The role of the RAI process:
- individual gap analysis
- identify potential risk
- create a CCP from CA
- implement & evaluate CA

The intent stated by CMS is to:
Ensure SNF residents are receiving the appropriate care and services,
and
Ensure that the facility is appropriately paid for the services it renders.
A look at the RAI Foundation

The roots of the RAI process reach back to 1987.
OBRA's the goal for residents who enter into a skilled facility to attain and or maintain their highest most practicable level, stave off avoidable decline, and enjoy the maximum quality of life. This goal has not changed.

The MDS 3.0 tool is **NEW**, not a Revision

Process Review with Overview

1. The MDS remains a preliminary screening tool.
2. Care Area Triggers (CATs)
   (previously Triggers)
3. Care Area Assessments (CAAs)
   (previously Resident Assessment Protocols [RAPs])

Purpose to create a Comprehensive Care Plan (CCP)
MDS 3.0 Interview Focus

CMS states that one of the most significant advances by conversion to the MDS 3.0 will be the direct interview items.

These were created with the goal to consistently elicit the resident’s voice.

Some Additional Changes

The new MDS 3.0 goes LIVE October 1st & Includes:

- 38 Pages (with larger font)
- Includes Skip Patterns
- Time frame for submission shortened
- CMS States 45% less staff time (RAI)
- Some reimbursable items eliminated
- Section G changes include ADL scale to 0-16
- Enhances the Interview Process

Care Area Triggers (CATs)

So About those CATs:

- There are 20 (adding pain & return to community)
- Alerts evaluator to potential problem/need/strength
- Guides evaluator to conduct assessment
- All Triggering MDS care areas are found on MDS 3.0 to exclude delirium & mood state
More on CAAs

The goals of CAAs include:
- Promote highest practicable level of functioning for a resident through an assessment of triggered care areas from the MDS, and
- Determine if there is a problem and understand the causes and or the contributing factors.

Care Area Assessments (CAAs)

CAA Purpose:
- To provide a more comprehensive assessment of a triggered area, and
- Their goal then is to drive the development of an individualized plan of care similar to that of a RAP.

Different from RAPs

CAAs are not mandated as RAPs currently are. Providers have a choice post identification of a CAT, they may:
- Use a CAA Resource (appendix C) or
- Use a evidenced-based or expert endorsed resource.
Care Planning

- Facilities use results of the MDS and the CAA process to identify care areas needing further assessment.
- Chapter 4 of MDS 3.0 manual will provide detailed instructions.
- Unique risk factors are evaluated to determine if there is a need/problem/concern
  - improve as able, and
  - maintain status & avoid decline.

So WHY the Change?

The goal(s) of the changes includes:

- Increase Resident Quality of Life
- Increase Process Accuracy
- Increase Process Validity
- Increase Resident Participation

Focus Goal Quality of Life

Respect for the individual resident is determined to be fundamental to high quality care and resident quality of life.

One of the most direct ways of conveying this respect is to directly ask the resident about how he/she feels and about his or her preferences.
Is Interview Feasible?

CMS advises that a large body of research has proven that even residents with moderate cognitive impairment can accurately and reliably answer simple interview questions about how they feel and about what they want. CMS notes that this could be true with some residents with significant cognitive impairment.

Is Interview Efficient?

CMS states that using the resident as the primary information source is not only time well spent but that it can be faster particularly as it relates to pain, mood, and preferences. Accessing multiple data sources is necessary for those residents who despite being approached can not or who do not wish to Participate in some or all of the interview.

Interview Question Process?

Processes are included to support the interview question evaluation. If the item being asked is about something that is not fixed or absolute, then having more than two response choices can make accurately responding for the residents easier for older adults.
New CATs Pain and RTC

NEW...The CATs includes:

1. Pain to enhance identification & treatment to reduce negative outcome r/t under treated pain,

2. The resident goal that he/she expects to be discharged to the community,

Continued Community Return...

3. The resident and care planning team determine discharge to the community is feasible, and

4. The resident (or their family/significant other if resident unable to respond) wants to speak to someone about the possibility of returning to the community.

