
 - **Physical activity**
- ✓ **Declines in physical functioning, cognition, new onset or worsening of pain or other health issues may affect both social relationships and mood**
- ✓ **Psychosocial well-being may be negatively impacted by significant life changes, such as death of a loved one**

■ **PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE
TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):**

- 1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:**

D0200A1 = 1

- 2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:**

D0500A1 = 1

- 3. Interview for activity preference item “How important is it to you to do your favorite activities?” has a value of 3 (not very important) or 4 (not important at all) as indicated by:**

F0500F = 3 or F0500F = 4

■ PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE
TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):

4. **Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities as indicated by:**

F0800Q = not checked

5. **Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:**

E0200A >= 1 and E0200A <= 3) AND

(I4800 = 0 OR I4800 = -) AND

(I4200 = 0 OR I4200 = -)

■ PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE
TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

(E0200B \geq 1 and E0200B \leq 3) **AND**

(I4800 = 0 OR I4800 = -) **AND**

(I4200 = 0 OR I4200 = -)

7. Any six items for interview for activity preferences has the value of 4 (not important at all) and resident is primary respondent for daily and activity preferences as indicated by:

(Any 6 of F0500A through F0500H = 4) **AND**

(F0600 = 1)

■ CARE PLAN EXERCISE PSYCHOSOCIAL WELL-BEING

- ✓ **Step 1 – Identification of Triggered CAA**

- ✓ **Step 2 – Analysis of triggered Psychosocial Well-Being CAA**
 - **MDS items that caused this CAA to be triggered**
 - **Issues/conditions not captured in MDS data**
 - **Areas of concern**
 - **Links to other CAAs**

■ CARE PLAN EXERCISE PSYCHOSOCIAL WELL-BEING

✓ **Step 3 – Decision Making:**

- **Proceed to Psychosocial well-Being Care Plan**

▪ **YES** _____ **NO** _____

✓ **Care Plan Development:**

- **Problem Statement:**
- **Goal Statement:**
- **Interventions:**
- **Responsible Discipline(s):**

OFFICE OF INSPECTOR GENERAL SKILLED NURSING FACILITY REPORT FEBRUARY 2013



■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Background

- **Report based only on medical records review**
- **To participate in Medicare, SNFs must meet certain quality of care requirements**
- **Must develop a care plan and provide services in accordance with that care plan**
- **Must plan for discharge**
- **In 2007, 74% of facilities surveyed had at least one deficiency related to quality of care**
- **Other reports found that:**
 - **Psychosocial services were not care planned appropriately or provide all services identified in care plans**

■ OFFICE OF INSPECTOR GENERAL REPORT

- **Other reports and investigations found that:**
 - **Psychosocial services were not care planned appropriately or all services identified in care plans were not provided**
 - **Nearly all records reviewed with atypical antipsychotic drugs failed to meet one or more Medicare requirements for assessments or care plans**
 - **Quality of care issues associated with discharges between SNFs and other facilities**
 - **Failure to provide adequate care**
 - **Inadequate staffing and services**

■ OFFICE OF INSPECTOR GENERAL REPORT

- ✓ **Medicare requirements related to quality of care:**
 - **Developing care plans and providing services**
 - **Measureable objectives with time tables**
 - **Customized to individual**
 - **Discharge planning**
 - **Summary of stay**
 - **Status at time of discharge**
 - **Post-discharge plan of care**

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Care Plan Findings

- For 37% of stays, care plan or service requirements were not met
- For 26% of stays, care plans were not developed that met requirements
- For 19% of stays, care plans did not address one or more identified problem areas
- For 7% of stays, care plans did not include measureable objectives or detailed time frames
- Care plans often generic, not customized
 - Found “many perfect computer generated care plans”

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Care Plan Findings

- **Little to no documentation of implementation**
- **Missing information on restorative nursing programs, toileting programs and preventive wound care**
- **For 15% of stays, SNFs failed to provide at least one service at the frequency or duration prescribed in the care plans**
- **Found several examples of more services provided than indicated in care plan**
 - ✓ **Typically involved therapy**
 - ✓ **12 straight days with an explanation of need**
 - ✓ **Continued therapy even though all goals met**

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Discharge Planning Findings

- For 31% of stays, SNFs did not meet discharge planning requirements
- For 16% of stays, no summaries of stay or discharge status
- Found summaries with only minimum information such as “has done well”
- Lacked clinical information
- For 23% of stays, SNFs did not have post-discharge plans of care
 - Specific instructions not provided or only verbal instructions

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ **Quality of Care Findings**

- **Wound care**
 - **Poor tracking**
 - **Poor or inadequate care**
 - **Nursing notes regarding treatments provided confusing and inconsistent**
 - **Interventions, such as pressure relief, not provided**
 - **Lack of detailed wound information**

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Medication Management Findings

- 95% of claims for atypical antipsychotic drugs for elderly residents
 - Were for off-label use
 - Or for condition specified in “black-box warning”

Example: Resident with dementia given and antipsychotic drug with “black-box warning” not approved for dementia-related psychosis. Medical record indicated resident more confused, agitated, not sleeping well but did not address these issues in any way.

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Therapy Findings

- **Inappropriately high levels**
 - **Resident with dislocated hip and could not bear weight and should not ambulate**
 - **SNF provided “ultra high” levels of PT for entire stay**
 - **Resident receiving hospice care for terminal lung cancer**
 - ✓ **PT 5 days a week for 5 weeks**
 - ✓ **Wanted to participate at first then later did not want to continue**
 - ✓ **SNF continues therapy at same level of intensity for remainder of stay**

■ OFFICE OF INSPECTOR GENERAL REPORT

✓ Recommendations

- **Strengthen regulations on care planning and discharge planning**
- **Provide guidance to SNFs to improve care planning and discharge planning**
- **Increase surveyor efforts to identify SNFs that don't meet requirements**
- **Link payments to meeting quality of care requirements**

CHAPTER 5 SUBMISSION AND CORRECTION OF THE MDS ASSESSMENT



■ TRANSMITTING MDS DATA

- ✓ **All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to the QIES ASAP system**
- ✓ **Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS**
- ✓ **Assessments completed for purposes other than OBRA and SNF PPS reasons AND are not in a certified bed are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans**

■ TRANSMITTING MDS DATA

- ✓ **Facilities must be certain they are submitting assessments under the appropriate authority**
- ✓ **There must be a federal and/or state authority to submit assessments to the QIES ASAP**
- ✓ **Provider indicates the submission authority in A0410:**
 - **Code = 1** Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
 - **Code = 2** Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
 - **Code = 3** Unit is Medicare and/or Medicaid certified

■ SUBMISSION TIME FRAME FOR MDS RECORDS

Type	A0310A	A0310B	A0310F	Completion/ Event Date	Submit By
Admission	01	All values	10,11,99	V0200C2	V0200C2 + 14
Annual	03	All values	10,11,99	V0200C2	V0200C2 + 14
SCSA	04	All values	10,11,99	V0200C2	V0200C2 + 14
SCPA	05	All values	10,11,99	V0200C2	V0200C2 + 14
Quarterly	02	All values	10,11,99	Z0500B	Z0500B + 14
SCPQA	06	All values	10,11,99	Z0500B	Z0500B + 14
PPS	99	01 - 07	10,11,99	Z0500B	Z0500B + 14

