

## Physical Restraints (P0100)

- Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body
- *“Resident has the right to be free from physical and chemical restraints imposed for the purpose of discipline or convenience and not required to treat the medical symptoms”*
- Research shows that restraints have many negative side effects and risks that far outweigh the benefit
- Prior to use, a resident assessment must be completed
- Use of restraints should be the exception, not the rule

401

## Physical Restraints (P0100) Assessment

- Assess resident to determine need for the restraint, then evaluate the effect the device has on the resident not the type of device, intent, or reason for use
- Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material or equipment attached or adjacent to the body:
  - Can the resident easily and intentionally remove the device
  - Does the device restrict freedom of movement



402

## Physical Restraints (P0100) Requirements

- Any manual method or physical or mechanical device, material, or equipment that meets the definition must have:
  - Physician documentation of medical symptom to support device
  - Physician order for the type of restraint and parameters
  - Care plan and process in place for systematic and gradual restraint reduction, as appropriate

403

## Physical Restraints Clarifications (P0100)

- Removes easily:
  - Resident can intentionally remove restraint, in the same manner as it was applied by staff
- Freedom of movement:
  - Any change in place or position for the body or any part of the body that the person is able to control or access
- Medical symptom/diagnoses:
  - Must have clear link between restraint use and how it benefits the resident by addressing the specific medical symptom
  - Physical restraints as an intervention do not treat the underlying causes of medical symptoms

404

## Physical Restraints (P0100)

- Record the frequency that the resident was restrained by any of the listed devices at any time, day or night, over the last 7 days

### Used in Bed

- **A = Bed rail:**
  - Any combination of partial or full rails
  - Bed rails used for positioning but meet the definition of a restraint
  - Immobile residents who cannot voluntarily get out of bed may not meet the definition of restraint
- **B = Trunk Restraint:**
  - Resident cannot easily remove
  - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs

405

## Physical Restraints (P0100)

### Used in Bed

- **C = Limb Restraint:**
  - Resident cannot easily remove
  - Restricts movement of any part of an upper or lower extremity; including mittens
- **D = Other:**
  - Any device that does not fit into the listed categories but meets the definition of a restraint and has not been excluded from this section

406

## Physical Restraints (P0100)

### Used in Chair or Out of Bed

- **E = Trunk Restraint:**
  - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs
- **F = Limb Restraint:**
  - Restrict movement of any part of an upper or lower extremity; including mittens
- **G = Chair Prevents Rising:**
  - Chair with locked lap board
  - Chair that places the resident in a recumbent position that restricts rising
  - Chair that is soft and low to the floor
  - Chair that has a cushion placed in the seat that prohibit the resident from rising
  - Geriatric chairs
  - Enclosed-frame wheeled walkers

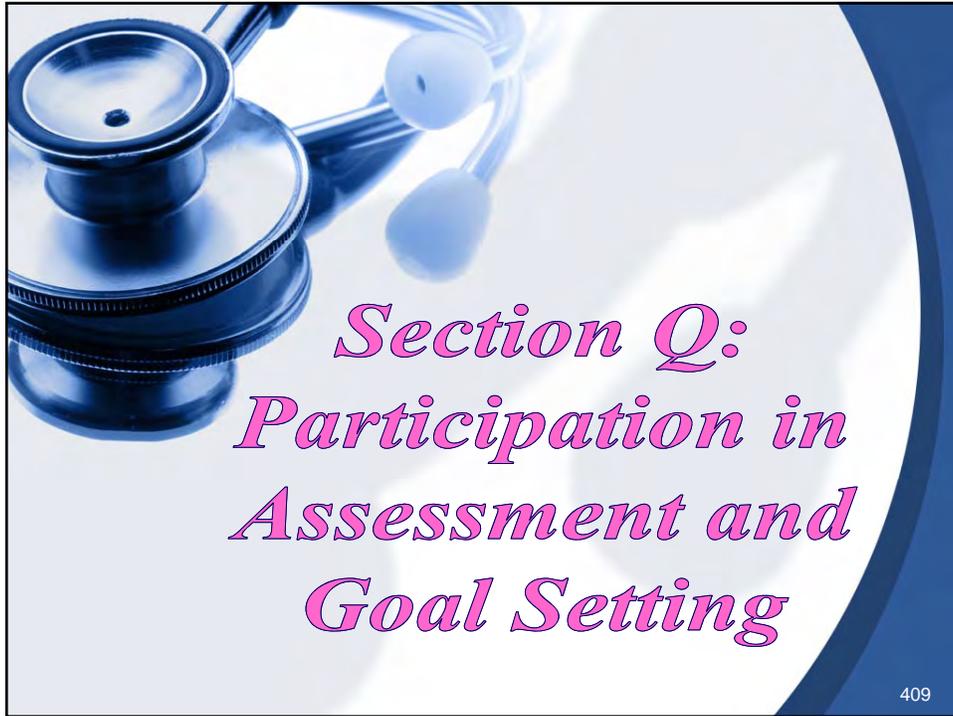
407

## Physical Restraints (P0100)

### Used in Chair or Out of Bed

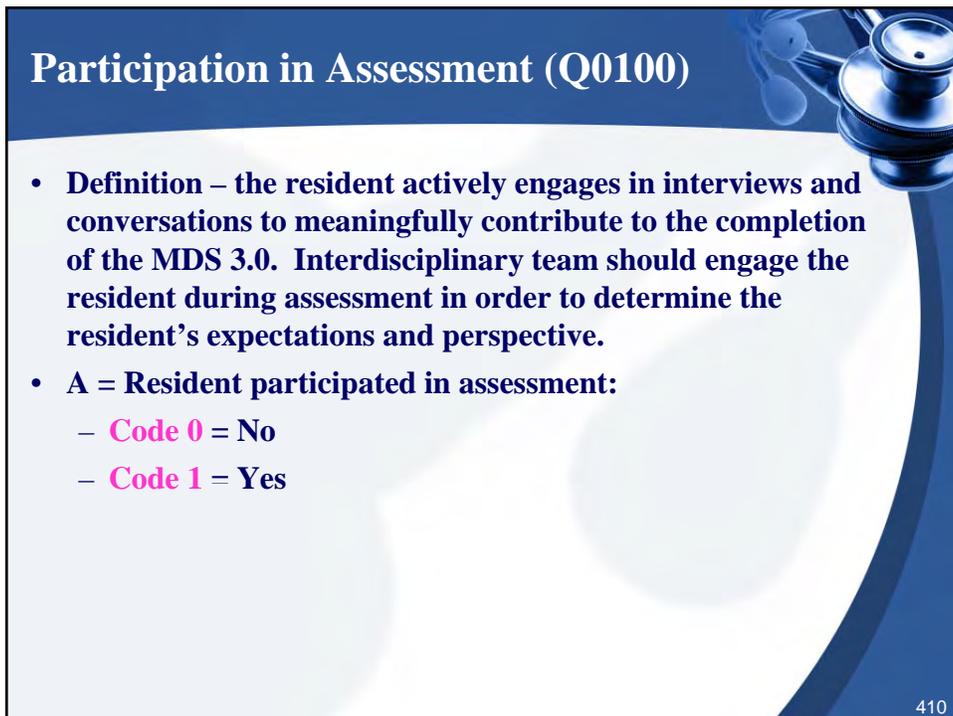
- **H = Other:**
  - Any device that does not fit into the listed categories but meets the definition of a restraint and has not been excluded from this section
- Record the frequency that the resident was restrained by any of the listed devices at any time, day or night, over the last 7 days
- Coding for all P0100 items:
  - **Code 0 = Not used**
  - **Code 1 = Used less than daily**
  - **Code 2 = Used daily**

