

COMMONWEALTH OF KENTUCKY
OFFICE OF INSPECTOR GENERAL AND
MYERS AND STAUFFER LC
PRESENT
MDS ADVANCED TRAINING



■ *MDS 3.0 RAI MANUAL V1.12*

- ✓ Updated – effective October 1, 2014
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- ✓ Updates included grammar, capitalization and very minor item changes
- ✓ Only pages with actual updates have updated footer dates

Long Term Care Facility Resident Assessment Instrument User's Manual		
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html		
Footer Dates Effective Through October 1, 2014		
Version 1.12		
Chapter	Sections and Pages	Footer Date
Chapter 1	Resident Assessment Instrument (RAI)	
	Pages 5-7, 9-10, 12, 14	October 2014
	Pages 2-4, 16-18	October 2013
	Pages 1, 8, 15	May 2013
Chapter 2	Assessment Instruction	
	Pages 2, 6, 9-12, 18, 21-51	October 2014
	Pages 5, 15	October 2013
	Pages 1, 3, 7-8, 13-14, 17	May 2013
	Pages 4, 19-20	April 2012
	Pages 16	October 2011

■ OCTOBER 1, 2014 UPDATES

- ✓ New MDS assessment form, version 1.12.0
- ✓ A0310B = 06 Readmission/return assessment – Deleted
- ✓ A0410 = Renamed item – Unit Certification or Licensure Designation
 - Response options;
 - 1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
 - 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
 - 3. Unit is Medicare and/or Medicaid certified
- ✓ A0500 = First name – no blanks allowed
- ✓ A1500 = PASRR removed from;
 - Discharge
 - PPS assessments
 - Quarterly

3

■ OCTOBER 1, 2014 UPDATES

- ✓ A1510 = Level II PASRR Conditions removed from;
 - Discharge
 - PPS assessments
 - Quarterly
- ✓ A1550 = Conditions related to ID/DD status removed from;
 - Discharge
 - PPS assessments
 - Quarterly
- ✓ A1600-1800 = Grouped these items under the heading “Most Recent Admission/Entry or Reentry into this Facility”
- ✓ A1900 = **NEW item** - Admission date
- ✓ O0250 = Flu season changed to influenza vaccination season
- ✓ O0250A = Influenza season changed to influenza vaccination season

4

■ *OCTOBER 1, 2014 UPDATES*

- ✓ **O0250B = Added to Discharge item set**
- ✓ **O0250C = Verbiage changes to include influenza vaccination season and influenza vaccine**
- ✓ **X0150-X0700 = Includes associated MDS item on prior assessment;**
 - **X0150 = Equivalent to A0200 on prior assessment**
 - **X0200 = Equivalent to A0500 on prior assessment**
 - **X0300 = Equivalent to A0800 on prior assessment**
 - **X0400 = Equivalent to A0900 on prior assessment**
 - **X0500 = Equivalent to A0600A on prior assessment**
 - **X0600 = Equivalent to A0310 on prior assessment**
 - **X0600B = Deleted response 06**
 - **X0700A = Equivalent to A2300 on prior assessment**
 - **X0700B = Equivalent to A2000 on prior assessment**
 - **X0700C = Equivalent to A1600 on prior assessment**

5

*MEDICARE UNSCHEDULED
ASSESSMENTS FOR SNF*



6

■ *START OF THERAPY (SOT) OMRA
ASSESSMENT (A0310C=1)*



- ✓ **Optional**
- ✓ **Completed only to classify into a Rehabilitation group**
- ✓ **Completed only if not already classified into a Rehabilitation group**
- ✓ **May be combined with scheduled PPS assessment**
- ✓ **ARD = set on days 5-7 after the start of therapy**
- ✓ **Date of the earliest therapy eval is counted as day 1 when determining the ARD, regardless if treatment is provided or not on that day**
- ✓ **MDS Completion = ARD plus 14 days**
- ✓ **Transmission = MDS Completion plus 14 days**

7

■ *START OF THERAPY (SOT) OMRA
ASSESSMENT (A0310C=1)*

- ✓ **SOT OMRA is not necessary if:**
 - **Rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay**
 - **Unless it is a Medicare Short Stay assessment, there is never a need to combine an SOT with a Medicare 5-day or Medicare Readmission/Return assessment**



8

■ *END OF THERAPY (EOT) OMRA (A0310C=2)*

- ✓ Completed when a resident classified in a Rehabilitation group, continues to need Part A services, and did not receive any therapy services for three consecutive calendar days for any reason
- ✓ May be combined with scheduled PPS assessment
- ✓ Establishes a new non-therapy RUG
- ✓ Last day therapy was provided is day 0
- ✓ Day 1 is first day after last therapy session provided whether therapy was scheduled or not scheduled
- ✓ ARD = set for day 1, 2, or 3 after the date of the last therapy session
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days



9

■ *END OF THERAPY (EOT) OMRA (A0310C=2)*

- ✓ When an EOT is not required:
 - Discharged on or prior to the third consecutive day of missed therapy services
 - When the last day of Part A benefit is prior to the third day of missed therapy services
 - If last day of Part A is on the third consecutive day or after of missed therapy services, then an EOT is required
 - When discharge from Part A is equal to the discharge from facility, and is on or prior to the third consecutive day of missed therapy services

10

■ *END OF THERAPY (EOT-R) OMRA (A0310C=2)*

End of Therapy with Resumption (EOT-R)

- ✓ Resumption of therapy must occur no more than five consecutive days after the last day of therapy provided
- ✓ May be used when the resident will resume therapy services at the same therapy level intensity as prior to the discontinuation of therapy
- ✓ Providers are not required to consider possible ADL changes when determining if a resumption of therapy will occur

11

■ *END OF THERAPY (EOT-R) OMRA (A0310C=2)*

End of Therapy with Resumption Billing

- ✓ The facility should bill the non-therapy RUG on the EOT beginning the day after the patient's last therapy session. The facility would then begin billing the therapy RUG that was in effect prior to the EOT beginning on the day that therapy resumed (O0450B).



12

■ *START & END OF THERAPY (A0310C=3)*

- ✓ **SOT/EOT – Both Start and End of Therapy:**
 - **ARD must be 5-7 days after the start of therapy**
 - **ARD must be 1-3 days after the last day of therapy**
 - **Completed to classify into a Rehabilitation Plus Extensive Services or Rehabilitation AND into a non-therapy group when Part A continues after the discontinuation of all therapy**
- ✓ **If assessment does not classify into a therapy RUG CMS will not accept the assessment**

13

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ **COT Observation Period: A successive 7-day window beginning the day following the ARD of the resident's last rehabilitation PPS assessment used for payment**
- ✓ **A COT is required if the therapy received during the COT observation period does not reflect the RUG-IV classification level on the patient's most recent PPS assessment used for payment**
- ✓ **When the last PPS assessment was an EOT-R, the end of the COT observation period is day 7 after the resumption date (O0450B), rather than ARD**
 - **Resumption date is counted as day 1**
- ✓ **May be used to classify a patient into a higher or lower RUG category**