Community Referral

Support the American Disabilities Act (1990 with further interpretation Olmstead v. L.C. decision in 1999), this ruling stated that individuals have the right to receive care in the least restrictive (most integrated) setting and that governments have a responsibility to enforce and support these choices.
Community Referral

An individual in a facility can choose to leave at any time.
The discharge assessment process requires facility staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives.

Community Referral

The discharge planning goal is to assist the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing comprehensive plan of care interventions, interdisciplinary coordination, fostering independent functioning, using rehab programs, and community referrals.

Transitioning Considerations

Considerations to include:
- Reliability of the Resident/Others to Report?
- Methods to address when not reliable?
- Anticipated declines...clinically unavoidable...
Considerations

While it is agreed that a resident who is mentally, cognitively, physically, and or any combination of impairment may still benefit personally and benefit the process as a reporter on their own condition, there are times when they are not.

Section by Section Review

As the change is within the new MDS 3.0, lets take each section and individually evaluate it. You may want to also take note of which dept will be best to complete each section for your facility MDS Completion P&P as while CMS does not tell providers who should do which section, it is expected we will have a P&P.

MDS 3.0 Colored Key

On page 1 of 38, the following key can be found:

GREEN-items shaded are included in both the RUGs III and IV Grouper. This is further separated by information included in:

Symbol indicating in RUGs III
Symbol indicating in RUG IV
Colored Key

PURPLE—the sections which are OUTLINED in purple indicate that the questions are resident interview items.

Colored Key

ORANGE—sections that are outlined in orange indicates alternatives in resident interview.

Colored Key

Dark Red—items in RED indicate potential triggers for CAAs.
Red circle with white 2 in it=Need for two items required to trigger
* =Need for three items required to trigger
MDS 2.0 to 3.0 Comparisons

<table>
<thead>
<tr>
<th>2.0</th>
<th>3.0</th>
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<tr>
<td>Size (8 pages)</td>
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<td>18 sections (A-W)</td>
<td>19 sections (A-Z)</td>
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<tr>
<td>Most items 7 day look back</td>
<td>Still most items 7 day ...</td>
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<tr>
<td>Multiple data input</td>
<td>Resident primary source</td>
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Most Significant Revisions

There are six sections which encompass the most significant revisions we will include:

- Cognitive Assessment
- Mood Assessment
- Behavior Assessment
- Customary Routine
- Pain Assessment
- Rehab Coding
- Significant Change related to end stage/palliative

Section A

Individual Section A Identification Information review. From A0100 Facility provider Numbers-Through A2400 Medicare Stay is to provide key data to identify:

- Residents (individually)
- Residence (home)
- Rationale (for assessment)
Facility Provider Numbers

The CCN (CMS Certification Number) replaces the “Medicare/Medicaid Provider” in survey, certification and assessment related activities.

Assessment Types

<table>
<thead>
<tr>
<th>OBRA</th>
<th>Medicare</th>
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<tr>
<td>Standard:</td>
<td>PPS:</td>
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<tr>
<td>Admission</td>
<td>PPS Assessment Sched.</td>
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<td>Significant Change</td>
<td>OMRA</td>
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<td>&gt; rehab start</td>
</tr>
<tr>
<td>Entry/Discharge</td>
<td>&gt; rehab end</td>
</tr>
<tr>
<td></td>
<td>&gt; rehab start/end</td>
</tr>
</tbody>
</table>

Race/Ethnicity

To complete this section, ask the resident or family/significant other (if resident unable):

A. American Indian or Alaska Native
B. Asian
C. Black or African American
D. Hispanic or Latino
E. Native Hawaiian or other pacific islander
F. White

Note: include ALL that apply
Preadmission Screening and Resident Review
PASSR

The Code of Federal Regulations outlines several categorical determinations (or temporary exemptions) that can apply to individuals screened and determined to have serious mental illness.