■ SUBMISSION TIME FRAME FOR MDS RECORDS

Type	A0310A	A0310B	A0310F	Completion/ Event Date	Submit By
Discharge Assess	All values	All values	10 or 11	Z0500B	Z0500B + 14
Death in Facility	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	1	A1600	A1600 + 14
Correction Request	N/A	N/A	N/A	X1100E	X1100E + 14

V0200C2 = Care Plan Completion Date

Z0500B = MDS Assessment Completion Date

A2000 = Date of discharge or death

A1600 = Date of Entry

X1100E = Date of RN Coordinator Signature on Correction Request

■ COMPLETION TIMING

- ✓ **All non-comprehensive OBRA, and PPS assessments:**
 - **Z0500B must be no later than 14 days from ARD (A2300)**
- ✓ **Admission assessment:**
 - **Z0500B must be no later than 13 days after A1600**
 - **CAA Completion Date (V0200B2) must be no more than 13 days after A1600**
- ✓ **Annual assessments:**
 - **V0200B2 must be no later than 14 days from A2300**



■ COMPLETION TIMING

- ✓ **Significant Change and Significant Correction Comprehensive assessments:**
 - **V0200B2 must be no later than 14 days from A2300**
AND
 - **V0200B2 must be no later than 14 days from determination date**
- ✓ **Tracking records (entry/death in facility):**
 - **Must be completed (Z0500B) within 7 days of Event Date:**
 - **A1600 for entry record**
 - **A2000 for death in facility record**

■ ENCODING DATA TIMING

- ✓ **Encoding is defined as entering the MDS assessment information into the facility's MDS software.**
- ✓ **Comprehensive assessments:**
 - **Within 7 days after Care Plan Completion Date (V0200C2 + 7)**
- ✓ **Quarterly, Discharge or PPS assessment:**
 - **Within 7 days after MDS Completion Date (Z0500B + 7)**
- ✓ **Tracking records:**
 - **Within 7 days of Event Date:**
 - **A1600 + 7 for Entry record**
 - **A2000 + 7 for Death in Facility record**

■ VALIDATION EDITS

- ✓ QIES ASAP system has validation edits to monitor the timeliness and accuracy of MDS record submissions
- ✓ Initial Submission Feedback:
 - Confirms file was received
 - Assigns file submission number
 - Assigns date & time file was received for processing
 - Displays submission file number
- Detailed information on validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on CMS MDS website and in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide* on the QTSO MDS 3.0 website.



■ VALIDATION EDITS

- ✓ **QIES ASAP system performs three types of validation:**
 - **Fatal file errors:**
 - **Fatal files are rejected and must be corrected and resubmitted**
 - **Fatal record errors:**
 - **Include “out of range” responses or inconsistent relationships between items**
 - **Fatal records are rejected and must be corrected and resubmitted**
 - **Non-fatal errors (warnings):**
 - **Include missing or non-critical questionable data**
 - **Must evaluate non-fatal errors to identify the need for corrective actions**



■ ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS

HIPPS Codes

- ✓ **Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC)**

- ✓ **The HIPPS code consists of five positions:**
 - **The first three positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident**
 - **The last two positions are an Assessment Indicator (AI) code indicating which type of assessment was completed**
 - **The standard grouper logic uses MDS 3.0 items to determine both the RUG-IV group and the AI code**

■ ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS

- ✓ **The HIPPS codes used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes:**
 1. **The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The RUG version code in Item Z0100B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare Part A HIPPS code.**
 2. **The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS**
- ✓ **There is also a Medicare Short Stay indicator (Z0100C) on the MDS**

■ ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS

- ✓ **The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in the QIES ASAP system**
- ✓ **The claim must include the correct HIPPS code for the assessment**
- ✓ **If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3616a)**

■ MDS CORRECTION POLICY

- ✓ **Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay - the MDS must be accurate as of the ARD**
- ✓ **Minor changes in resident's status should be noted in resident's record (e.g., in progress notes)**
- ✓ **Significant change in status warrants a new comprehensive assessment**



■ MDS CORRECTION POLICY

- ✓ **Electronic record submitted to and accepted into QIES ASAP system is the legal assessment**
- ✓ **Corrections made to electronic record after data transmission, or to paper copy maintained in medical record are not recognized as proper corrections**
- ✓ **It is the responsibility of the provider to ensure that any corrections made are submitted to the QIES ASAP system in accordance with the MDS Correction Policy**



■ MDS CORRECTION POLICY

- ✓ **Software used by provider to encode MDS must run all CMS standard edits as defined in data specifications**
- ✓ **Enhanced record rejection standards have been implemented in QIES ASAP system:**
 - **Out of range responses or inconsistent responses cause record rejection**
 - **Records with inaccurate data (fatal errors) are not stored in QIES ASAP database**
- ✓ **Once assessment is accepted in the QIES ASAP system, corrections must be processed using the modification or inactivation procedures**

■ MDS CORRECTION POLICY

- ✓ **Clinical corrections must assure accuracy**
- ✓ **Resident is accurately assessed**
- ✓ **Care plan is accurate**
- ✓ **Resident is receiving necessary care**
- ✓ **May need to perform a:**
 - **Significant Change in Status assessment**
 - **Significant Correction of Prior assessment**
 - **Corrections to record in the QIES ASAP system by sending in modification or inactivation record**



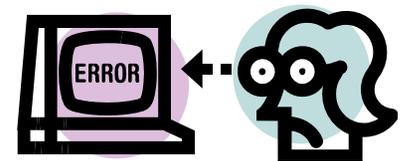
■ ERRORS IDENTIFIED DURING ENCODING PERIOD

- ✓ **Correcting errors that have not yet been accepted in the QIES ASAP system**
- ✓ **Encoding period is up to 7 days after the MDS completion and before submission**
- ✓ **Changes may be made for any item during encoding and editing period, but must reflect the observation period**
- ✓ **Provider is responsible for running encoded MDS assessment data against CMS edits that software vendors are responsible for building into computer systems**
- ✓ **Only assessments that meet all of the required edits are considered complete**



■ ERRORS IDENTIFIED AFTER ENCODING PERIOD BEFORE SUBMISSION

- ✓ **Significant error(s)** - error(s) that inaccurately reflect resident's clinical status and/or result in inappropriate plan of care:
 - Correct errors in original OBRA assessment
 - Submit corrected assessment to QIES ASAP
 - Perform new SCSA or SCPA with current ARD and update care plan, as necessary
- ✓ If Medicare only or Discharge, no SCSA or SCPA is required
- ✓ **Minor Error(s)** - all errors (not significant) related to coding of MDS items:
 - Correct errors in original OBRA assessment
 - Submit corrected assessment to QIES ASAP



■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **A correction can be submitted for any accepted record within 3 years of the target date of the record for facilities that are still open**
- ✓ **If a facility is terminated, the corrections must be submitted within 2 years of the facility termination date**
- ✓ **A record may be corrected even if subsequent records have been accepted for the resident**