408



*Section Q:  
Participation in  
Assessment and  
Goal Setting*

409



**Participation in Assessment (Q0100)**

- **Definition** – the resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team should engage the resident during assessment in order to determine the resident's expectations and perspective.
- **A = Resident participated in assessment:**
  - **Code 0** = No
  - **Code 1** = Yes

410

## Participation in Assessment (Q0100)

- **B = Family or significant other participated in assessment:**
  - Spousal, kinship (e.g., sibling, child, parent, nephew) or in-law relationship
  - Partner, housemate, primary community caregiver, or close friend
  - Does not include nursing home staff:
    - **Code 0** = No, did not participate
    - **Code 1** = Yes, did participate
    - **Code 9** = No family or significant other available
- **C = Guardian or legally authorized representative participated in assessment:**
  - Authorized to make decisions instead of the resident
  - Includes giving and withholding consent for medical treatment:
    - **Code 0** = No, did not participate
    - **Code 1** = Yes, did participate
    - **Code 9** = No guardian or legally authorized representative available



411

## Resident's Overall Expectation (Q0300)

- Complete only when A0310E=1
- Ask resident about overall expectations & goals:
  - Expectations about returning to community
- Ask resident if has considered:
  - Current medical status
  - Social supports
  - Services and support in community
- If resident unable to express goals or gives consent to involve family, significant other, legal representative or guardian



412

## Resident's Overall Expectation (Q0300)

- **A = Select one for resident's overall goal established during assessment process:**
  - **Code 1** = Expects to be discharged to the community
  - **Code 2** = Expects to remain in this facility
  - **Code 3** = Expects to be discharged to another facility/institution
  - **Code 9** = Unknown or uncertain
- **B = Indicate information source for Q0300A:**
  - **Code 1** = Resident
  - **Code 2** = If not resident, then family or significant other
  - **Code 3** = If not resident, family, or significant other, then guardian or legally authorized representative
  - **Code 9** = Unknown or uncertain

413

## Discharge Plan (Q0400)

- **Is active discharge plan already occurring for resident to return to community including?**
  - **Code 0** = No
  - **Code 1** = Yes, skip to Q0600



414

## Resident's Preference to Avoid Being Asked Q0500B (Q0490)

- Complete only if A0310A=02, 06, 99
- Does resident's clinical record document a request that this question be asked only on comprehensive assessments?
  - Code 0 = No
  - Code 1 = Yes, skip to Q0600
  - Code 8 = Information not available
- Do not skip if this is a comprehensive assessment

415

## Return to Community (Q0500)

- Ask if would like to talk to someone about returning to the community:
  - Explain will not require to leave facility or promise will be able to leave
  - Explore possibility of different ways of receiving ongoing care
- If unable to communicate preference; contact family, significant other, guardian or legal representative



416

## Return to Community (Q0500B)

- Ask the resident: “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”
  - **Code 0** = No, resident, family, et al states does not want to talk to someone about possibility of returning to community
  - **Code 1** = Yes, resident, family, et al states that he or she does want to talk to someone about possibility of returning to community
  - **Code 9** = Unknown or uncertain, resident cannot understand or respond and the family or significant other, or guardian or legally authorized representative is not available or has not been appointed by court

417

## Return to Community (Q0500B)

- A “yes” will trigger follow-up care planning and contact with the LCA within 10 business days
- Follow-up is expected in a “reasonable” amount of time and 10 business days is recommended (not required)
- SNF/NF should not assume the resident cannot transition out of facility due to their level of care needs

418

## Resident's Preference to Avoid Being Asked Question Q0500B Again (Q0550)

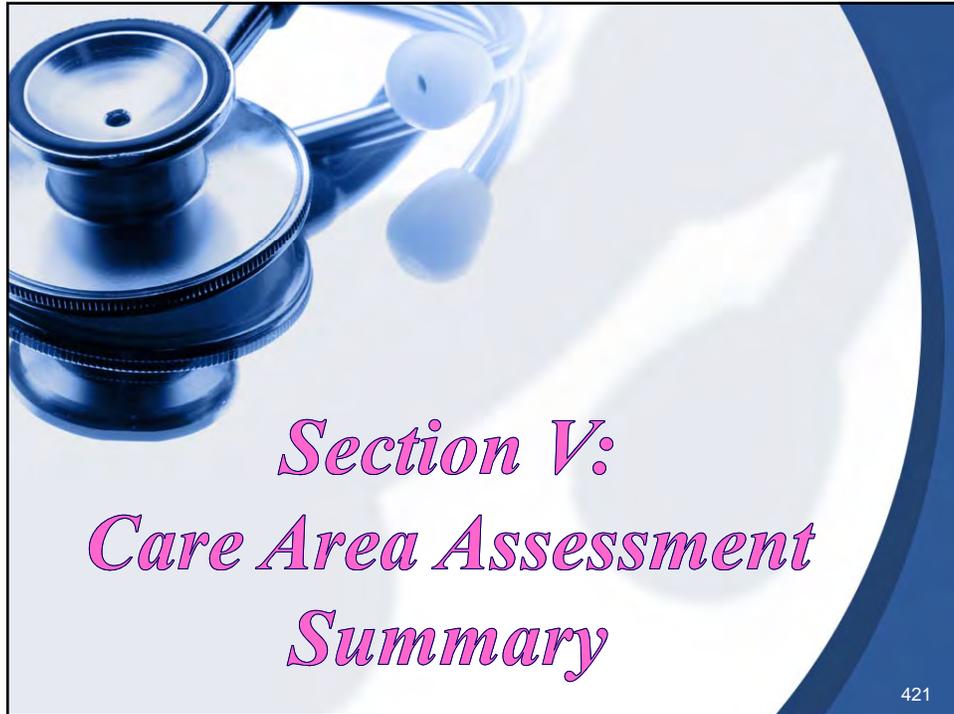
- **A = Does the resident want to be asked about returning to the community on all assessments:**
  - **Code 0** = No - document in resident's clinical record and ask again only on the next comprehensive assessment
  - **Code 1** = Yes
  - **Code 8** = Information not available
- **B = Indicate information source for Q0550A:**
  - **Code 1** = Resident
  - **Code 2** = If not resident, then family or significant other
  - **Code 3** = If not resident, family or significant other, then guardian or legally authorized representative
  - **Code 8** = No information source available