(prior to or MCD will recoup)

PASSR

If an individual is being discharged from a hospital setting and being admitted for the same condition that they were hospitalized for and the attending MD certifies that their stay will be less than 30 days they can be admitted to a Skilled Nursing Facility (SNF), providing they meet a Level of Care.

Preadmission Screening and Resident Review

Level I
PASSR Level I is required pre-upon Admission, typically completed by the discharging facility.

Level II
PASSR Level II is required if the resident stays beyond 30 days by the 40th Day.
Look Back Period

The look back period continues for all items is seven (7) days unless another time frame is indicated. Note a section may have more than one look back period within it...

Section B

Individual Section B. Hearing, Speech, and Vision

Note BO100 Persistent Vegetative State/no Discernable Consciousness Skip Pattern if you code “1” for Yes

Section C

Staff Assessment and Delirium

- Resident Council
- Family Council
- Staff Participation
BIMS
BIMS:
Brief Interview for Mental Status
- Interview Techniques
- Clinical Record Documentation
Discussion points related to the BIMS

Delirium
New
- Completed on everyone
- Uses Confusion Assessment Method (CAM®)
  - Base on resident observations
  - Review of medical record
- Acute onset mental change status
  - Remember 7 day look back period
  - Review medical record prior to look back period

Section D
Section D: Mood
- 14 day look back period
- Coding the presence of indicators does not automatically mean a dx of depression or other mood disorder.
- Assessors are simply making note of the symptom and not making or assigning a diagnosis.
Section D

Standardized, structured depression interview (PHQ-9):

- Across multiple settings and organizations
- 9 Assessment items
- Asking for symptom presence (if presence ask re: frequency)
- Provides a summary for depression score with sensitivity to improvement or decline

CMS reported that over 80% of non comatose residents were able to complete the interview.

Perception is reality...

- While perception may be reality it is not yours in section D; however, it is the reality of the resident. So please remember it is the response by the resident and not your opinion.
- Uses the Patient Health Questionnaire (PHQ-9©) Resident Mood Interview.
- If the resident selects more than one answer use the highest frequency.
- Interview complete if 7 of 9 questions answered. If blank for 3 or more items, interview NOT complete, convert to staff interview.

Section E

Behavior

Mental Illness of Psychosis is included in behavior section:

A. Hallucinations (perceptual)
B. Delusions (misconception or misconception)
Section E

The revision:
- New items to better evaluate impact of the behavior on the resident and delivery of care impact.
- Separates out the rejection of care (thus informed choice vs. not).
- Separates out Wandering (notes impact on that resident and others to include privacy and potential injury)
- Removes and replaces alterability with more specific impact questions.

Section F

Section F: Preferences for Customary Routine

Who gets to respond here?
- Resident
- and
- Family
- No Look back

Section G

Functional Status

NEW

“7” Coded on MDS for self-performance (activity occurs 1–2 Times)

Eating is active
Section G

Section G: Physical Functioning

See color coded MDS 3.0 for individual review

See ADL Flow Sheet Provided for discussion

Section H

Bowel and Bowel * Overview of Section

Separates out trial and current programs

Only One bowel elimination pattern

Indwelling Urinary Catheter is not coded “continent”

(7 Day Look back)

Toileting Program v. Trial

There are 3 keys to determining a program v. trial:

1. Individualized, resident specific based on an assessment of actual voiding patterns.
2. Evidence the program was communicated to staff and the resident verbally and through the care plan, flow records, and written summary.
3. Notations of the resident’s response to the program and resulting evaluations as needed.
Urinary Continence Coding

- Always Continent
- Occasionally Incontinent (less than 7 episodes of incontinence in last 7 days)
- Frequently Incontinent (7 or more episodes of incontinency with at least one continent void in the look back)
- Always Incontinent (no continent voids in look back)
- Not Rated (Catheter or ostomy present or no urine output for the entire 7 day look back)

Urinary Toileting Program

There are 3 important questions?

- Has a trial program been attempted?
- What was the response?
- What is the Current toileting program or trial?

Constipation Defined

Constipation [ ] Yes [ ] No?