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **Errors must be corrected within 14 days after being identified**
- ✓ **Modification:**
 - **Moves the inaccurate record into a history file**
 - **Replaces with the corrected active record**
 - **Requires MDS correction request items in Section X**
- ✓ **Inactivation:**
 - **Moves inaccurate record into history file**
 - **Does not replace it with new record**
 - **Requires MDS correction request items in Section X:**
- ✓ **Section X contains the minimum amount of information necessary to enable location of erroneous MDS record**

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **Modification may be used for clinical or demographic errors in the following items:**
 - **A0310: Type of Assessment; *where there is no Item Set Code (ISC) change***
 - **A1600: Entry Date (all assessment types)**
 - **A2000: Discharge Date (all assessment types)**
 - **A2300: Assessment Reference Date (ARD); *only if error is data entry/typographical error***
 - **Clinical Items (B0100 – V0200C)**

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **Error is discovered in a Entry tracking, Death in facility, Discharge, or PPS (that is not an OBRA):**
 1. **Create a corrected record with all items included**
 2. **Complete Section X (correction request) with new record:**
 - **A0050 = 2**
 3. **Submit modified record**
- ✓ **Minor error is discovered in a OBRA only assessment:**
 1. **Create a corrected record with all items included**
 2. **Complete Section X (correction request) with new record:**
 - **A0050 = 2**
 3. **Submit modified record**

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- **Significant error is discovered in a OBRA only assessment:**
 1. Create a corrected record with all items included
 2. Complete Section X (correction request) with new record:
 - A0050 = 2
 3. Submit modified record
 4. Perform a new SCPA or SCSA and update care plan:
 - A SCSA is required only if correction revealed resident met SCSA criteria
 - If criteria for SCSA is not met, a SCPA is required

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **When errors in an OBRA assessment in the QIES ASAP system has been corrected in a more current OBRA assessment, the facility is not required to perform a new additional assessment (SCSA or SCPA)**
- ✓ **In this situation, the facility has already updated the resident's status and care plan**
- ✓ **The facility must use the modification process to assure that the erroneous data is corrected in the system**

■ EXAMPLE 1:

ITEM SET CODE AND A0310 MODIFICATIONS

- ✓ **A modification of a typographical error in the Reason for Assessment (A0310A – D,F) may be performed if the change does not result in a change to the ISC used for the assessment:**

A0310A = 99	None of the above
A0310B = 03	30-day scheduled assessment
A0310C = 4	Change of Therapy OMRA (COT)
A0310F = 99	None of the above

Q: If A0310C should have been coded as “0” (stand alone 30-day assessment), can this assessment be corrected through modification?

A: Yes, as the ISC used for the modified assessment (NP) is the same as the ISC used for the previously accepted assessment

■ EXAMPLE 2:

ITEM SET CODE AND A0310 MODIFICATIONS

- ✓ **A modification of a typographical error in the Reason for Assessment (A0310A – D,F) may be performed if the change does not result in a change to the ISC used for the assessment:**

A0310A = 99 None of the above

A0310B = 07 Unscheduled assessment used for PPS

A0310C = 4 COT

A0310F = 99 None of the above

Q: If A0310B should have been coded as “3” (30-day/COT combined), can this assessment be corrected through modification?

A: No, as the ISC used for the modified assessment (NP) is the different from the ISC used for the previously accepted assessment (NO)

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ **An Inactivation Request is required for errors in the following items:**
 - **A0200: Type of Provider**
 - **A0310: Type of Assessment; *where there is an ISC change***
 - **A1600: Entry Date on Entry record (A0310F=1) *when the look back period and/or clinical assessment would change had the MDS been modified***
 - **A2000: Discharge Date on a Discharge/Death in facility record (A0310F=10, 11, 12) *when the look back period and/or clinical assessment would change had the MDS been modified***
 - **A2300: ARD on an OBRA or PPS assessment *when the look back period and/or clinical assessment would change had the MDS been modified***

■ INACTIVATION

- ✓ **Inactivations should be rare and are appropriate only under narrow circumstances**
- ✓ **In such cases:**
 - **A new ARD must be established**
 - **ARD must equal the date the error was determined**
 - **May be later**
 - **Not earlier**
 - **New assessment must include new signatures and dates based on the new look back period**
- ✓ **Required to submit only Section X items and A0050=2**
 - **All that is needed to locate the record**

■ SPECIAL MANUAL CORRECTION REQUEST

- ✓ **Errors requiring manual corrections request:**
 - **Incorrect value in A0410**
 - **Wrong facility ID in control item FAC_ID**
 - **Test record inadvertently submitted as production**
- ✓ **Facility must notify State Agency of issue:**
 - **State sends facility Correction/Deletion request form**
 - **Facility completes form and must submit to its State Agency via certified mail USPS**
 - **State Agency must approve, sign and send form to QIES Help Desk via certified mail USPS**
- ✓ **Completely removes record from data base**
- ✓ **Data Correction Algorithm on page 5-15**

■ POST TEST #7

- ✓ **What does QIES ASAP stand for?**
 - **Quality Improvement and Evaluation System (QIES)
Assessment Submission and Processing System (ASAP)**
- ✓ **Is an assessment completed for a Medicare Advantage plan transmitted?**
 - **No; assessments completed for purposes other than OBRA and SNF PPS reasons are not to be submitted**
- ✓ **What is the Initial Submission Feedback report?**
 - **A confirmation that the transmitted MDS file was received for processing and editing by the QIES ASAP system**
- ✓ **What are the three types of validation edits performed by the QIES ASAP system?**
 - **Fatal file errors, Fatal record errors, Non-Fatal errors (warnings)**
- ✓ **How far back can a correction be submitted for any accepted record?**
 - **3 years if facility is still open**
 - **2 years if facility is terminated (closed)**

CHAPTER 6

MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)



■ MEDICARE SNF PROSPECTIVE PAYMENT SYSTEM

- ✓ **RUG classification system uses information from the MDS to classify residents**
- ✓ **2005 – CMS initiated STRIVE time study:**
 - **First nationwide time study since 1997**
 - **Data collected used to update payment systems**
 - **Based on analysis, CMS developed RUG-IV model**
- ✓ **Over half of State Medicaid programs use the MDS for payment systems:**
 - **Choice to use RUG-III or RUG-IV**
 - **Kentucky uses RUG-III**

■ RELATIONSHIP BETWEEN THE ASSESSMENT AND THE CLAIM

- ✓ **SNF PPS establishes a schedule of Medicare assessments**
- ✓ **These scheduled assessments establish per diem payment rates for associated standard payment periods**
- ✓ **Unscheduled off-cycle assessments may impact the per diem rates**
- ✓ **Responsibility of the facility to ensure claims are accurate and meet all Medicare requirements**
- ✓ **RUG assignment is not an indication that Part A requirements have been met**