419

## Referral (Q0600)

- **Make a referral for resident to local contact transition agency when individual says yes they would like to talk to someone about available long-term care community options and supports**
- **Has a referral been made to the Local Contact Agency?**
  - **Code 0** = No, referral not needed
  - **Code 1** = No, referral is or may be needed
  - **Code 2** = Yes, referral made
- **Document reasons in resident's clinical record**
- **Assessments will be rejected if not completed**

420



*Section V:  
Care Area Assessment  
Summary*

421

**Items From the Most Recent Prior OBRA  
or Scheduled PPS Assessment (V0100)**

- **Complete only if A0310E=0 and the prior assessment is A0310A=01-06 or A0310B=01-06**
- **The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status to prior status**
- **These values are derived from a prior OBRA or scheduled PPS assessment performed since the most recent admission of any kind (entry/reentry) if available**
- **Complete only if prior assessment has been completed since the most recent admission of any kind**
- **Copy values in V0100A, B, C, D, E and F from the prior assessment to current assessment**

422

## Items From the Most Recent Prior OBRA or Scheduled PPS Assessment (V0100)

- **A = Prior Assessment Federal OBRA Reason for Assessment (A0310A):**
  - Must be value of 01 through 06 or 99
- **B = Prior Assessment PPS Reason for Assessment (A0310B):**
  - Must be value of 01 through 07 or 99
  - V0100A and V0100B cannot both be 99
- **C = Prior Assessment Reference Date (A2300):**
  - MM-DD-YYYY
- **D = Prior Assessment BIMS Summary Score (C0500)**
- **E = Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300)**
- **F = Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600)**

423

## CAAs and Care Planning (V0200)

- **20 Care Areas:**
  - Identify triggered areas require further assessment
  - Decision as to whether or not area is care planned
  - Identify location and date of the CAA documentation
  - CAA summary documents IDT's, resident's, family or representative's final decision(s) on which triggered areas will be care planned
- **AA = Care Area Triggered:**
  - Identifies all triggered care areas
- **AB = Care Planning Decision:**
  - Identifies new or revised care plan, or continuation of current care plan
  - For each triggered care area, complete the "Location and Date of CAA Documentation" column

424

## CAAs and Care Planning (V0200)

- **B = Signature of RN Coordinator for CAA Process and Date Signed:**
  - 1 = Signature
  - 2 = Date RN coordinating CAA process certifies that the CAAs have been completed
    - MM-DD-YYYY
  - Must be completed within 14 days of an admission for an Admission assessment or within 14 days of ARD (A2300) for other comprehensive assessment
  - This date is considered the completion date for the RAI

425

## CAAs and Care Planning (V0200)

- **C = Signature of Person Completing Care Plan Decision and Date Signed:**
  - 1 = Signature of staff member facilitating care planning decision-making (not required to be same person as signing in V0200B):
    - Does not have to be an RN
  - 2 = Date staff member completes Care Plan Decisions
    - Date on which staff member completes the care planning decision column, which is done after care plan is completed
    - Must be completed within 7 days of completion of comprehensive assessment (MDS and CAAs) as indicated by date in V0200B2
    - Assessment must be transmitted within 14 days of date in V0200C2

426

## CAAs and Care Planning (V0200)

- Guidelines for completing a comprehensive assessment that is in progress when a resident is discharged:
  - Complete all required MDS items Sections A through Z; indicate date of completion in Z0500B
  - Check all triggered care areas in V0200A
  - Sign and date the CAAs were completed at V0200B1 and 2
  - Dash fill all “Care Planning Decision” items in V0200AB, indicating decisions unknown
  - Sign and date care planning decisions were completed in V0200C1 and 2, using same date as V0200B2
  - Transmit the assessment

427

## *Section X: Correction Request*

428

## Modification Process

- Complete only if A0050 = 2 or 3
- Must reproduce information exactly as it appeared on erroneous record
- Modification used to correct:
  - Transcription errors
  - Data entry errors
  - Software product errors
  - Item coding errors
  - Other error requiring modification
- Corrected record replaces prior erroneous record
- Moves erroneous record from the active file to an archive file



429

## Inactivation Process

- Used when the event did not occur
- Only includes item A0050 and Section X items
- All other MDS sections are skipped
- Moves inactivated record from the active file to an archive file (history file)
- Type of Provider (X0150):
  - Code 1 = Nursing home (SNF/NF)
  - Code 2 = Swing Bed



430

## **Name, Gender, Birth Date, and SSN (X0200-X0500)**

- **Identifies an existing record to be modified/inactivated**
- **Must reflect the information EXACTLY as it appears on the erroneous record:**
  - **X0200 - Name of resident**
  - **X0300 - Gender**
  - **X0400 - Birth date**
  - **X0500 - Social Security Number**

431

## **Type of Assessment (X0600)**

- **Identifies an existing record to be modified/inactivated**
- **Must reflect the information EXACTLY as it appears on the erroneous record:**
  - **X0600 - Type of assessment (from erroneous record):**
    - **A = Federal OBRA Reason for Assessment**
    - **B = PPS Assessment**
    - **C = PPS Other Medicare Required Assessment-OMRA**
    - **D = Is this a Swing Bed clinical change assessment?**
    - **F = Entry/discharge reporting**

432

## Date on Existing Record to be Mod/Inact. (X0700) Correction Attestation Section (X0800)

- Complete only one date in X0700
- X0700 - Date on existing record to be mod/inact.:
  - A = Assessment Reference Date, complete only if X0600F=99
  - B = Discharge Date, complete only if X0600F=10, 11, or 12
  - C = Entry date, complete only if X0600F=01
- X0800 - Correction Number:
  - Enter number of correction request to mod/inact. existing record, including the present one

433

## Reasons for Modification (X0900)

- X0900 - Reasons for Modification
  - Completed only when A0050 = 2
  - Skipped when A0050 = 3
  - Check all that apply:
    - A = Transcription error
    - B = Data entry error
    - C = Software product error
    - D = Item coding error
    - E = End of therapy – resumption date
    - Z = Other error requiring modification

434

**Reasons for Inactivation (X1050)  
RN Assessment Coordinator Attestation of  
Completion (X1100)**

- **X1050 - Complete only if A0050 = 3:**
  - *Check all that apply:*
    - A = Event did not occur
    - Z = Other error requiring inactivation
- **X1100 - RN Assessment Coordinator Attestation of Completion:**
  - A = Attesting individual's first name
  - B = Attesting individual's last name
  - C = Attesting individual's title
  - D = Signature
  - E = Attestation date