Constipation is defined as 2 or fewer bowel movements during the look back period or if for the most movements, the stool is hard and difficult for the resident to pass (regardless of the frequency)
Bowel Coding Choices:

- Always Continent
- Occasionally Incontinent (1 episode in look back)
- Frequently Incontinent (more than 1 episode with at least 1 continent bowel movement in look back)
- Always Incontinent (None in look back)

Section I

Active Disease Diagnosis

- Look back is 7 Days
- Two-step Process
- 13 Categories
- 10 Additional Lines

Two-Step Process

There is a two-step process in the Active Disease Diagnosis:

- Step 1 is a 30 day look back (required physician or Extender per State documented diagnosis)
- Step 2 is a 7 day look back include active or inactive
Section J
Health Conditions has MDS changes:

- Significant Expansion of Pain Assessment
  - ask pain Treatments (routine, PRN, non-medication)
  - ask about pain response (frequency, effect on function such as sleep, reduce activities, severity, preferences...)
- Expansion of Falls, includes:
  - Frequency
  - Injuries

Pain Management
Considerations?

- Been on a scheduled pain medication regimen?
- Received PRN medication for pain?
- Received other modality for pain management other than medication?

Note 5 Day Look Back

Pain Assessment

- Resident Interview
  - numeric pain scale
  - verbal descriptor scale
- Staff Assessment for Pain
  - indicators (c/o pain, non-verbal sounds, posturing, none of these indicators skip to SOB J100)

Staff assessment interview of family/visitors, staff, observation
Short of Breath

Dyspnea-Shortness of Breath (SOB)

- Look back is 7 days
- Differentiate between
  - with exertion
  - when sitting
  - when lying flat
  - none of the above

Prognosis

- Presence of chronic disease with life expectancy of less than 6 months
- Requires Physician Documentation

Falls

- Fall-unintentional change in position...
- Intercepted fall (would have fallen if he/she had not caught self or by other) still considered falls...
- Fall History (on admission 180 day look back)
- Falls since Admission
- Number of Falls (since admission or prior assessment)
Section K
Focus on Swallowing
➢ Do not code swallowing problems when interventions were successful in treating the problem
➢ Do code even if it occurred only 1 time in look back

Height-Weight
➢ Height
  record on admission assessment
  obtain/record when last weight > 1 year
  record to the nearest whole inch, round as needed
➢ Weight
  record on admission assessment
  enter weight < 30 days prior to ARD (if > re-weigh)
  compares weight with 2 periods in time

Weight Loss
Note: Weight loss is addressed, not gain
➢ Weight loss considerations
  ~ weight loss >5% past 30 days
  ~ weight loss >10% past 180 days
➢ Weight loss, note if:
  ~ Physician prescribed loss
  ~ Not Physician prescribed
Nutritional Approaches
Parenteral/IV Feeding includes when administered for nutrition or hydration includes:
- IV fluids, TPN, KVO, and via heparin lock
- Hypodermoclysis/subq ports for hydration

Does not include:
- IV meds, for dilution, flushes, reconstitutions, IV parenteral/fluids in conjunction with chemotherapy or dialysis, and routine adm as part of operative or diagnostic and or recovery room stay

Intake Percentage
- Artificial
  - Total Calories
    (review 7 days intake records & ? need to consult RD)
- Average Fluid
  - review last 7 days & include daily total amount by IV and or tube feeding

Section L
Oral Assessment
- Ask if problems/discomfort chewing, mouth, facial
- Ask if recently had dentures or partials (see fit, chips,)
- Visualize back of mouth with light
- Observe and feel oral sources
- Note abnormalities
- If resident unable to self report, observe while eating
Section M

Skin Conditions
- Eliminates staging of Stasis Ulcer
- Report highest stage of existing ulcer(s)
- No back or reverse staging anymore
- Includes item for "non-stageable"

Section M continued

- Report pressure ulcer dimensions
- Embeds NPUAP PUSH Tool
- Includes venous, arterial, diabetic ulcers on problem list records, nurses notes, and pressure ulcer risk assessments
- 7-day look-back period

Section M Considerations

Areas to include:
- Determination of Pressure Ulcer Risk
- Unhealed Pressure Ulcer(s) (current # at each stage)
- Coding
- Unstagable
- Types of Tissue Involvement
- Worsening or Healed prior Assessment
- Number of Venous and Arterial Ulcers
- Other Ulcers, Wounds, Skin Problems & Tx
Section N
Section N: Medications
Changes...