■ RELATIONSHIP BETWEEN THE ASSESSMENT AND THE CLAIM

- ✓ **Two data items must be included in Medicare claim:**
 - **Assessment Reference Date (ARD)**
 - **Links assessment with billing records**
 - **Health Insurance Prospective Payment System (HIPPS) Code**
 - **CMS provides standard software and logic for calculation**
 - **5 position code**
 - **First 3 positions contain RUG-IV group, i.e., RUX, LE1**
 - **Assessment Indicator (AI)**
 - **Last 2 positions identify assessment type**
 - **Based on coding of A0310**
 - **First digit identifies scheduled PPS assessment**
 - **Second digit identifies unscheduled PPS assessment**

■ SNF PPS ELIGIBILITY CRITERIA

- ✓ **Beneficiaries must meet the established eligibility requirements for Part A**
- ✓ **Refer to *Medicare General Information, Eligibility, and Entitlement Manual*; Chapter 1**
- ✓ ***Medicare Benefit Policy Manual*; Chapter 8**
- ✓ **Summary of four Part A requirements:**
 - **Technical Eligibility**
 - **Clinical Eligibility**
 - **Physician Certification**
 - **Refer to Medicare Benefit Policy Manual, Chapter 8**

■ TECHNICAL ELIGIBILITY REQUIREMENTS

- ✓ **Beneficiary is enrolled in Part A and has days available**
- ✓ **3-day prior qualifying hospital stay:**
 - **3 consecutive midnights in inpatient status**
- ✓ **Admission for SNF services is within 30 days of discharge from acute care stay or within 30 days of discharge from SNF level of care**

■ CLINICAL ELIGIBILITY REQUIREMENTS



- ✓ **Beneficiary needs and receives:**
 - **Medically necessary skilled care**
 - **On a daily basis**
 - **Provided by or under the direct supervision of skilled nursing or skilled rehabilitation professional**
- ✓ **Skilled services can only be provided in SNF**
- ✓ **The services must be for a condition:**
 - **Which resident was treated during qualifying hospital stay, OR**
 - **Arose while in SNF for treatment of condition related to hospital stay**

■ PHYSICIAN CERTIFICATION



- ✓ **Must certify and then periodically recertify the need for extended care**
- ✓ **Certifications are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification:**
 - **Affirms that the resident meets the existing SNF level of care definition, OR**
 - **Validates via written statement that the beneficiary's assignment to one of the upper RUG-IV (Top 52) groups is correct**

■ PHYSICIAN CERTIFICATION

- ✓ **Re-certifications are used to document the continued need for skilled extended care services:**
 - **The first re-certification is required no later than the 14th day**
 - **Subsequent re-certifications are required at no later than 30 days intervals after the date of the first re-certification**
 - **The initial certification and first re-certification may be signed at the same time**

RUG-IV 66-GROUP MODEL



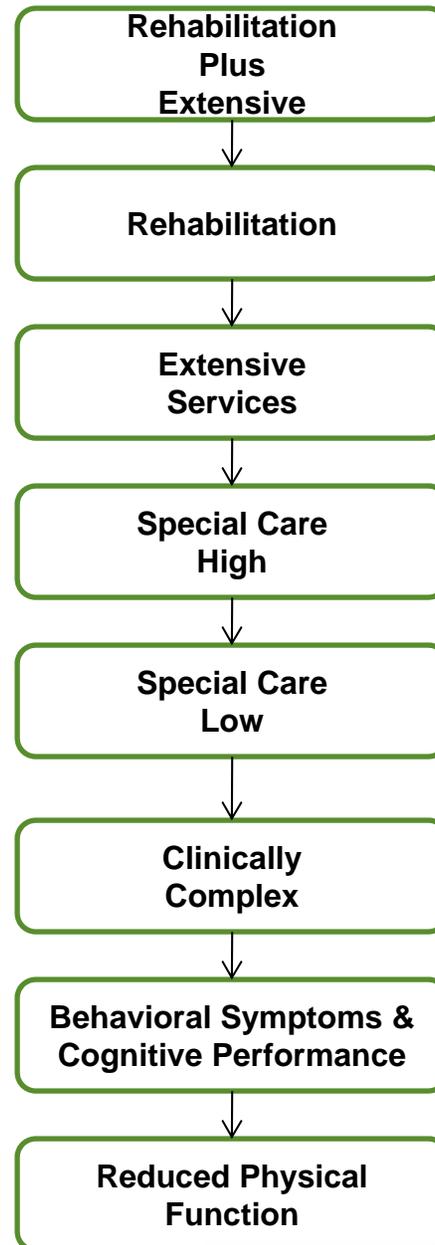
■ RUG-IV 66-CLASSIFICATION SYSTEM

- ✓ **Reimbursement levels differ based on the resource needs of residents**
- ✓ **Resource intensity of resident measured by MDS items**
- ✓ **Residents are classified into one of 66 Resource Utilization Groups (RUGs)**
- ✓ **Each major category is further divided into levels and then into final classification**
- ✓ **ADLs, depression, restorative nursing help to determine final RUG, depending on the category**

■ RUG-IV CLASSIFICATION SYSTEM

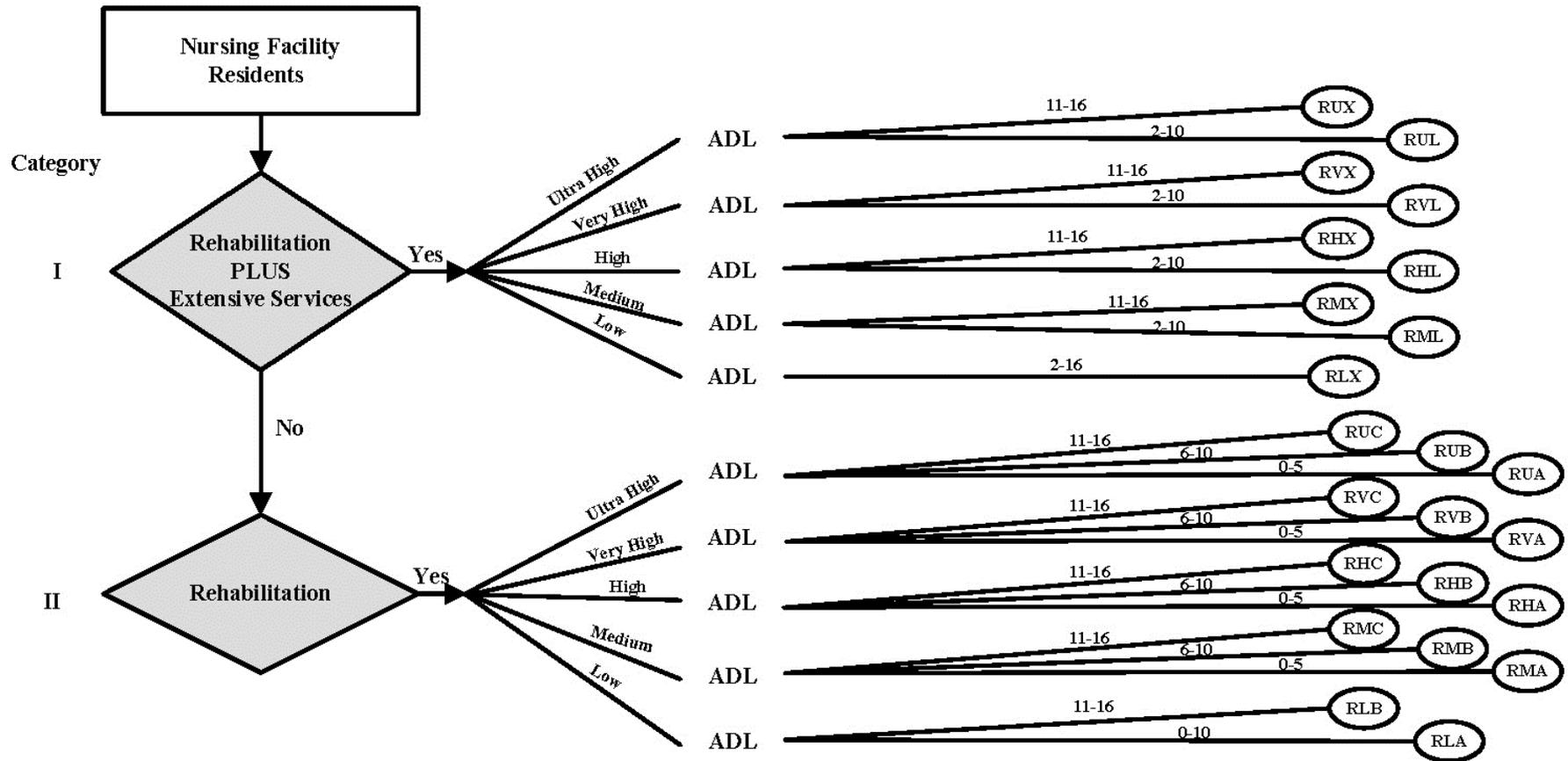
- ✓ **Hierarchical Classification:**
 - Starting at the top and working down
 - First group for which the resident qualifies
- ✓ **Index Maximizing Classification:**
 - Classifies in the group with the highest Case Mix Index (CMI)
- ✓ **Non-Therapy Classification:**
 - Some instances a non-therapy classification is required
 - A non-therapy RUG uses all the RUG items except the rehabilitation items (O0400A-C)