14

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ COT ARD may not precede the ARD of the first PPS assessment
- ✓ ARD = Day 7 of COT observation period
- ✓ MDS Completion = ARD plus 14
- ✓ Transmission = MDS Completion plus 14

15

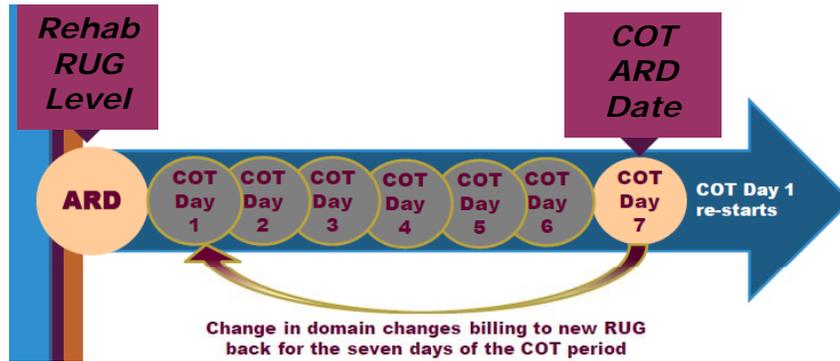
■ *ROLLING 7 DAY OBSERVATION PERIOD*

Example:

- ✓ ARD of 14-day PPS assessment = Day 13
- ✓ Window for COT observation = Days 14-20
- ✓ Next COT observation window = Days 21-27
- ✓ Next COT observation window = Days 28-34, etc.

16

■ DETERMINE IF THERE IS A CHANGE IN THE RTM/RUG LEVEL



17

■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ In order to determine if a COT is required, providers should perform an informal evaluation that considers the intensity of the therapy the resident received during the COT observation period

But what must a facility actually consider?

- ✓ Total Reimbursable Therapy Minutes (RTM)
- ✓ Number of Therapy Disciplines
- ✓ Number of Therapy Days
- ✓ Restorative Nursing (for patients in a Rehabilitation Low category)



18

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ A COT is required in cases where the therapy intensity received during the COT observation period would cause the resident to be classified into a different RUG category
- ✓ ADL changes are excluded from this determination

RUG Category Shortcut = Second character in RUG code

RUC: Ultra-High Rehab

RHL: High Rehab

RVX: Very-High Rehab

RMA: Medium Rehab

**As long as the second character does not change,
no COT OMRA is required!**

19

■ *CHANGE OF THERAPY OMRA AND
SNF BILLING*

- ✓ The COT retroactively establishes a new RUG beginning Day 1 of the COT observation period and continues until the next scheduled or unscheduled PPS assessment
- ✓ **Example:** A resident's 30-day assessment ARD set for Day 30. Based on the 30-day assessment ARD, the therapy services provided to this resident are evaluated on Day 37. If a COT is required, then payment would be set back to Day 31.

20

■ *CHANGE OF THERAPY OMRA AND INDEX MAXIMIZATION*

- ✓ **Index maximization:** In some situations a resident may simultaneously meet the qualifying criteria for both a therapy and a non-therapy RUG. For some of these cases the RUG-IV per diem payment rate for the non-therapy RUG will be higher; therefore, although the resident is receiving therapy services, the index maximized RUG is a non-therapy RUG.
- ✓ *A facility is required to evaluate change of therapy for all residents receiving any amount of skilled therapy services, including those who have index maximized into a non-therapy RUG group*

21

■ *CHANGE OF THERAPY OMRA AND INDEX MAXIMIZATION EXAMPLE*

- ✓ **A COT is only required for residents in such cases that the therapy services received during the COT observation period are no longer reflective of the RUG-IV category after considering index maximization. For example:**

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives only enough therapy to qualify for RLB (\$356.78) and HC2 (\$401.48).

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives enough therapy to qualify for RUB (\$558.79) and HC2 (\$401.48).

22

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ COT and Day of Discharge:
 - If Day 7 of the COT observation period is also on or before the day of discharge, then a COT OMRA would not be required
- ✓ COT and Scheduled PPS Assessments:
 - If the ARD of a scheduled PPS assessment is set for on or prior to Day 7 of the COT observation period, then no COT OMRA would be required. This resets the COT observation period.
 - May choose to combine assessments

23

■ *CHANGE OF THERAPY OMRA (A0310C=4)
PROPOSED RULE CHANGES FOR 2015*

COT Technical Change Proposed

- ✓ May complete COT OMRA for a resident not currently classified into a Rehab group, or receiving a level of therapy sufficient for classification into a Rehab group
 - **ONLY** in the rare case where:
 - The resident had qualified for a Rehab group on a prior assessment during the current Part A stay
 - And no discontinuation of therapy between day 1 of the COT observation period for the COT that classified the current non-therapy group and the ARD of the COT that classified into the therapy group

24

■ *CHANGE OF THERAPY OMRA (A0310C=4)
PROPOSED RULE CHANGES FOR 2015*

“Under the proposed policy, while a COT OMRA may be used to *reclassify* a resident into a therapy RUG in the circumstances described, it may not be used to *initially* classify a resident into a therapy RUG”

25

■ *UNSCHEDULED “STANDALONE”
PPS ASSESSMENT INTERVIEW ITEMS*

- ✓ Includes SOT, EOT, COT
 - Interview items may be coded using the responses provided by the resident on a previous assessment
 - Only if the DATE of the interview responses from the previous assessment (as documented in Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in Z0400) for which those responses will be used

Note: *In limited circumstances, providers may conduct interview portions of the assessment up to two calendar days after the ARD*

26

■ *UNSCHEDULED "STANDALONE"
PPS ASSESSMENT ARD*

✓ Includes SOT, EOT, COT

- Set the ARD for a day within the allowable ARD window, but may only do so no more than 2 days after the window has passed
- **Example:** If a resident misses therapy on July 2-4, then the facility must complete an EOT OMRA for this resident and the ARD must be set for either July 2nd, 3rd, or 4th. However, the decision for which of those days should be used for the ARD on the EOT OMRA may be made after July 4th, the last day of the ARD window but NO later than July 6.

27

MDS 3.0 ITEM UPDATES

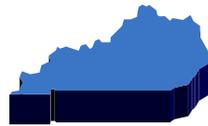


28

■ **UNIT CERTIFICATION OR LICENSURE DESIGNATION (A0410)**

✓ Enter code:

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified



29

■ **ADMISSION DATE (A1900)**
10/1/2014

- ✓ Included on all record types
- ✓ Date this episode of care in this facility began
- ✓ The Admission Date may be the same as the Entry Date (A1600) for the entire stay; if the resident is never discharged

30

SECTION G: ACTIVITIES OF DAILY LIVING



■ *ADL SELF-PERFORMANCE CODING (G0110 COLUMN 1)*

✓ **Activity Occurred 3 or More Times:**

- **Code 0** = Independent, no help or staff oversight at any time
- **Code 1** = Supervision, oversight, encouragement, or cueing
- **Code 2** = Limited assistance:
 - Resident highly involved in activity
 - Staff provide guided maneuvering of limbs or other non-weight-bearing assistance:
 - Guided maneuvering vs. weight-bearing is determined by who is supporting the weight of the resident's extremity or body