- Elimination of the number of and new medications
- Elimination of the number of days of medication types

Injections * Insulin

- Includes any medication, antigen, vaccine, etc. by SQ, IM, ID
- Number of days any type of injection received while a resident is in the nursing only...
- Include insulin injections in this item as well as item NO350 Insulin
- Days-insulin days includes # of days in look back
- Orders-record the # of days during look back insulin orders were changed (count ss only if new, dc’d, or 1st time used)

More on Medications
Tips to Ponder

- Combination meds should be coded in all categories that constitute the combinations
- OTC agents for sleep are not included as hypnotics
- Code the medication per the classification not the reason that it is being given (which should be documented regardless if the standard reason or not)
- Code long acting medications only if given during the look back period
Section O

Look back 14 days TX       Current definitions
Look back 14 days Program   Isolated/quarantine added
Look back 7 days rehab      BiPAP/CPAP added
Influenza and pneumococcal vaccine added  “Other” eliminated from restorative nursing

Special Tx and Procedures

Coding Categories

➢ While not a resident included for care planning purposes will not be captured in RUG III or IV rate
➢ While a resident included for care planning will be captured in the RUG III and IV rate

Special Tx and Procedures

Coding Tips

➢ BiPAP/CPAP if ventilator is being used as a substitute
➢ Ventilator or respirator (do not code if used to sub for a BiPAP/CPAP)
➢ Tracheotomy care
➢ Suctioning (naso or tracheal
➢ Oxygen
➢ Radiation
And...
- Chemotherapy for cancer treatment only
- Dialysis
- Hospice Care (must be State and or Medicare certified)
- Respite Care
- Isolation/quarantine for active infections (not history)
- Transfusions excluding if given during actual dialysis and or chemo
- IV Medications (not during dialysis or chemo, MAY include IV meds via epidural, intrathecal, or baclofen pump)

Section P
Section P: Restraint Categories
- There are 2 major categories
  - Used in Bed
  - Used in Chair or Out of Bed
- Clarification of Key Concepts
  - Remove Easily
  - Freedom of Movement
  - Medical Symptom/Dx

Section Q
Section Q: Participation in Assessment & Goal Setting

Significantly revised to address the role of the resident and the family in relation to goal setting as it pertains to the resident and or families expectations.

Discharge Planning Collaborative
Return to the Community
This is new...has a related CAA...will be supported by a lead designated agency which in Alabama will be Medicaid presently.

If Return to the Community is triggered, this will currently require you to manually follow-up.

Please see section Q handout

Section V
Section V: Care Area Assessments (CAA) Summary

- Complete only if determined to proceed
- Confirm BIMS Score
- Prior Assessment Resident Mood Interview
- Prior Assessment Staff Assessment of Resident Mood

CAA Summary
Remember

- The CAA itself is not required but if not used another expert endorsed assessment of the triggered area is.
- There are 20 potential care area triggers (CATs)
- There are 20 potential CAAs corresponding to CATs
Section X
Section X: Correction Request
- Type of Record
- Type of Provider
- Type of Assessment
- Attesting Individuals Name, Title, and date
- General (resident name, social security #, birth date, gender)

Section Z
Section Z: Assessment Administration
- Medicare Part A HIPPS code
- RUG version code
- Non Rehab Medicare A billing
- State Medicaid Billing (if required by State)
- Alternate State Medicaid Billing (if required by State)
- Insurance Billing
- Signatures

Medicare Matters
Both the MDS 3.0 and RUGs IV will bring about significant changes in your Medicare Reimbursement.
Medicare Update
The update includes:
➢ Therapy Cap & Physician Fee Schedule
   a. cap expectations process extended through 12.31.10
   b. Physician fee schedule fix expired 3.31 with 4.1.10
decrease of 21.2% technically implemented.
➢ Operational Implications
   a. Medicare Part A Management critical (ARDs & minute tracking)
   b. Due to changes in minutes efficiencies in other areas key.