■ RUG-IV
HIERARCHICAL
GROUPING:
8 MAJOR
CATEGORIES

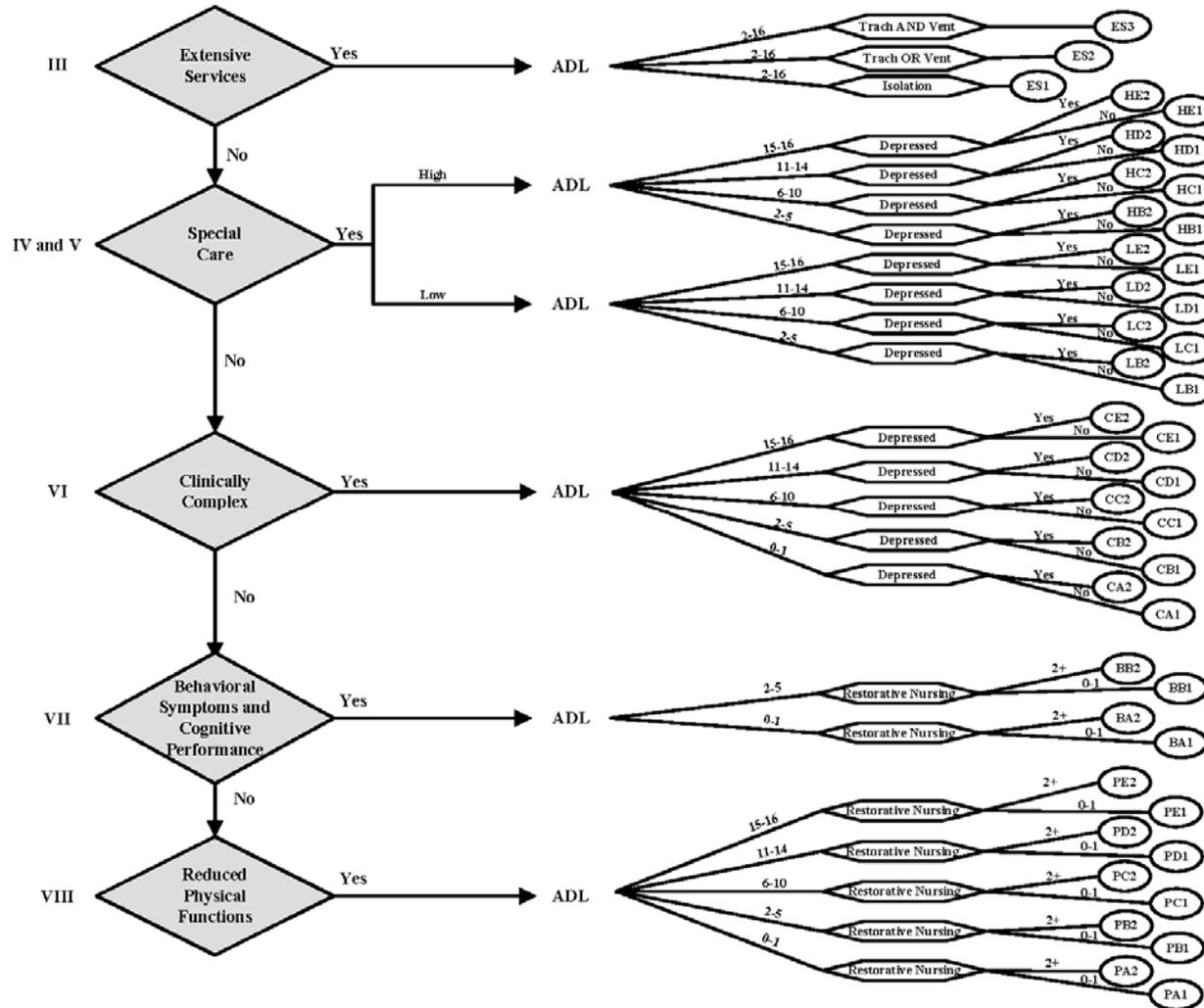


RUG-IV REHABILITATION CATEGORIES

66-GROUP CLASSIFICATION MODEL SCHEMATIC



RUG-IV CLINICAL CATEGORIES 66-GROUP CLASSIFICATION MODEL SCHEMATIC



■ STEPS IN DETERMINING RUG-IV CATEGORY

- ✓ **Calculation of ADL score**
- ✓ **Calculation of total Rehabilitation therapy minutes**
- ✓ **Medicare Short Stay Assessment determination**
- ✓ **Identification of RUG-IV category**



■ STEPS IN DETERMINING RUG-IV CATEGORY

✓ Calculation of ADL score:

- Late-Loss ADLs:
 - Bed Mobility
 - Transfer
 - Toileting
 - Eating



■ CALCULATION OF ADL SCORE

✓ Bed Mobility, Transfer, Toileting

Self- Performance Column 1 =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A = ____
2	and	(any number)	1	G0110B = ____
3	and	-, 0, 1, or 2	2	G0110I = ____
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