■ *ADL SELF-PERFORMANCE CODING
(G0110 COLUMN 1)*



✓ **Activity Occurred 3 or More Times:**

- **Code 3 = Extensive assistance:**
 - Resident involved in part of activity
 - Staff provide weight-bearing support, OR
 - Full staff performance part but not all of the time
- **Code 4 = Total dependence:**
 - Full staff performance every time during entire 7-day period
 - No participation by resident for any aspect of ADL activity

33

■ *ADL SELF-PERFORMANCE CODING
(G0110 COLUMN 1)*

✓ **Activity Occurred 2 or Fewer Times:**

- **Code 7 = Activity occurred only once or twice**
- **Code 8 = Activity did not occur:**
 - Activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

34

RULE OF 3



■ *INSTRUCTIONS FOR THE RULE OF 3*

- ✓ **The Rule of 3 is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS**
- ✓ **It is very important that staff fully understand the components of each ADL, the ADL Self-Performance coding level definitions and the Rule of 3**
- ✓ **To properly apply the Rule of 3, the facility must note which activities occurred, how many times, what type and what level of support was required over the 7-day observation period**
- ✓ **The Rule of 3 steps must be used in sequential order**
- ✓ **Use the first instruction encountered that meets the coding scenario**

■ INSTRUCTIONS FOR THE RULE OF 3

Exceptions for the Rule of 3:

- ✓ Code 0, Code 4, and Code 8 – as the definition for these coding levels are finite and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred
- ✓ Code 7 – as this code only applies if the activity occurred only 1 or 2 times

37

■ INSTRUCTIONS FOR THE RULE OF 3

Rule of 3:

1. When activity occurs 3 times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level.
3. When an activity occurs 3 or more times and at multiple levels, **but not 3 times at any one level**, apply the following:
 - a) Convert episodes of full staff performance to weight-bearing assistance.
 - b) When there are 3 or more episodes of a combination of full staff performance, and weight-bearing assistance – code extensive assistance (3).
Do not proceed to “c” below if “b” applies.
 - c) When there are 3 or more episodes of a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance, code limited assistance (2).

38

■ *INSTRUCTIONS FOR THE RULE OF 3*

If none of the above are met, code Supervision (1):

- ✓ This box corresponds to a, b, and c under the third Rule above
- ✓ The instruction in this box only applies when the third Rule applies, i.e., an activity occurs 3 times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight bearing, 2 times weight bearing)
- ✓ If the coding scenario does not meet the third Rule, do not apply a, b, and c of the third Rule. Code (1) Supervision

39

*ADL SAMPLE EXERCISES
RUG-III*



EXAMPLE #1

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
		Toilet Use - How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination; changes pad; manages ostomy or catheter and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.														
Transmitted Value			Int		Int		Int		Int		Int		Int		Int	
3	Self Perform	N	1	ES	1	FS	1	FS	1	TS			7	FS	1	TS
		D	2	ES	0	ES	3	ES	2	ES	1	ES	1	FS	1	NS
		E			7						1	NS	7			
3	Support Provided	N	1		1		1						0			
		D	0		0		2		2		0					
		E			7						0		7			
ADL Score																

5 Applicable Rule:

EXAMPLE #2

3	0	1	4	0	2	2
3	4	1	1	1	0	4
2	2	0	4	3	2	0

How would you code Self-performance?

Applicable Rule:

EXAMPLE #3

3	0	1	2	0	2	2
0	4	0	1	1	1	0
0	0	0	0	3	0	0

How would you code Self-performance?

Applicable Rule:

EXAMPLE #4

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
Transmitted Value		Bed Mobility-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.														Review Value
			Int		Int		Int		Int		Int		Int		Int	
	0	N	0	TS	0	TS	0	TS	0	FS	0	FS	0	FS	0	
	D	0	ES	0	ES	0	ES	0	ES	0	ES	0	FS	0	NS	
	E	0	NS	3	NS	3	NS	2	NS	0	ES	0	TS	2	NS	
ADL Score		N	0		0		0		0		0		0		0	
	2	D	0		0		0		0		0		0		0	
	1	E	0		2		2		2		0		0		2	

Applicable Rule:

EXAMPLE #5

		N=Nights		D=Day		E=Evenings											
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD			
Date		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13			
Transmitted Value	3	Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).														Review Value	
			Int		Int		Int		Int		Int		Int		Int		
		N	8	TS	7	TS	8	TS	8	FS	4	TS	8	FS	3		TS
ADL Score	2	Support Provided		D		E		N		D		E		ARD			
		N	8	2	8	8	2	8	2	8	2	8	2	2	2		
		D	0	0	0	0	0	0	0	0	0	0	0	0	0		
ADL Score	4	Support Provided		D		E		N		D		E		ARD			
		N	8	2	8	8	2	8	2	8	2	8	2	2	2		
		D	0	0	0	0	0	0	0	0	0	0	0	0	0		

4 Applicable Rule:

EXAMPLE #6

3		1				2
	4			1		4
		0				

How would you code Self-performance?

Applicable Rule:

EXAMPLE #7A

		N=Nights		D=Day		E=Evenings										
Date		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
Date		5/15/13		5/16/13		5/17/13		5/18/13		5/19/13		5/20/13		5/21/13		
4	Self Perform	N	8	TS	8	TS	8	TS	8	FS	8	FS	8	FS	8	TS
		D	8	ES	8	ES	8	ES	8	ES	4	ES	8	FS	8	NS
		E	8	NS	8	NS	8	NS	8	NS	8	ES	8	TS	8	NS
	Support Provided	N	8		8		8		8		8		8		8	
D		8		8		8		8		3		8		8		
E		8		8		8		8		8		8		8		

ADL Score **5** Applicable Rule:

Review Value
ADL Score

47

MEDICAL DOCUMENTATION EXAMPLE #7B



- ✓ **5/19/13 @ 8:00 AM:** Resident required total assistance of one CNA when transferred from bed to chair. Ed Skeleton, RN
- ✓ **5/19/13 @ 12:00 PM:** Resident required total assistance of two CNAs when transferred from chair to bed for nap. Ed Skeleton, RN
- ✓ **5/19/13 @ 2:00 PM:** Resident required total assistance of one CNA when transferred from bed to chair prior to attending activities. Ed Skeleton, RN

48

EXAMPLE #7B

		N=Nights		D=Day		E=Evenings												
		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	ARD										
		Date	5/15/13	5/16/13	5/17/13	5/18/13	5/19/13	5/20/13	5/21/13									
Transmitted Value		Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).												Review Value				
			Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	Int					
	7	Self Perform	N	8	TS	8	TS	8	TS	8	FS	8	FS		8	FS	8	TS
			D	8	ES	8	ES	8	ES	8	ES	4	ES		8	FS	8	NS
			E	8	NS	8	NS	8	NS	8	NS	8	ES		8	TS	8	NS
	3	Support Provided	N	8		8		8		8		8			8		8	
			D	8		8		8		8	3		8			8		8
			E	8		8		8		8		8			8		8	

ADL Score **1** Applicable Rule:

ADL Score

MEDICAL DOCUMENTATION EXAMPLE #7C

- ✓ **5/19/13 @ 8:00 AM: Family (daughter and son) provided total assistance when transferring from bed to chair. Ed Skeleton, RN**
- ✓ **5/19/13 @ 12:00 PM: Two hospice staff provided total assistance when transferred from chair to bed for nap. Ed Skeleton, RN**
- ✓ **5/19/13 @ 2:00 PM: Daughter provided total assistance when transferring from bed to chair prior to attending activities. Ed Skeleton, RN**

EXAMPLE #7C

		N=Nights		D=Day		E=Evenings								
		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	ARD						
		Date	5/15/13	5/16/13	5/17/13	5/18/13	5/19/13	5/20/13	5/21/13					
Transmitted Value	4	Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).												Review Value
			Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	
		Self Perform	N 8	TS 8	TS 8	TS 8	FS 8	FS 8	FS 8	FS 8	TS 8	TS 8	TS 8	
			D 8	ES 8	ES 8	ES 8	ES 4	ES 8	FS 8	FS 8	NS 8	NS 8	NS 8	
		E 8	NS 8	NS 8	NS 8	NS 8	ES 8	ES 8	TS 8	TS 8	NS 8	NS 8		
ADL Score	3	Support Provided	N 8	8	8	8	8	8	8	8	8	8	8	
			D 8	8	8	8	8	3	8	8	8	8		
			E 8	8	8	8	8	8	8	8	8	8		
ADL Score		5												ADL Score

Applicable Rule:

EXAMPLE #8

		N=Nights		D=Day		E=Evenings								
		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	ARD						
		Date	5/09/13	5/10/13	5/11/13	5/12/13	5/13/13	5/14/13	5/15/13					
Transmitted Value	3	Toilet Use - How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet, cleanses self after elimination; changes pad; manages ostomy or catheter and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.												Review Value
			Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	
		Self Perform	N 1 ₀	TS 1	TS 1	TS 1	FS 1	FS 1	FS 1	FS 1	TS 1	TS 1	TS 1	
			D 1	ES 1 ₀	ES 3	ES 3	ES 1 ₀	ES 1	FS 1	FS 1	NS 1	NS 1	NS 1	
		E 3 ₃	ND 1	NS 1	NS 1	NS 1	ES 1	ES 1	TS 1	TS 1	NS 1	NS 1		
ADL Score	2	Support Provided	N 0	0	0	0	0	0	0	0	0	0		
			D 0	0	2	2	0	0	0	0				
			E 0	0	0	0	0	0	0	0				
ADL Score		4												ADL Score

Applicable Rule:

EXAMPLE #9

3	0	1		0	0	2
	4	0	0	1	0	4
0	0	0	0		0	0

How would you code Self-performance?

Applicable Rule:

EXAMPLE #10

		N=Nights		D=Day		E=Evenings												
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD				
		5/15/13		5/16/13		5/17/13		5/18/13		5/19/13		5/20/13		5/21/13				
Transmitted Value		Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).														Review Value		
			Int		Int		Int		Int		Int		Int		Int			
	4	Self Perform	N	0	TS	4	TS	2	TS	2	FS	0	FS	2	FS		2	TS
			D	1	ES	3	ES	4	ES	1	ES	1	ES	3	FS		1	NS
		E	1	NS	2	NS	0	NS	1	NS	2	ES	0	TS	0	NS		
3	Support Provided	N	8		8		3		8		8		8		8			
		D	2		2		2		1		2		2		1			
		E	3		2		2		2		2		8		2			
ADL Score	5	<u>Applicable Rule:</u>														ADL Score		

■ *EXAMPLE #11*

3	0	1	2	0	0	2
0	4	0	1	1	0	
0	0	2	0		0	0

How would you code Self-performance?

Applicable Rule:

55

■ *EXAMPLE #12*

3	0	1	2			2
	4			1	0	
1				3		

How would you code Self-performance?

Applicable Rule:

56

EXAMPLE #13

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
Date		5/15/13		5/16/13		5/17/13		5/18/13		5/19/13		5/20/13		5/21/13		
Transmitted Value		Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).														Review Value
		Int		Int		Int		Int		Int		Int		Int		
4	Self Perform	N	8	TS	8	TS	3	TS	8	FS	8	FS	8	FS	8	TS
		D	2	ES	7	ES	2	ES	1	ES	1	ES	1	FS	1	NS
		E	3	NS	2	NS	2	NS	7	NS	2	ES	8	TS	2	NS
3	Support Provided	N	8		8		3		8		8		8		8	
		D	2		2		2		1		2		2		1	
		E	3		2		2		2		2		8		2	
ADL Score	5	Applicable Rule:														ADL Score

EXAMPLE #14

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
Date		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
Transmitted Value		Transfer - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).														Review Value
		Int		Int		Int		Int		Int		Int		Int		
1	Self Perform	N	8	TS	8	TS	8	TS	8	FS	8	FS	8	FS	8	TS
		D	8	ES	3	ES	8	ES	0	ES	8	ES	2	FS	8	NS
		E	8	NS	8	NS	8	NS	8	NS	8	ES	8	TS	8	NS
2	Support Provided	N	8		8		8		8		8		8		8	
		D	8		2		8		0		8		2		8	
		E	8		8		8		8		8		8		8	
ADL Score	1	Applicable Rule:														ADL Score

EXAMPLE #15

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
Transmitted Value		Bed Mobility-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.														Review Value
			Int		Int		Int		Int		Int		Int		Int	
	Self Perform	N	0	TS	0	TS	0	TS	0	FS	0	FS	0	FS	0	
	D	0	ES	0	ES	0	ES	0	ES	0	ES	0	FS	0	NS	
	E	0	NS	3	NS	0	NS	2	NS	0	ES	0	TS	0	NS	
ADL Score	Support Provided	N	0		0		0		0		0		0		0	
	D	0		0		0		0		0		0		0		
	E	0		2		0		2		0		0		0		
		Applicable Rule:														ADL Score

0

2

1

EXAMPLE #16

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
Transmitted Value		Eating-How resident eats and drinks regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).														Review Value
			Int		Int		Int		Int		Int		Int		Int	
	Self Perform	N	8	TS	8	TS	8	TS	8	FS	8	FS	8	FS	8	
	D	2	ES	2	ES	2	ES	2	ES	2	ES	2	FS	4	NS	
	E	2	NS	3	NS	2	NS	3	NS	2	ES	2	TS	2	NS	
ADL Score	Support Provided	N	8		8		8		8		8		8		8	
	D	2		2		2		2		2		2		2		
	E	2		2		2		2		2		2		2		
		Applicable Rule:														ADL Score

2

2

2

EXAMPLE #17

		1	2	0	0	2
1				1	0	
1						

How would you code Self-performance?