435

*Section Z:  
Assessment  
Administration*

436

## Medicare Part A Billing (Z0100)

- **Medicare Part A Billing:**
  - **A = Medicare Part A HIPPS code:**
    - Health Insurance Prospective Payment System (HIPPS) code is comprised of the RUG category followed by an indicator of the type of assessment completed
    - A five position code; RUG (3) + assessment type (2)
    - HIPPS details in Chapter 6 of RAI manual
    - Does not include stays billable to Medicare Advantage HMO plans
  - **B = RUG version code:**
    - RUG-IV Medicare 66 grouper
  - **C = Is this a Medicare Short Stay assessment:**
    - **Code 0** = No
    - **Code 1** = Yes
    - Short stay details in Chapter 6 of RAI Manual

437

## Medicare Part A Non-Therapy Billing (Z0150)

- **Medicare Part A Non-Therapy Billing:**
  - **A = Medicare Part A Non-therapy HIPPS code**
  - **B = RUG version code**
- Typically the software data entry product will calculate these values
- RUG-IV classification ignoring all rehabilitation therapy

438

## State Medicaid Billing (Z0200) Alternate State Medicaid Billing (Z0250)

- **Z0200 - State Medicaid Billing:**
  - **A = RUG Case Mix group**
  - **B = RUG version code**
  - **If the state has selected a standard RUG model, these items will usually be populated automatically by the software data entry product**
- **Z0250 - Alternate State Medicaid Billing:**
  - **A = RUG Case Mix group**
  - **B = RUG version code**
  - **States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model**

439

## Insurance Billing (Z0300)

- **Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs)**
- **Insurance Billing:**
  - **A = RUG billing code:**
    - **This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs**
  - **B = RUG billing version:**
    - **This is the billing version appropriate to the billing code in Item Z0300A**

440

## Signatures of Persons Completing the Assessment or Entry/Death Reporting (Z0400)

- **Signatures of Persons Completing Assessment or Entry/Death Reporting (Z0400):**
  - **Signature/title**
  - **Section(s)**
  - **Date Section(s) completed**
- **All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed**
- **If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed**
- **Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response**

441

## Signatures of Persons Completing the Assessment or Entry/Death Reporting

- **The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for the development of:**
  - **An individualized care plan**
  - **The Medicare Prospective Payment System**
  - **Medicaid reimbursement programs**
  - **Quality monitoring activities**
  - **The data-driven survey and certification process**
  - **The quality measures used for public reporting**
  - **Research and policy development**

442

## Signatures of Persons Completing the Assessment or Entry/Death Reporting

### Coding Instructions

- **Read the Attestation Statement carefully:**
  - You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status
  - Penalties may be applied for submitting false information



443

## Signatures of Persons Completing the Assessment or Entry/Death Reporting

- **Two or more staff members can complete items within the same section of the MDS:**
  - Any staff member who has completed a sub-set of item within a section should identify which item(s) he/she completed within that section
- **May use electronic signatures:**
  - When permitted to do so by state and local law
  - When authorized by the nursing home's policy
  - Must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs

444

## Signature of RN Assessment Coordinator Verifying Assessment Completion (Z0500)

- **Signature of RN Assessment Coordinator Verifying Assessment Completion:**
  - Signature certifies completion of assessment
  - When copy of MDS is printed and dates are automatically encoded, be sure to note that it is a “copy” document and not the original
    - A = Signature
    - B = Date (MM-DD-YYYY)
- **Steps for Assessment:**
  - Verify that all items on this assessment or tracking record are complete
  - Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections

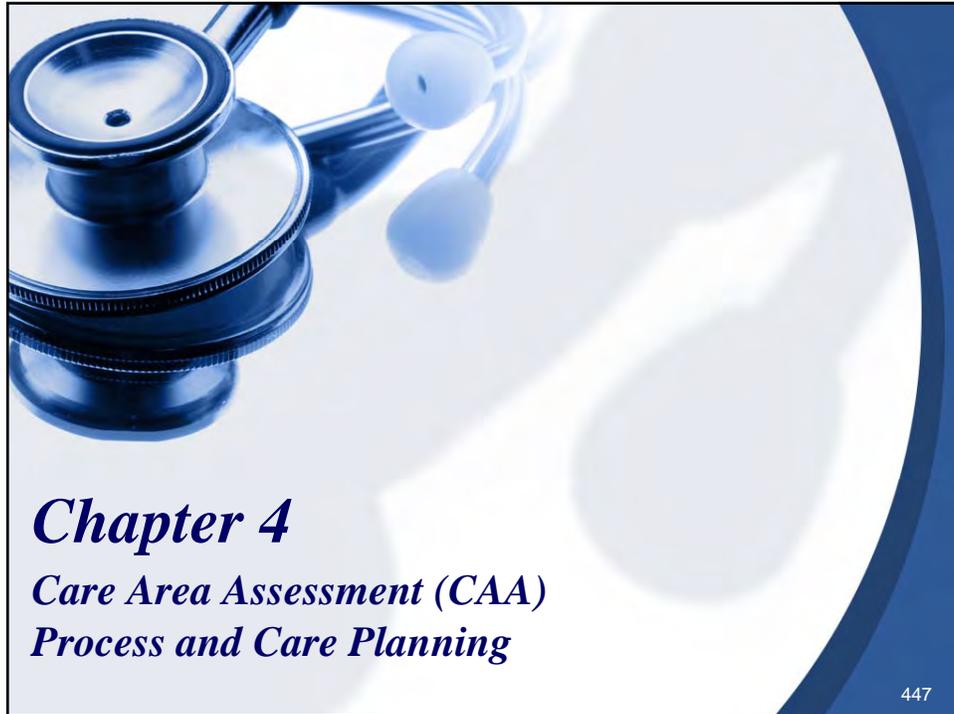
445

## Signature of RN Assessment Coordinator Verifying Assessment Completion (Z0500)

### Coding Instructions:

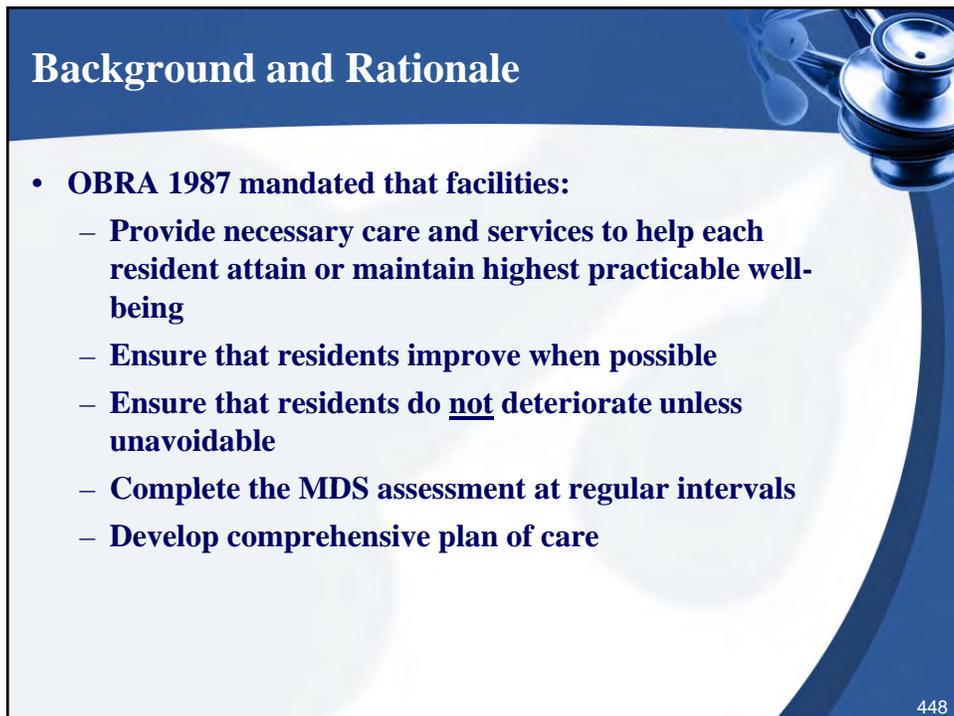
- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator
- This date will generally be later than the date(s) at Z0400
- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed
- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals

446

A blue-tinted image featuring a stethoscope in the upper left corner and a faint silhouette of a human heart in the background. The overall design is clean and professional, with a dark blue curved border on the right side.

***Chapter 4***  
***Care Area Assessment (CAA)***  
***Process and Care Planning***

447

A blue-tinted image featuring a stethoscope in the upper right corner and a faint silhouette of a human heart in the background. The overall design is clean and professional, with a dark blue curved border on the right side.

**Background and Rationale**

- **OBRA 1987 mandated that facilities:**
  - **Provide necessary care and services to help each resident attain or maintain highest practicable well-being**
  - **Ensure that residents improve when possible**
  - **Ensure that residents do not deteriorate unless unavoidable**
  - **Complete the MDS assessment at regular intervals**
  - **Develop comprehensive plan of care**

448

## Overview of the RAI and Care Area Assessments (CAAs)

### MDS Assessment



449

## CAA Process Framework

- Guides review of triggered areas
- Clarifies functional status and related 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



450

## 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 done for OBRA comprehensive assessments (initial, annual, significant change, significant correction of full)

451

## What Are the Care Area Assessments (CAAs)



- Triggered responses to items on there 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
- Required only for OBRA comprehensive assessments
- When a PPS is combined with a OBRA comprehensive; the CAA process must be completed

452

## 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**

453

## 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**



454

## 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

455

## What the CAA Process Involves

- Care Area Triggers (CATs):
  - Identify conditions that may require further evaluation
  - Each triggered item must be assessed but may or may not be addressed in care plan
  - Provide a “flag” for IDT, indicating need for assessment prior to care plan decision
  - May identify causes, risk factors and complications associated with the CAA
  - Care plan then addresses these factors



456

## 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

457

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



458

## 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 mixed causes of impaired behavior, cognition or mood**

459

## 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**

460

## 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**
  - **Review resident's condition with health care practitioner to identify links and pertinent tests, consultations or interventions**
  - **Determine if resident could potentially benefit from therapy**
  - **Develop individualized care plan**

461

## 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**

462

## 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

463

## 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 exactly is the issue/problem for resident and why is it a problem
  - Complications affecting or caused by the care area
  - Risk factors that affect decision to proceed to care planning
  - Factors to be considered in developing individualized care plan interventions:
    - To care plan or not to care plan

464

## 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**



465

## 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**



466

## 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

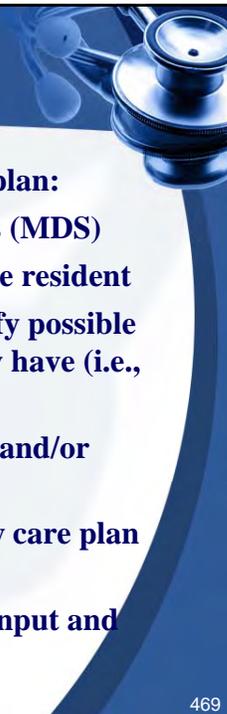
467

## 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 be in the active record

468

## The RAI and Care Planning



- **A well-developed and executed assessment care plan:**
  - 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)
  - 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

469

## 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

470

## 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**

471

## The Overall Care Plan



- **The overall care plan should be oriented towards:**
  - **Preventing avoidable declines**
  - **Managing risk factors to the extent possible**
  - **Addressing ways to preserve and build on resident's strengths**
  - **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**

472

## 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**



473

## CAA Tips and Clarifications

- **Care plan process:**
  - **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**

474

## 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

475

## Using the CAA Resources

- Step 1 - Identification of triggered CAAs:
  - Automated software
  - Manually
- Step 2 - Analysis of triggered CAAs:
  - Review items that caused this CAA to be triggered
  - 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