■ CALCULATION OF ADL SCORE



✓ Eating

Self-Performance Column 1 (G0110H) =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 2, 7, or 8	and	-, 0, 1, or 8	0	G0110H = __
-, 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	-, 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

- **Total ADL score = sum of the 4 late-loss ADLs**
- **Total ADL score range 0 to 16:**
 - **0 represents most independent**
 - **16 represents most dependent**

■ THERAPY MINUTES

✓ Unallocated Minutes:

- For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy

✓ Allocated Minutes:

- Used for RUG-IV classification
- Calculated by grouper software:
 - Individual minutes = 100%
 - Concurrent minutes = 50%
 - Group minutes = 25%
- Part A – limitation that group minutes cannot exceed 25% of the total minutes:
 - If group minutes exceed 25% of total, minutes are adjusted
 - Limitation is applied after allocation of group minutes

■ GROUP THERAPY MINUTES ALLOCATION

Adjustment of Group Therapy Minutes Example

Four residents participate in a group session for a total of 60 minutes

Facility records 60 minutes of group therapy for each resident on each MDS.

Unallocated group time divided by four by RUG-IV grouper.

Allocated group therapy minutes (15 minutes) used to determine each patient's RUG classification.

Unadjusted

Adjusted

■ ST MINUTES CALCULATION EXAMPLE A

✓ Speech-language Pathology Services:

- Individual Minutes = 110
- Concurrent Minutes = 99
- Group Minutes = 100
- Calculate total SLP minutes = $110 + 99/2 + 100/4 = 184.5$
(retain the decimal)
- Check group proportion (after group allocation) = $(100/4)/184.5 = 0.136$
- Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25
- Use unadjusted total SLP minutes

Total Speech-Language Pathology Services Minutes = 184.5
(retain the decimal)

■ OT MINUTES CALCULATION EXAMPLE B

✓ Occupational Therapy:

- Individual Minutes = 78
- Concurrent Minutes = 79
- Group Minutes = 320
- Calculate total OT minutes = $78 + 79/2 + 320/4 = 197.5$
(retain the decimal)
- Check group proportion (after group allocation) = $(320/4)/197.5 = 0.405$
- Adjust OT minutes for Medicare Part A since group proportion is greater than .25

Adjusted Occupational Therapy Minutes = $[(78 + 79/2) \times 4]/3 =$
156.6666 *(retain the decimal)*

■ PT MINUTES CALCULATION EXAMPLE C

✓ Physical Therapy:

- Individual minutes = 92
- Concurrent minutes = 93
- Group minutes = 376
- Calculate total PT minutes = $92 + 93/2 + 376/4 = 232.5$
(retain the decimal)
- Check group proportion = $(376/4)/232.5 = 0.404$
- Adjust PT minutes for Medicare Part A since group proportion is greater than .25

Adjusted Physical Therapy Minutes = $[(92 + 93/2) \times 4]/3 =$
184.6666 *(retain the decimal)*

■ TOTAL ADJUSTED THERAPY MINUTES
EXAMPLE A, B, C

**Sum SLP, OT and PT minutes after any adjustment =
 $184.5 + 156.6666 + 184.6666 = 525.8332$**

**Drop decimals = 525 minutes
*(this is the total therapy minutes value
for RUG-IV classification)***

■ MEDICARE SHORT STAY ASSESSMENT CONDITIONS

- ✓ **RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment**
- ✓ **To be considered a Medicare Short Stay assessment, all eight of the following conditions must be met:**
 1. **The assessment must be a Start of Therapy OMRA (SOT) (A0310C = 1)**
 2. **A PPS 5-day (A0310B = 01) has been completed**
 - **May be alone or combined with SOT OMRA**
 3. **The ARD of the SOT must be on or before the 8th day of the Part A Medicare covered stay**

■ MEDICARE SHORT STAY ASSESSMENT CONDITIONS "CONTINUED"

4. The ARD of the SOT must be the last day of the Medicare Part A stay (A2400C)
5. The ARD of the SOT may not be more than 3 days after the start of therapy date (O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date
6. Rehabilitation therapy (ST, OT, PT) started during the last 4 days of the Medicare Part A stay

■ MEDICARE SHORT STAY ASSESSMENT CONDITIONS “CONTINUED”

7. At least one therapy discipline continued through the last day of the Medicare Part A stay

- **At least one therapy discipline must have a dash-filled end of therapy date indicating**
 - **Ongoing therapy**
 - **Resident discharged, therapy was planned to continue if remained in facility**
 - **SNF benefit exhausted, therapy continued**
 - **Payer source changed, therapy continued**
 - **End of therapy date equal to end of covered Medicare stay**

■ MEDICARE SHORT STAY ASSESSMENT CONDITIONS "CONTINUED"

- 8. The RUG group assigned to the SOT must be Rehabilitation Plus Extensive Services or a Rehabilitation group**

In addition to the preceding 8 Rules, there are two more rules to know:

- 9. Z0100C must equal 1 (Yes)**
- 10. Therapy minutes must average at least 15 minutes a day**

■ MEDICARE SHORT STAY AVERAGE THERAPY MINUTES CALCULATION

- ✓ **Total Therapy Minutes divided by the number of days from the start of therapy through the assessment reference date**

Example:

If therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days

- ✓ **Discard all numbers after the decimal point and record the result**

■ MEDICARE SHORT STAY RUG-IV CATEGORIES

- ✓ **If all eight conditions are met, the resulting RUG-IV group is recorded in MDS Item Z0100A:**
 - 1. 15-29 average daily therapy minutes ▶ Rehabilitation Low category (RLx)**
 - 2. 30-64 average daily therapy minutes ▶ Rehabilitation Medium category (RMx)**
 - 3. 65-99 average daily therapy minutes ▶ Rehabilitation High category (RHx)**
 - 4. 100-143 average daily therapy minutes ▶ Rehabilitation Very High category (RVx)**
 - 5. 144 or greater average daily therapy minutes ▶ Rehabilitation Ultra High category (RUx)**

■ CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

1) ADL 2-16

2) Extensive Services:

- Tracheostomy care while a resident
- Ventilator/Respirator while a resident
- Infection isolation while a resident

3) Rehabilitation Therapy:

- Ultra High Intensity
- Very High Intensity
- High Intensity
- Medium Intensity
- Low Intensity



OR Medicare Short Stay

- Average Therapy
Minutes
Calculation

■ CATEGORY I:
REHABILITATION PLUS EXTENSIVE SERVICES

<u>Intensity</u>	<u>ADL Score</u>	<u>RUG Class</u>
Ultra High	11 – 16	RUX
	2 – 10	RUL
Very High	11 – 16	RVX
	2 – 10	RVL
High	11 – 16	RHX
	2 – 10	RHL
Medium	11 – 16	RMX
	2 – 10	RML
Low	2 – 16	RLX