Applicable Rule:

EXAMPLE #18

		N=Nights		D=Day		E=Evenings										
		Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		ARD		
		5/09/13		5/10/13		5/11/13		5/12/13		5/13/13		5/14/13		5/15/13		
Eating-How resident eats and drinks regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).																
Transmitted Value			Int		Int		Int		Int		Int		Int		Int	
4	Self Perform	N	4	TS	4	TS	4	TS			4	FS	4	FS		
		D	1	ES	1	ES	1	ES	1	ES	1	ES	1	FS	4	NS
		E					3	NS					1	TS	1	
2	Support Provided	N	2		2		2			2		2				
		D	2		1		1		1		1		1		2	
		E					2								2	
ADL Score	3															

Applicable Rule:

EXAMPLE #19

		N=Nights		D=Day		E=Evenings												
		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	ARD										
		Date	5/09/13	5/10/13	5/11/13	5/12/13	5/13/13	5/14/13	5/15/13									
Transmitted Value	0	Bed Mobility-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.												Review Value				
			Int	Int	Int	Int	Int	Int	Int	Int	Int	Int	Int					
		Self Perform	N	0	TS	0	TS	0	TS	0	FS	0	FS		0	FS	0	TS
			D	0	ES	0	ES	0	ES	0	ES	0	ES		0	FS	0	NS
	E	0	NS	1	NS	0	NS	0	NS	0	ES	0	TS	0	NS			
ADL Score	1	Support Provided	N	0	0	0	0	0	0	0	0	0	0	0	0	0		
			D	0	0	0	0	0	0	0	0	0	0	0	0	0		
			E	0	1	0	0	0	0	0	0	0	0	0	0	0		
		ADL Score																
		Applicable Rule:																

EXAMPLE #20

1	0	0	0	0	0	0
	4	3	4			
2	2	1				

How would you code Self-performance?

Applicable Rule:

■ *EXAMPLE #21*

3	0	1	2	0	0	2
0	4	0	0	1	0	4
0	0	0	0	3	0	0

How would you code Self-performance?

Applicable Rule:

65

*SECTION O:
RESTORATIVE NURSING*



■ *RESTORATIVE NURSING PROGRAMS (O0500)*
(34-66)

- **Nursing interventions that promote resident's ability to adapt and adjust to living as independently and safely as possible**
- **Focus is to achieve and maintain optimal physical, mental and psychosocial functioning**



67

■ *RESTORATIVE NURSING PROGRAMS (O0500)*

- ✓ **Must meet specific criteria prior to coding:**
 - **Measurable objectives and interventions documented in care plan and medical record**
 - **Evaluation by licensed nurse in medical record dated within the observation period**
 - **Nursing assistants/aides must be trained in the techniques that promote resident involvement**
 - **An RN or LPN must supervise the activities in a nursing restorative program**
 - **Groups no larger than 4 residents per supervising helper or caregiver**



68

■ *RESTORATIVE NURSING PROGRAMS (O0500)*

✓ Techniques provided by restorative nursing staff:

- A = Range of Motion (Passive)
- B = Range of Motion (Active)
- C = Splint or Brace Assistance

✓ Training and Skill Practice in:

- D = Bed Mobility
- E = Transfer
- F = Walking
- G = Dressing and/or Grooming
- H = Eating and/or Swallowing
- I = Amputation/Prosthesis Care
- J = Communication



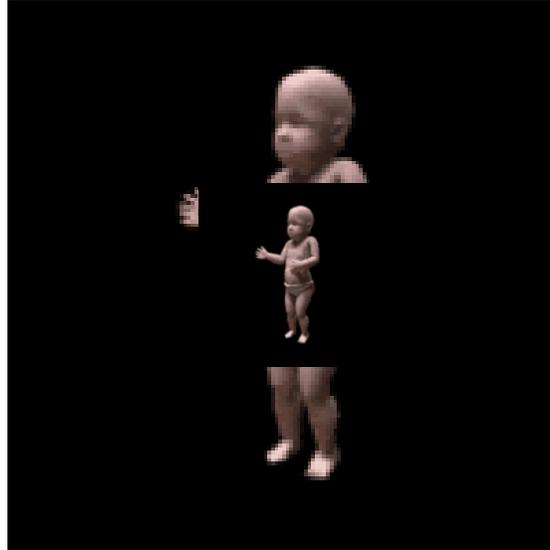
69

■ *RESTORATIVE NURSING PROGRAMS (O0500)*

- ✓ Record the number of days that each of the restorative nursing programs were performed for at least 15 minutes/day in the last 7 days
- ✓ Enter 0 if none or programs were less than 15 minutes daily
- ✓ The time provided for each program must be coded separately
- ✓ Cannot claim techniques that therapists claim under O0400A, B or C
- ✓ Does not require a physician order

70

■ *RESTORATIVE "DANCING" PROGRAM*



71

*NURSING RESTORATIVE
PROGRAM EXERCISES*



72

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#1A - PEPPER MINT
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

Transmitted Values

O0500A Passive Range of Motion	6 days
O0500B Active Range of Motion	6 days

Reviewed Values

O0500A Passive Range of Motion	<u>Answer</u>
O0500B Active Range of Motion	days
	days

Rationale:

73

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#1B - PEPPER MINT
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

Transmitted Value

O0500 Passive Range of Motion	6 days
--------------------------------------	---------------

Reviewed Value

O0500A Passive Range of Motion	<u>Answer</u>
	days

Rationale:

74

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#2 - CHOCOLATE ALMOND
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

Transmitted Value

O0500F Walking **7 days**

Reviewed Value

O0500F Walking **Answer**
days

Rationale:

75

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#3 - DOUBLE CHOCOLATE ALMOND
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

Transmitted Values

H0200C Scheduled Toileting YES
M1200C Turning/Repositioning YES

Reviewed Values

H0200C Scheduled Toileting
M1200C Turning/Repositioning

Answer

Rationale:

76

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#5 – BUBBLE GUM
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

<u>Transmitted Values</u>		<u>Reviewed Values</u>	<u>Answer</u>
O0500B Active Range of Motion	7 days	O0500B Active Range of Motion	days
O0500D Bed Mobility	7 days	O0500D Bed Mobility	days
O0500E Transfers	7 days	O0500E Transfers	days
O0500G Dressing or Grooming	7 days	O0500G Dressing or Grooming	days
O0500H Eating	7 days	O0500H Eating	days
O0500J Communication	7 days	O0500J Communication	days

Rationale:

79

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#6 – RASPBERRY SHERBET
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

<u>Transmitted Values</u>		<u>Reviewed Values</u>	<u>Answer</u>
O0500A Passive Range of Motion	7 days	O0500A Passive Range of Motion	days
O0500C Splint/Brace Assistance	7 days	O0500C Splint/Brace Assistance	days

Rationale:

80

■ *NURSING RESTORATIVE PROGRAM EXERCISE
#7- CHERRY CORDIAL
OBSERVATION PERIOD 5/9 - 5/15/09 (ARD)*

Transmitted Value

O0500B Active Range of Motion 7 days

Reviewed Value

**O0500B Active Range of Motion Answer
days**

Rationale:

81

*CARE AREA ASSESSMENT
SUMMARY*



82

■ *CARE AREA ASSESSMENT SUMMARY*

- ✓ **MDS does not constitute a comprehensive assessment**
- ✓ **MDS is a preliminary assessment to identify potential problems, strengths, preferences**
- ✓ **CAAs indicate the need for additional assessment based on problem identification which forms a link between the MDS and care planning**
- ✓ **20 Care Areas**
- ✓ **Important to obtain input from resident, family, significant other, guardian, legal representative**
- ✓ **Guides staff to look for causal or confounding factors**
- ✓ **Care plan then addresses these factors;**
 - **Promoting highest practicable level of function**
 - **Improve where possible**
 - **Maintain and prevent avoidable declines**