476

## 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 that is 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

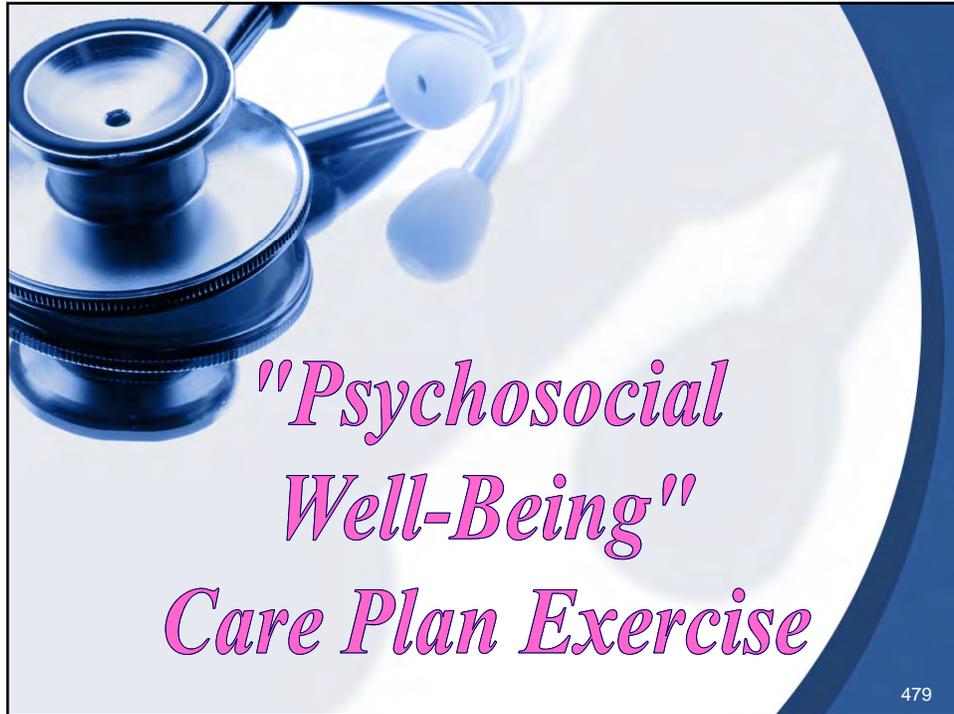
477

## 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:**
  - Pages 16-41

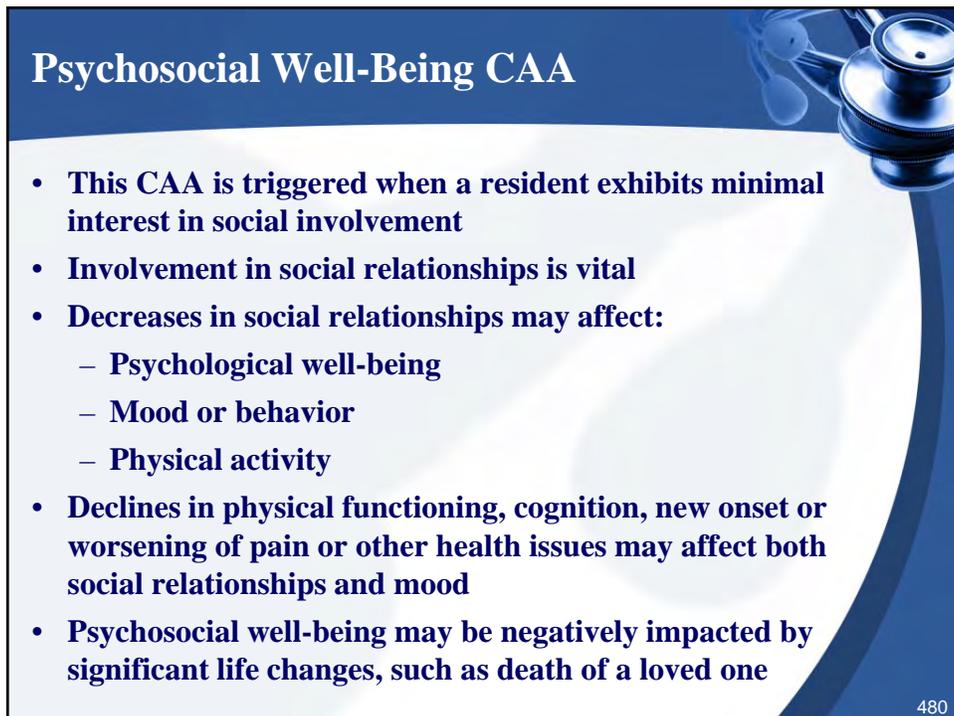
478

A blue stethoscope is positioned in the upper left corner of the slide. The background features a faint, light-colored heart shape. The text is centered and written in a pink, italicized serif font.

*"Psychosocial  
Well-Being"  
Care Plan Exercise*

479

### Psychosocial Well-Being CAA

A blue stethoscope is positioned in the upper right corner of the slide. The background features a faint, light-colored heart shape.

- **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**

480

## 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  $F0500F = 4$

481

## 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:  
 $F0800Q = \underline{\text{not}}$  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:  
 $E0200A \geq 1$  and  $E0200A \leq 3$  **AND**  
 $(I4800 = 0$  OR  $I4800 = -)$  **AND**  
 $(I4200 = 0$  OR  $I4200 = -)$

482

## 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 >= 1 and E0200B <= 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)

483

## Care Plan Exercise Psychosocial Well-Being

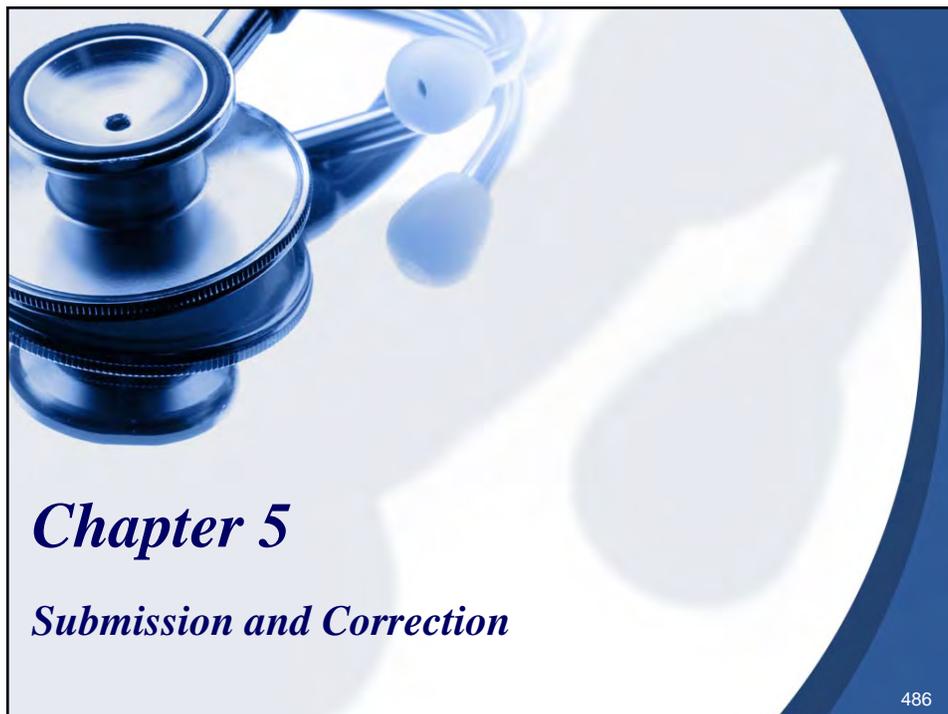
- Step 1 – Identification of Triggered CAA
- Step 2 – Analysis of triggered Psychosocial Well-Being CAA
  - MDS items that caused this CAA to be triggered
  - Issues/conditions not captured in MDS data
  - Areas of concern
  - Links to other CAAs

484

## 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):**

485



486

## 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 CMS' Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (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 are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans

487

## 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 item A0410:
  - Value = 1 Neither federal nor state authority
  - Value = 2 State but not federal authority
  - Value = 3 Federal required authority

488

## Completion Timing

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



## Completion Timing

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

## Encoding Data Timing

- **Comprehensive assessments:**
  - Within 7 days after Care Plan Completion Date (V0200C2)
- **Quarterly, discharge or PPS assessment:**
  - Within 7 days after MDS Completion Date (Z0500B)
- **Tracking records:**
  - Must be completed within 7 days of Event Date:
    - A1600 for entry record
    - A2000 for death-in-facility record