■ **CATEGORY II:
REHABILITATION ULTRA HIGH INTENSITY CRITERIA**

1) 720 minutes or more

AND

One discipline for at least 5 days

AND

Second discipline for at least 3 days

– OR –

**2) Medicare Short Stay Indicator = Yes
Average minutes 144 or more**



<u>ADL Score</u>	<u>RUG Class</u>
11 - 16	RUC
6 - 10	RUB
0 - 5	RUA

■ **CATEGORY II:
REHABILITATION VERY HIGH INTENSITY CRITERIA**

1) 500 minutes or more

AND

One discipline for at least 5 days

– OR –

2) Medicare Short Stay Indicator = Yes

Average minutes 100-143

<u>ADL Score</u>	<u>RUG Class</u>
11 - 16	RVC
6 - 10	RVB
0 - 5	RVA

■ CATEGORY II:
REHABILITATION HIGH INTENSITY CRITERIA

1) 325 minutes or more

AND

One discipline for at least 5 days

– OR –

2) Medicare Short Stay Indicator = Yes

Average minutes 65-99

<u>ADL Score</u>	<u>RUG Class</u>
11 - 16	RHC
6 - 10	RHB
0 - 5	RHA

■ **CATEGORY II:
REHABILITATION MEDIUM INTENSITY CRITERIA**

1) 150 minutes or more

AND

5 distinct days of any combination of the 3 disciplines

– OR –

2) Medicare Short Stay Indicator = Yes

Average minutes 30-64

<u>ADL Score</u>	<u>RUG Class</u>
11 - 16	RMC
6 - 10	RMB
0 - 5	RMA

■ **CATEGORY II:
REHABILITATION LOW INTENSITY CRITERIA**

1) 45 minutes or more

AND

3 distinct days of any combination of the 3 disciplines

AND

2 or more Restorative Nursing Services for 6 or more days

– OR –

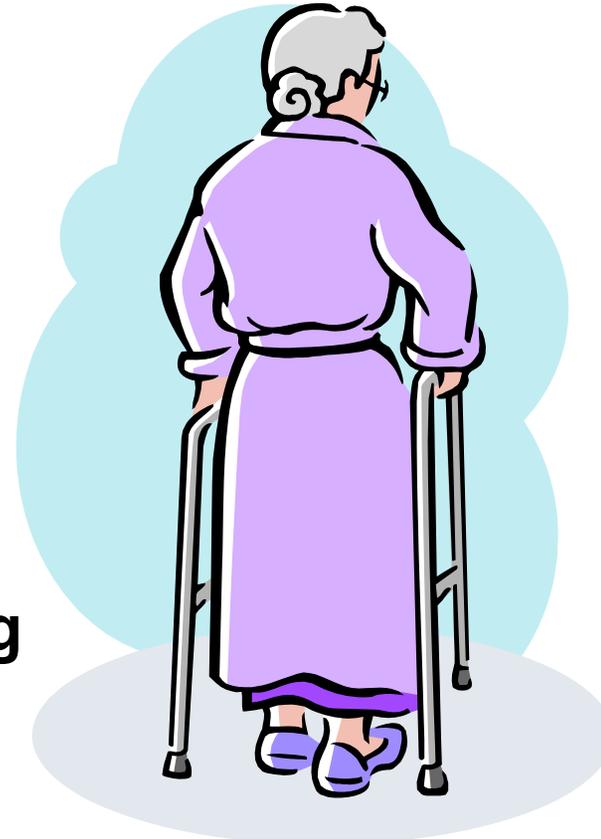
2) Medicare Short Stay Indicator = Yes

Average minutes 15-29

<u>ADL Score</u>	<u>RUG Class</u>
11 - 16	RLB
0 - 10	RLA

■ RESTORATIVE NURSING SERVICES

- ✓ **Urinary toileting program****
- ✓ **Bowel toileting program****
- ✓ **Passive ROM****
- ✓ **Active ROM****
- ✓ **Splint or brace assistance**
- ✓ **Bed mobility****
- ✓ **Walking training****
- ✓ **Transfer training**
- ✓ **Dressing and/or grooming training**
- ✓ **Eating and/or swallowing training**
- ✓ **Amputation/Prosthesis care**
- ✓ **Communication training**



*****Count as one service even if both provided***

■ CATEGORY III: EXTENSIVE SERVICES

- ✓ **ADL 2-16**
- ✓ **ADL 0 or 1 classifies as Clinically Complex**

<u>Extensive Service Conditions</u>	<u>RUG Class</u>
Tracheostomy care* <u>AND</u> Ventilator/respirator*	ES3
Tracheostomy care* <u>OR</u> Ventilator/respirator*	ES2
Infection isolation* without tracheostomy care* without ventilator/respirator* *while a resident	ES1

■ CATEGORY IV: SPECIAL CARE HIGH

- ✓ **ADL 2-16**
- ✓ **ADL 0 or 1 classifies as Clinically Complex:**
 - **Comatose & ADL dependent, or ADL did not occur**
 - **Septicemia**
 - **Diabetes with**
 - **Insulin injections (7 days) and**
 - **Insulin order changes (2 or more days)**
 - **Quadriplegia with ADL ≥ 5**
 - **COPD and SOB when lying flat**

■ CATEGORY IV: SPECIAL CARE HIGH

- **Fever and one of the following:**
 - **Pneumonia**
 - **Vomiting**
 - **Weight loss**
 - **Feeding tube***
- **Parenteral/ IV**
- **Respiratory therapy (7 days)**



****Tube feeding intake \geq 51% calories or 26-50% calories
and 501cc fluid or more per day***

■ CATEGORY IV: SPECIAL CARE HIGH

✓ Depression Evaluation:

- Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score ≥ 10 but not 99
- Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score ≥ 10



■ CATEGORY IV: SPECIAL CARE HIGH

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>
15 – 16	Yes	HE2
15 – 16	No	HE1
11 – 14	Yes	HD2
11 – 14	No	HD1
6 – 10	Yes	HC2
6 – 10	No	HC1
2 – 5	Yes	HB2
2 – 5	No	HB1

■ CATEGORY V: SPECIAL CARE LOW

- ✓ **ADL 2-16**
- ✓ **ADL 0 or 1 classifies as Clinically Complex:**
 - **Cerebral Palsy with ADL ≥ 5**
 - **Multiple Sclerosis with ADL ≥ 5**
 - **Parkinson's Disease with ADL ≥ 5**
 - **Respiratory failure and oxygen while a resident**
 - **Feeding tube with intake requirement**
 - **2+ Stage 2 pressure ulcers with 2+ skin treatments****
 - **Stage 3 or 4 pressure ulcer with 2+ skin treatments****

■ CATEGORY V: SPECIAL CARE LOW "CONT."

- **2+ venous/arterial ulcers with 2+ skin treatments****
- **1 Stage 2 pressure ulcer and 1 venous/arterial ulcer with 2+ skin treatments****
- **Foot infection, diabetic foot ulcer or other open lesion of foot with dressings to feet**
- **Radiation treatment while a resident**
- **Dialysis treatment while a resident**

■ CATEGORY V: SPECIAL CARE LOW "CONT."