83

■ *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**

84

■ *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)**

85

■ *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

86

■ *CAAs AND CARE PLANNING (V0200)*

- ✓ **B = Signature of RN Coordinator for CAA Process and Date Signed:**
 - **1 = RN 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**

87

■ *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**

88

■ *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**

89

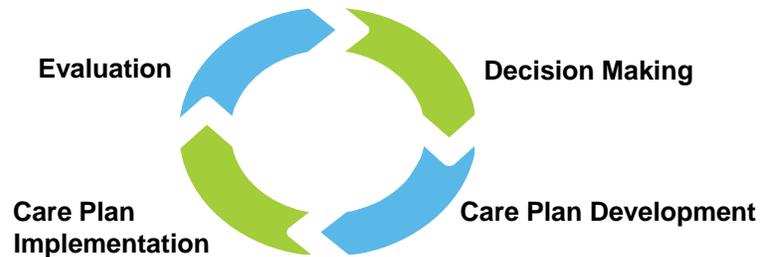
*CARE AREA ASSESSMENT (CAA)
PROCESS AND CARE PLANNING*



90

■ *OVERVIEW OF THE RAI AND CARE AREA ASSESSMENTS (CAAs)*

MDS Assessment



91

■ *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**



92

■ *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 (admission, annual, significant change, significant correction of full)

93

■ *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
- ✓ When a PPS is combined with a OBRA comprehensive; the CAA process must be completed

94

■ *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**

95

■ *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**



96

■ *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

97

■ *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



98

■ 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

99

■ 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

100

■ *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 or mood

101

■ *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

102

■ *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 rehabilitation interventions**
 - **Develop individualized care plan**

103

■ *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**

104

■ *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**

105

■ *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**

106

■ *OTHER CONSIDERATIONS REGARDING USE OF THE CAAs*

✓ **CAA documentation (continued):**

- **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**



107

■ *OTHER CONSIDERATIONS REGARDING USE OF THE CAAs*

✓ **CAA documentation (continued):**

- **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**



108

■ *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

109

■ *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

110

■ *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)**
 - **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**

111

■ *THE RAI AND CARE PLANNING*

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

112

■ *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**

113

■ *THE OVERALL CARE PLAN*

- ✓ **The overall care plan should be oriented towards (continued):**
 - **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**

114

■ *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



115

■ *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

116

■ *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

117

■ *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

118

■ *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

119

■ *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

120

"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**

122

■ *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

123

■ *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 = -)

124

■ *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)

125

■ *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**

126

■ *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):**

127

*OFFICE OF INSPECTOR GENERAL
"SKILLED NURSING FACILITIES OFTEN
FAIL TO MEET CARE PLANNING
AND DISCHARGE PLANNING REQUIREMENTS"
FEBRUARY 2013 REPORT*



128

■ OFFICE OF INSPECTOR GENERAL

- ✓ **Facilities often fail to meet care planning and discharge planning requirements**
- ✓ **Studies found deficiencies in:**
 - Quality of care
 - Did not develop appropriate care plans
 - Failed to provide adequate care
- ✓ **Findings:**
 - 37% of stays did not develop care plans that met requirements or did not provide services in accordance with care plan
 - 31% of stays did not meet discharge planning requirements
 - Medicare paid approx. \$5.1 billion for stays that did not meet these quality of life requirements
 - Reviewers found examples of poor care related to wound care, medication management and therapy

129

■ OFFICE OF INSPECTOR GENERAL

- ✓ **First OIG study found that from 2006-2008, SNFs increasingly billed for higher paying categories, even though beneficiary characteristics remained largely unchanged**
- ✓ **Another study found SNFs billed one-quarter of claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments**
 - Found 47% of claims misreported information which is used to create care plans
- ✓ **Upcoming study will review the quality of care and safety of Medicare beneficiaries transferred from hospitals to SNFs**

130

■ OFFICE OF INSPECTOR GENERAL

Medicare Coverage Requirements for Part A SNF Stays

- ✓ Medicare covers up to 100 days during any spell of illness
- ✓ 3 Consecutive hospital days and stay must have occurred within 30-days of admission to the SNF
- ✓ Beneficiary must need skilled services daily in an inpatient setting
- ✓ Must require the skills of a technical or professional personnel
- ✓ Services must be ordered by a physician for the same condition that the beneficiary was treated in the hospital

131

■ OFFICE OF INSPECTOR GENERAL

Medicare Requirements Related to Quality of Care

- ✓ Required to develop a care plan and provide services in accordance with care plan
- ✓ Requires SNFs to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with care plan
- ✓ Ensure a safe transition to the next care setting
 - Required to plan for discharge when facilities anticipate discharge
- ✓ Monitored by State Surveyors (2011)
 - 22% did not meet care planning requirements
 - 14% did not provide services according to care plan
 - 1% did not meet discharge planning requirements

132

■ OFFICE OF INSPECTOR GENERAL

Recommendations

- ✓ Strengthen the 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 do not meet care planning and discharge planning requirements and to hold these SNFs accountable
- ✓ Link payments to meeting Quality-of-Care requirements
- ✓ Follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care
- ✓ **CMS concurred with all five recommendations!!**

133

*MEDICARE SKILLED NURSING
FACILITY PROSPECTIVE
PAYMENT SYSTEM (SNF PPS)*



134

■ *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**

135

■ *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) to link assessment with billing records**
 - **Health Insurance Prospective Payment System (HIPPS) Code**

136

■ *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 and**
- ✓ ***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**

137

■ *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**

138

■ *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**

139

■ *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**

140

■ *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**

141

RUG-IV 66-GROUP MODEL



142

■ *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

143

■ *RUG-IV CLASSIFICATION SYSTEM*

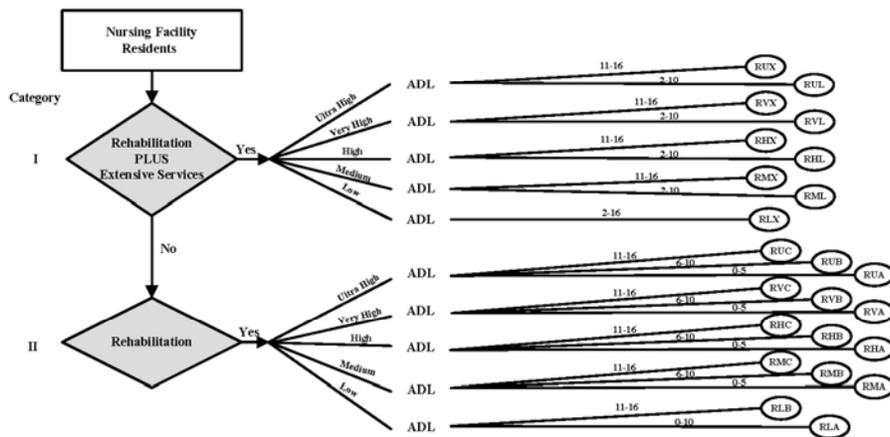
- ✓ **Index Maximizing Classification:**
 - Classifies in the group with the highest Case Mix Index (CMI)
- ✓ **Non-Therapy Classification:**
 - Some instances a non-therapy classification is required
 - A non-therapy RUG uses all the RUG items except the rehabilitation items (O0400A-C)