## Submission Timing

- **Comprehensive Assessments:**
  - Care Plan completion date (V0200C2) plus 14 days
- **Non-Comprehensive Assessments:**
  - Completion date (Z0500B) plus 14 days
- **Tracking Records:**
  - Entry date (A1600)/death date (A2000) plus 14 days
- **PPS Assessments:**
  - Completion date (Z0500B) plus 14 days
- **Discharge Assessments:**
  - Completion date (Z0500B) plus 14 days
- **Modification/Inactivation:**
  - RN Attestation date (X1100E) plus 14 days

## Validation Edits

- **QIES ASAP system has validation edits designed 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 name
  - Confirmation page can be printed
- **3 Types of validations:**
  - **Fatal file errors:**
    - Fatal files are rejected and must be corrected and resubmitted
  - **Fatal record errors:**
    - Fatal records are rejected and must be corrected and resubmitted
  - **Non-fatal errors (warnings):**
    - Must evaluate non-fatal errors to identify the need for corrective actions

493

## Additional Medicare Submission Requirements That Impact Billing Under the SNF PPS

- **SNFs must submit assessments according to a standard schedule**
- 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 uses MDS 3.0 items to determine both the RUG-IV group and the AI code

494

## 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**

495

## 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)**

496

## Correction Policy (May 20, 2013)

- 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
- Providers may **not** "change" a previously completed MDS form as resident's status changes during course of resident's stay
- Minor changes in resident's status should be noted in resident's record (e.g., in progress notes)



497

## Correction Policy (May 20, 2013)

- 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



498

## Correction Policy (May 20, 2013)

- 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

499

## Correction Policy (May 20, 2013)

- 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 QIES ASAP system by sending in modification or inactivation record



500

## Errors Identified During Encoding Period

- 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



501

## 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** Significant Change in Status or Significant Correction to Prior assessment 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



502

## Correcting Errors After Submission and Acceptance into the QIES ASAP System

- **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:
    - Minimum amount of information necessary to enable location of erroneous MDS record

503

## Correcting Errors After Submission and Acceptance into the QIES ASAP System

- **Effective May 20, 2013**, a Modification may now be used for **typographical 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)**
  - **Clinical Items (B0100 – V0200C)**

504

## 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

505

## 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 Significant Correction to Prior Assessment or Significant Change in Status Assessment and update care plan:
    - A SCSA is required only if correction revealed resident met SCSA criteria
    - If criteria for SCSA is not met, a SCSA is required

506

## Example 1: Item Set Code and A0310 Modifications

- A modification of a typographical error in the Reason for Assessment (RFA) (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 = 04; Change of Therapy OMRA (COT)

**Q:** If A0310C should have been coded as “00” (standalone 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

507

## Example 2: Item Set Code and A0310 Modifications

- A modification of a typographical error in the Reason for Assessment (RFA) (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 = 04; COT

**Q:** If A0310B should have been coded as “03” (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)

508

## Modification of A2300

- **Effective May 20, 2013, a modification may be used to address typographical errors in the Assessment Reference Date (ARD), A2300:**
- **If the change would result in a different look-back period than was used to code the previously accepted assessment, then this is not a typographical error**
- **Ask yourself: Would altering the ARD result in a change to the assessment timeframe used to code this assessment?**

**Yes = Inactivate the assessment**

**No = Modify the assessment**

509

## Modifications

- **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**

510

## New Error Messages

- As a result of this change, two new warning error messages could appear on your validation reports:
  - 1061: A change in the target date and/or RFA in combination with a change in the clinical item listed may indicate improper coding
  - 1062: A change in the target date and/or RFA in combination with a change in the clinical item listed and Medicare RUG may indicate improper coding
- Additionally, providers will see a fatal error in cases where the modified record contains an ISC change
  - 3839: Non-matching ISC: The ISC of the modification record does not match the ISC of the record to be modified

511

## Correcting Errors After Submission and Acceptance into the QIES ASAP System

- An Inactivation Request is still 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

512

## 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 look back period

513

## Inactivation Related to Event Date or Reason For Assessment Example

### Example:

- **Issue:** A SNF is coding a 30-day assessment. Item A2300 (Assessment Reference Date) is coded as 02-04-2013, but it was supposed to be coded as 01-04-2013. This error is discovered on February 20<sup>th</sup>.
- **Solution:** The improperly coded assessment must be inactivated and a new MDS 3.0 record must be created and submitted to the QIES ASAP. The ARD on this assessment can be no earlier than February 20<sup>th</sup> and all items and signatures must be reflective of this new ARD.

514

## Inactivation or Modification: What's the difference?

Modification	Inactivation
Used to correct record previously accepted by QIES ASAP system	Used to move record previously accepted by QIES ASAP system into ASAP database history
Replaces the corrected record as the active record. Previously accepted record maintained as inactive	Record not replaced. Could require that a new record be submitted and accepted.
Corrected record must include all MDS items and appropriate responses in Section X	Request for Inactivation only requires completing A0050 and Section X
Normally used to correct typographical errors	Used to inactivate record of an event that did not occur

515

## Summary

What can I modify now that I could not modify in the past?	What still requires an inactivation?
A0310: Type of Assessment; <u>where there is no ISC change</u>	A0200: Type of Provider
A1600: Entry Date (on entry tracking record)	A0310: Type of Assessment; <u>where there is an ISC change</u>
A2000: Discharge Date (on Discharge/Death in Facility record)	
A2300: Assessment Reference Date (ARD), when modification does not affect the look-back period and/or clinical assessment	Assessment Reference Date (Item A2300) when modification would change the look-back period and/or clinical assessment

516

## Special Manual Correction Request

- **Errors requiring manual corrections request:**
  - Incorrect value in A0410 (sub req)
  - Wrong facility ID in control item FAC\_ID
  - Test record inadvertently submitted as production
- **Facility must notify state of issue:**
  - State sends facility Correction/Deletion request form
  - Facility completes form and must submit to its State agency via certified mail USPS
  - State must approve, sign and send form to QIES Help Desk via certified mail USPS
- **Data Correction Algorithm, on page 15**

517

## *Chapter 6*

### *Prospective Payment System*

518

## 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**

519

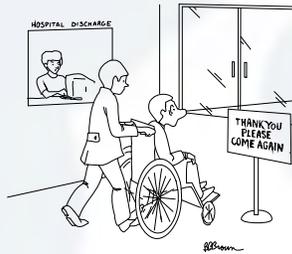
## Relationship between the Assessment and the Claim

- **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**
- **Two data items must be included in Medicare claim:**
  - **Assessment Reference Date (ARD)**
  - **Health Insurance Prospective Payment System (HIPPS) Code**