✓ ****Skin treatments:**

- **Pressure reducing chair***
- **Pressure reducing bed***
- **Turning/repositioning program**
- **Nutrition or hydration interventions**
- **Pressure ulcer care**
- **Dressings (not to feet)**
- **Ointments (not to feet)**



****Count as one treatment even if both provided***

■ CATEGORY V: SPECIAL CARE LOW

✓ Depression Evaluation:

- Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score ≥ 10 but not 99
- Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score ≥ 10



■ CATEGORY V: SPECIAL CARE LOW

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>
15 – 16	Yes	LE2
15 – 16	No	LE1
11 – 14	Yes	LD2
11 – 14	No	LD1
6 – 10	Yes	LC2
6 – 10	No	LC1
2 – 5	Yes	LB2
2 – 5	No	LB1

■ CATEGORY VI: CLINICALLY COMPLEX

- ✓ **Extensive Services with ADL of 0 or 1**
- ✓ **Special Care High or Low with ADL of 0 or 1**
- ✓ **ADL 0-16:**
 - **Pneumonia**
 - **Hemiplegia/hemiparesis with ADL ≥ 5**
 - **Surgical wounds or open lesions with skin treatment:***
 - ***Surgical wound care**
 - ***Dressings (not to feet)**
 - ***Ointments (not to feet)**
 - **Burns**
 - **Chemotherapy while a resident**
 - **Oxygen while a resident**
 - **IV medications while a resident**
 - **Transfusions while a resident**

■ CATEGORY VI: CLINICALLY COMPLEX

✓ Depression Evaluation:

- Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score ≥ 10 but not 99
- Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score ≥ 10

■ CATEGORY VI: CLINICALLY COMPLEX

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>
15 – 16	Yes	CE2
15 – 16	No	CE1
11 – 14	Yes	CD2
11 – 14	No	CD1
6 – 10	Yes	CC2
6 – 10	No	CC1
2 – 5	Yes	CB2
2 – 5	No	CB1
0 – 1	Yes	CA2
0 – 1	No	CA1

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

- ✓ **ADL 0-5:**
 - **If 6 or more, classifies into Reduced Physical Function**
- ✓ **Cognitive Performance determined by:**
 - **Brief Interview for Mental Status (BIMS) if interview was completed**
 - **Cognitive Performance Scale (CPS) items if the BIMS interview was not completed**
- ✓ **If resident doesn't qualify via Cognitive Performance, then evaluate Behavioral Symptoms items**

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

1. Brief Interview for Mental Status (BIMS):

- Resident Interview:
 - Repetition of 3 words
 - Temporal orientation
 - Recall
- Score range 0-15:
 - 15 - best cognitive performance
 - 0 - worst
- Qualify with BIMS Score ≤ 9
- If score is >9 but not 99, evaluate Behavioral Symptoms



■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

2. If not able to interview; cognitively impaired if 1 of the 3 following conditions is met:

a) Coma and ADL dependent, or ADL did not occur

b) Severely impaired cognitive skills

c) 2 or more of these impairment indicators:

- Problem being understood >0
- Short-term memory problem = yes (1)
- Cognitive skills problem >0

AND

- 1 or more severe impairment indicators:
 - Severe problem being understood ≥ 2
 - Severe cognitive skills problem ≥ 2

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

✓ If criteria for Cognitive Impairment not met, evaluate the following Behavioral Symptoms:

- Hallucinations
- Delusions
- Physical behavioral symptom directed toward others*
- Verbal behavioral symptoms directed toward others*
- Other behavioral symptoms not directed toward others*
- Rejection of care*
- Wandering*



**Code 2 or 3 = behavior occurred 4-6 days or daily*

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

✓ If meets criteria via Cognitive Impairment or Behavioral symptoms, determine Restorative Nursing Count:

- Urinary toileting program**
- Bowel toileting program**
- Passive ROM**
- Active ROM**
- Splint or brace assistance
- Bed mobility**
- Walking training**
- Transfer training
- Dressing and/or grooming training
- Eating and/or swallowing training
- Amputation/Prosthesis care
- Communication training

*****Count as one service even if both provided***

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

<u>ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG Class</u>
2 – 5	2 or more	BB2
2 – 5	0 or 1	BB1
0 – 1	2 or more	BA2
0 – 1	0 or 1	BA1

■ CATEGORY VIII: REDUCED PHYSICAL FUNCTION

- ✓ Residents who do not meet criteria in other categories
- ✓ Residents met criteria for the Behavioral Symptoms and Cognitive Performance category with ADL >5
- ✓ Determine Restorative Nursing Count

■ CATEGORY VIII: REDUCED PHYSICAL FUNCTION

<u>ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG Class</u>
15 – 16	2 or more	PE2
15 – 16	0 or 1	PE1
11 – 14	2 or more	PD2
11 – 14	0 or 1	PD1
6 – 10	2 or more	PC2
6 – 10	0 or 1	PC1
2 – 5	2 or more	PB2
2 – 5	0 or 1	PB1
0 – 1	2 or more	PA2
0 – 1	0 or 1	PA1

■ RAI MANUAL APPENDICES

- ✓ **A = Glossary and Common Acronyms**
- ✓ **B = State Agency and CMS Regional Office RAI/MDS Contacts**
- ✓ **C = Care Area Assessment (CAA) Resources**
- ✓ **D = Interviewing to Increase Resident Choice in MDS Assessments**
- ✓ **E = PHQ-9© Scoring Rules and Instructions for BIMS**
- ✓ **F = MDS Item Matrix**
- ✓ **G = References**
- ✓ **H = MDS 3.0 Forms**

■ POST TEST #7

- ✓ **What does “PPS” stand for?**
 - **Prospective Payment System**
- ✓ **What does “RUG” stand for? How does it work?**
 - **Resource Utilization Group**
 - **Residents with similar resource needs are classified into groups based on characteristics and clinical needs**
- ✓ **What is index maximizing?**
 - **All of the RUG-IV groups for which the assessments qualifies are determined**
 - **Group with highest CMI is selected**
- ✓ **What are the 3 MDS items that qualify for Extensive Services?**
 - **Tracheostomy care, ventilator/respirator, and infection isolation – all while a resident**
- ✓ **How many groups are in the RUG-IV 66 grouper?**
 - **66**

■ THE MDS SONG WRITTEN BY SUE SALYER

**MDS, MDS the Minimum Data Set,
MDS, MDS the form that we all have to complete and submit!**

**MDS, MDS, the Minimum Data Set,
It's somewhat long and tough, and yet,
We all are able to get it straight!**

**MDS, MDS, the Minimum Data Set,
It helps us plan the resident's care,
And follow the information documented there!**

**MDS, MDS, the Minimum Data Set,
It starts with A and goes to Z,
And should be completed perfectly!**



■ THE MDS SONG WRITTEN BY SUE SALYER

**MDS, MDS the Minimum Data Set,
It is the tool we use to assess,
What is best for the resident!**

**MDS, MDS, the Minimum Data Set,
It guides and directs the whole process,
And helps define needs of the resident!**

**MDS, MDS, the Minimum Data Set,
This story is not the ending,
But only the beginning!**

**MDS, MDS, the Minimum Data Set,
MDS, MDS, the Minimum Data Set,
MDS, MDS, the Minimum Data Set.....**

THANK YOU FOR COMING!