144

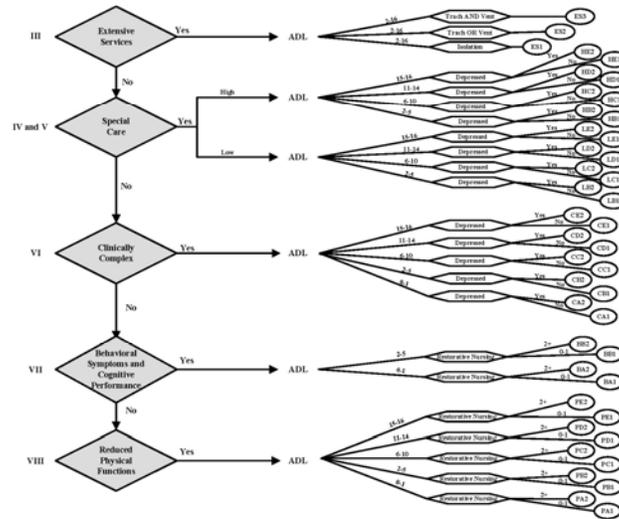
■ **RUG-IV**
HIERARCHICAL
GROUPING:
8 MAJOR
CATEGORIES



■ **RUG-IV REHABILITATION CATEGORIES**
66-GROUP CLASSIFICATION MODEL SCHEMATIC



■ RUG-IV CLINICAL CATEGORIES 66-GROUP CLASSIFICATION MODEL SCHEMATIC



147

■ CALCULATION OF ADL SCORE

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



148

■ *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

151

■ CALCULATION OF 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 minimum 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

152

■ GROUP THERAPY MINUTES ALLOCATION

Adjustment of Group Therapy Minutes Example

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



153

■ 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)

154

■ *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)*

155

■ *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)*

156

■ *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)*

157

■ *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)

158

■ *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

159

■ *MEDICARE SHORT STAY ASSESSMENT
CONDITIONS "CONTINUED"*

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

160

■ *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)

161

■ *MEDICARE SHORT STAY AVERAGE THERAPY MINUTES CALCULATION EXAMPLE #1*

- ✓ 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

162

■ *MEDICARE SHORT STAY AVERAGE THERAPY MINUTES CALCULATION EXAMPLE #2*

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

ARD						
Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Medicare Start Date						Medicare End Date ARD
			Therapy Eval.	Therapy 40 Min.	Therapy 45 Min.	Therapy 40 Min.

163

■ *MEDICARE SHORT STAY AVERAGE THERAPY MINUTES CALCULATION EXAMPLE #2*

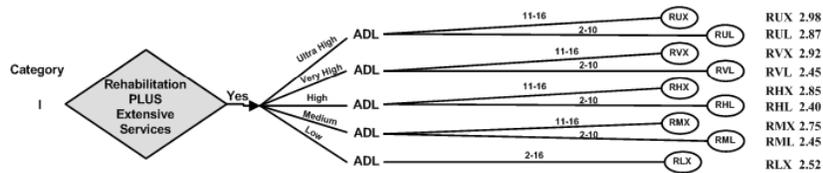
- ✓ To be considered a Medicare Short Stay assessment, all eight of the following conditions must be met:
 1. SOT OMRA
 2. PPS 5-day (A0310B = 01) has been completed
 3. Part A Medicare covered stay = 7 days
 4. The ARD of the SOT OMRA = end of Medicare stay
 5. ARD is not more than .3 days after start of therapy
 6. Therapy started within last 4 days of stay
 7. Therapy continued through last day of stay
 8. RUG = Rehabilitation classification

Therapy minutes = 125

RUG classification for days 4-7 = $(125/4 = 31.25)$ RMx

164

■ **CATEGORY I:**
REHABILITATION PLUS EXTENSIVE SERVICES



- ✓ **ADL 2-16**
- ✓ **Extensive Service Items**
- ✓ **Rehabilitation Intensity**

165

■ **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)
- OR Medicare Short Stay
 – Average Therapy
 Minutes
 Calculation**



166

■ **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>	<u>CMI</u>
11 - 16	RUC	1.74
6 - 10	RUB	1.74
0 - 5	RUA	1.11

169

■ **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>	<u>CMI</u>
11 - 16	RVC	1.68
6 - 10	RVB	1.24
0 - 5	RVA	1.23

170

■ *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>	<u>CMI</u>
11 - 16	RHC	1.61
6 - 10	RHB	1.33
0 - 5	RHA	1.02

171

■ *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>	<u>CMI</u>
11 - 16	RMC	1.52
6 - 10	RMB	1.36
0 - 5	RMA	0.94

172

■ **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>	<u>CMI</u>
11 - 16	RLB	1.67
0 - 10	RLA	0.79

173

■ **RESTORATIVE NURSING SERVICES**

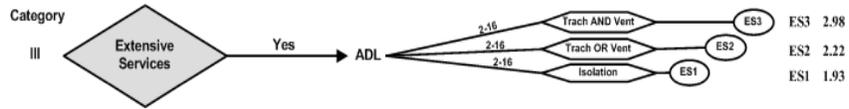
- ✓ Urinary toileting program**
- ✓ Bowel toileting program**
- ✓ Passive ROM**
- ✓ Active ROM**
- ✓ Splint or brace assistance
- ✓ Bed mobility**
- ✓ Walking training**
- ✓ Transfer training
- ✓ Dressing and/or grooming training
- ✓ Eating and/or swallowing training
- ✓ Amputation/Prosthesis care
-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



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

174

■ **CATEGORY III: EXTENSIVE SERVICES**



✓ **ADL 2-16**

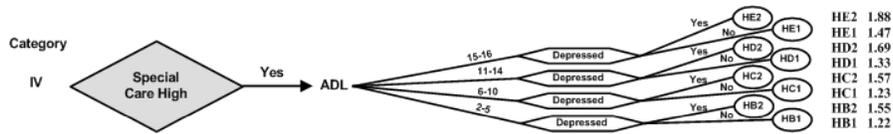
■ **CATEGORY III: EXTENSIVE SERVICES**

✓ **ADL 2-16**

✓ **ADL 0 or 1 classifies as Clinically Complex**

<u>Extensive Service Conditions</u>	<u>RUG Class</u>	<u>CMI</u>
Tracheostomy care* AND Ventilator/respirator*	ES3	2.98
Tracheostomy care* OR Ventilator/respirator*	ES2	2.22
Infection isolation* without tracheostomy care* without ventilator/respirator* *while a resident	ES1	1.93