520

## SNF PPS Eligibility Criteria

- **Technical Eligibility**
- **Clinical Eligibility**
- **Physician Certification**
- **Refer to Medicare Benefit Policy Manual, Chapter 8**



521

## 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
- **30-day transfer rule:**
  - **Medical appropriateness exception**

522

## 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 personnel
- **Skilled services can only be provided in SNF**
- **The service must be for a condition:**
  - Which resident was treated during qualifying hospital stay OR
  - Arose while in SNF for treatment related to hospital stay



523

## 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

524

## 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**

525



## *RUG-IV Classification System 66-Group Payment System*

526

## RUG-IV 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 groups
- ADLs, depression, restorative nursing help to determine final RUG, depending on the category

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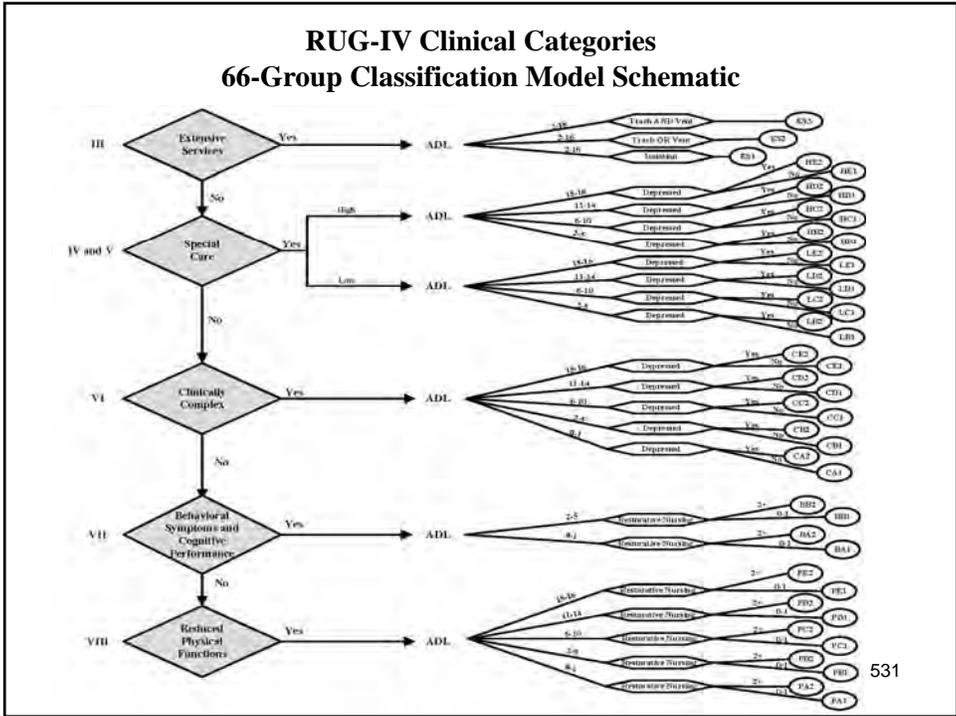
## RUG-IV Classification System

- **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)

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### RUG-IV Clinical Categories 66-Group Classification Model Schematic



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### 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



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## Steps in determining RUG-IV category

- Calculation of ADL score:
  - Late-Loss ADLs:
    - Bed Mobility
    - Transfer
    - Toileting
    - Eating

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## 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	

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## Calculation of ADL Score

- Eating**

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



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## 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
  - Total therapy minutes are not rounded

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## Group Therapy Minutes Allocation

### Allocation of Group Therapy Minutes Example

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



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## ST Therapy 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)

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## OT Therapy 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)

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## PT Therapy 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)

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## 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)*

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## 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 (SOT) (A0310C = 1)
  2. A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed
  3. The ARD of the SOT must be on or before the 8th day of the Part A Medicare covered stay
  4. The ARD of the SOT must be the last day of the Medicare Part A stay (A2400C)

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## Medicare Short Stay Assessment Conditions “continued”

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
7. At least one therapy discipline continued through the last day of the Medicare Part A stay
8. The RUG group assigned to the SOT must be Rehabilitation Plus Extensive Services or a Rehabilitation group

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## 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
- **For 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

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## 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)

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## 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 (RUX, RUL)
  - Very High Intensity (RVX, RVL)
  - High Intensity (RHX, RHL)
  - Medium Intensity (RMX, RML)
  - Low Intensity (RLX)

*Residents who qualify for both a Rehabilitation RUG and Extensive Services classify into Rehabilitation Plus Extensive Services*

*OR Medicare Short Stay  
– Average Therapy  
Minutes Calculation*



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## 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

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## 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

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## 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

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## Category II: Rehabilitation Medium Intensity Criteria

- 1) 150 minutes or more  
AND  
5 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

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## Category II: Rehabilitation Low Intensity Criteria

1) 45 minutes or more

AND

3 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

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## 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**

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## 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*	ES1

*\*while a resident*

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## 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  $\geq 5$
  - COPD and SOB when lying flat
  - 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*

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## Category IV: Special Care High

- **Depression Evaluation:**
  - **Resident Mood Interview (PHQ-9©):**
    - D0200A-I
    - Total Severity Score  $\geq 10$  but not 99
  - **Staff Assessment Resident Mood (PHQ-9-OV©):**
    - D0500A-J
    - Total Severity Score  $\geq 10$

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## 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

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## Category V: Special Care Low

- ADL 2-16
- ADL 0 or 1 classifies as Clinically Complex:
  - Cerebral Palsy with ADL  $\geq 5$
  - Multiple Sclerosis with ADL  $\geq 5$
  - Parkinson's Disease with ADL  $\geq 5$
  - 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\*\*

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## 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

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## 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*

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## Category V: Special Care Low

- **Depression Evaluation:**
  - Resident Mood Interview (PHQ-9©):
    - D0200A-I
    - Total Severity Score  $\geq 10$  but not 99
  - Staff Assessment Resident Mood (PHQ-9-OV©):
    - D0500A-J
    - Total Severity Score  $\geq 10$



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## 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

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## 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  $\geq 5$
  - 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

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## Category VI: Clinically Complex

- **Depression Evaluation:**
  - **Resident Mood Interview (PHQ-9©):**
    - D0200A-I
    - Total Severity Score  $\geq 10$  but not 99
  - **Staff Assessment Resident Mood (PHQ-9-OV©):**
    - D0500A-J
    - Total Severity Score  $\geq 10$

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## 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

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## 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**

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## 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  $\leq 9$**
- **If score is  $>9$  but not 99, evaluate Behavioral Symptoms**



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## 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  $\geq 2$
    - Severe cognitive skills problem  $\geq 2$

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## 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*



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## 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**

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## 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

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

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

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## 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

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## 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 = PHG-9 Scoring Rules and Instructions for BIMS**
- **F = MDS Item Matrix**
- **G = References**
- **H = MDS 3.0 Forms**

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## *Evaluation*

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