■ **CATEGORY IV: SPECIAL CARE HIGH**



- ✓ **ADL 2-16**
- ✓ **Mood Symptom Determination**

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



**Tube feeding intake ≥ 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**



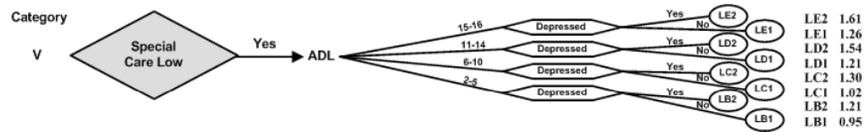
179

■ *CATEGORY IV: SPECIAL CARE HIGH*

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>	<u>CMI</u>
15 – 16	Yes	HE2	1.88
15 – 16	No	HE1	1.47
11 – 14	Yes	HD2	1.69
11 – 14	No	HD1	1.33
6 – 10	Yes	HC2	1.57
6 – 10	No	HC1	1.23
2 – 5	Yes	HB2	1.55
2 – 5	No	HB1	1.22

180

■ *CATEGORY V: SPECIAL CARE LOW*



- ✓ ADL 2-16
- ✓ Mood Symptom Determination

181

■ *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**

182

■ *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

183

■ *CATEGORY V: SPECIAL CARE LOW "CONT."*

✓ ****Skin treatments:**

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



**Count as one treatment even if both provided*

184

■ *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**



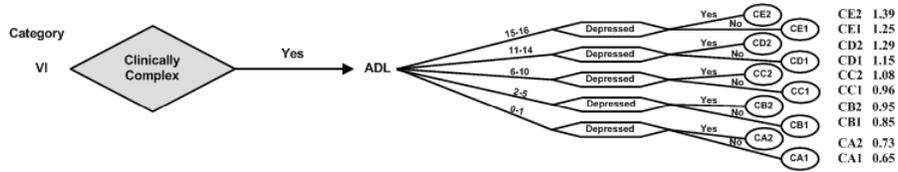
185

■ *CATEGORY V: SPECIAL CARE LOW*

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>	<u>CMI</u>
15 – 16	Yes	LE2	1.61
15 – 16	No	LE1	1.26
11 – 14	Yes	LD2	1.54
11 – 14	No	LD1	1.21
6 – 10	Yes	LC2	1.30
6 – 10	No	LC1	1.02
2 – 5	Yes	LB2	1.21
2 – 5	No	LB1	0.95

186

■ **CATEGORY VI: CLINICALLY COMPLEX**



- ✓ **ADL 0-16**
- ✓ **Mood Symptom Determination**

187

■ **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**

188

■ *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**

189

■ *CATEGORY VI: CLINICALLY COMPLEX*

<u>ADL Score</u>	<u>Depressed</u>	<u>RUG Class</u>	<u>CMI</u>
15 – 16	Yes	CE2	1.39
15 – 16	No	CE1	1.25
11 – 14	Yes	CD2	1.29
11 – 14	No	CD1	1.15
6 – 10	Yes	CC2	1.08
6 – 10	No	CC1	0.96
2 – 5	Yes	CB2	0.95
2 – 5	No	CB1	0.85
0 – 1	Yes	CA2	0.73
0 – 1	No	CA1	0.65

190

■ *CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE*



- ✓ **ADL 0-5**
- ✓ **Restorative Nursing Program Determination**

191

■ *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

192

■ *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**



193

■ *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**

194

■ *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*

195

■ *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

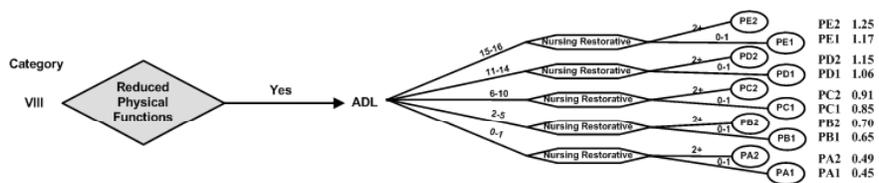
***Count as one service even if both provided*

196

■ **CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE**

<u>ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG Class</u>	<u>CMI</u>
2 – 5	2 or more	BB2	0.81
2 – 5	0 or 1	BB1	0.75
0 – 1	2 or more	BA2	0.58
0 – 1	0 or 1	BA1	0.53

■ **CATEGORY VIII: REDUCED PHYSICAL FUNCTION**



- ✓ **ADL 0-16**
- ✓ **Restorative Nursing Program Determination**

■ **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*

■ **CATEGORY VIII: REDUCED PHYSICAL FUNCTION**

<u>ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG Class</u>	<u>CMI</u>
15 – 16	2 or more	PE2	1.25
15 – 16	0 or 1	PE1	1.17
11 – 14	2 or more	PD2	1.15
11 – 14	0 or 1	PD1	1.06
6 – 10	2 or more	PC2	0.91
6 – 10	0 or 1	PC1	0.85
2 – 5	2 or more	PB2	0.70
2 – 5	0 or 1	PB1	0.65
0 – 1	2 or more	PA2	0.49
0 – 1	0 or 1	PA1	0.45

*CALCULATE THE
RUG-IV CLASSIFICATION
OF RESIDENT 1*



■ *MDS SAMPLE EXERCISE*

	ADLs	Transmitted Values	ADL Score
G0110A1	Bed Mobility/SP	3	
G0110A2	Bed Mobility/S	3	
G0110B1	Transfer/SP	3	
G0110B2	Transfer/S	3	
G0110H1	Eating/SP	1	
G0110H2	Eating/S	1	
G0110I1	Toilet Use/SP	3	
G0110I2	Toilet Use/S	2	
ADL Score			

■ *MDS SAMPLE EXERCISE*

Extensive Service		Transmitted Values
O0100E,2	Tracheostomy Care	
O0100F,2	Ventilator/respirator	
O0100M,2	Isolation Infection	

203

■ *MDS SAMPLE EXERCISE*

Rehabilitation		Transmitted Values
O0400A	Speech therapy/Days	
	Speech therapy/Minutes	
O0400B	OT/Days	
	OT/Minutes	
O0400C	Physical Therapy/Days	
	Physical Therapy/Minutes	
Nursing Restorative Criteria, if applicable		

204

■ *MDS SAMPLE EXERCISE*

Special Care High		Transmitted Values
B0100	Coma + ADL dependence	
I2100	Septicemia	
I2900 N0350A N0350B	Diabetes + Insulin Injections + Insulin Orders	
I5100	Quadriplegia	
I6200 J1100C	COPD + SOB when lying down	

205

■ *MDS SAMPLE EXERCISE*

Special Care High, continued		Transmitted Values
J1550A	Fever + one of the following:	
I2000 J1550B K0300 K0510	Pneumonia Vomiting Weight Loss Tube Feeding and Criteria	
K0510A	Parenteral/IV Feeding	
O0400D	Respiratory Therapy X 7 days	

206

■ *MDS SAMPLE EXERCISE*

Special Care Low		Transmitted Values
I4400	Cerebral Palsy + ADL =>5	
I5200	Multiple Sclerosis + ADL =>5	
I5300	Parkinson's Disease	
I6300 O0100C	Respiratory Failure + O2	
K0510B	Feeding Tube with requirements	
	Two or more Stage 2 PU + tx.	
D0300	Mood Symptoms Severity Score	

207

RUG-IV CATEGORY



■ TRANSMITTED RUG-IV CATEGORY

CMI =

209



210

THANK YOU FOR COMING!!