Important Website Addresses
SNF Main Information site:
www.cms.gov/center/snf.asp

MDS 3.0:

MDS RUGs Report:

Web Addresses
Program Transmittals:

OIG website:
www.oig.hhs.gov

Federal Register Main Site:
www.gpoaccess.gov/fr/index.html
Calculation of ADL Score

What is Changing?

- No longer able to look back into hospital stay for reimbursement.
- Paid at nursing RUG level day following D/C from rehab when resident remains skilled.
- When paying at nursing level and resident needs rehab, CMS pays the Rehab RUG from actual therapy started.

Rehab Component of Skilled

Rehab billing starts only after the initial evaluation and treatment has been ordered and provided.

Therefore, the nursing component will be the only payment until provisions for rehab component has been met.

IV's are no longer qualifiers.

RUGs Key Comparisons

RUGs III
- 53 groups
- 23 rehab groups
- 5 levels rehab intensity
- ADL splits different
- Projections Used
- 1 OMRA Type
- 5 SE qualifiers for X and L

RUGs IV
- 66 groups
- 23 rehab groups
- 5 levels rehab intensity
- ADL splits more consistent
- Short Stay Rehab Class
- 3 OMRA types
- 3 SE qualifiers for X and L
Other Medicare Required Assessments

There is a transition with the OMRA:

- 8-10 day OMRA now a 1-3 end of therapy OMRA (if you kept your residents in their rehab RUG 8-10 days following rehab discharge then don’t forget to calculate this loss)
- Addition of 13 Nursing RUGs (will need to further analyze as available)
- Strong need to plan conversion from rehab RUG to Nursing RUG (reimbursement differences between rehab & nursing RUG to be smaller)

RUG IV System

8 Major Categories of RUGs:

- Rehab + Extensive (vent, infection isolation, trach care)
- Rehab
- Extensive Services

RUGs IV System continued

- Special Care – High
- Special Care – Low
- Clinically Complex
- Behavioral Symptoms & Cognitive Performance
- Reduced Physical Function
### Cat. I-Rehab Plus Extensive Services

<table>
<thead>
<tr>
<th>ADL Score 2-16</th>
<th>ADL Score</th>
<th>RUG-IV</th>
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<tr>
<td>Rehab Ultra High PLUS ES</td>
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### Cat. II Rehabilitation

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### Cat. III – Extensive Services

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<td>Tracheostomy care OR ventilator or respirator</td>
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<tr>
<td>Infection Isolation</td>
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### Cat. IV – Special Care High

**ADL = 2 - 16**

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</thead>
<tbody>
<tr>
<td>15 - 16</td>
<td>Depression</td>
<td>HE2</td>
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</table>

- Comatose and ADL dependent or did not occur
- Septicemia
- Diabetics with both: daily injections (7 days), insulin order chgs, 2+ days
- Quadriplegia and ADL >5
- Fever with 1 of following: (pneumonia, weight loss, vomiting, Feeding Tube 2) Parenteral/IV Feeding

Respiratory Therapy = 7 days

### Cat. V-Special Care Low

**ADL = 2 - 16**

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>End Split</th>
<th>RUG IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 16</td>
<td>Depression</td>
<td>LEa</td>
</tr>
<tr>
<td>11 - 14</td>
<td>No Depression</td>
<td>LEb</td>
</tr>
</tbody>
</table>

- Cerebral Palsy and ADL >5
- Multiple Sclerosis and ADL >5
- Parkinson’s Disease and ADL >5
- Respiratory failure and O2
- Feeding Tube 3
- Stage 3 + 4 pressure ulcer w/2+ Tx
- Stage 2 pressure ulcer w/2+ Tx
- Stage 2 pressure ulcer (i) and venous/arterial (j) with 2+ ulcer Tx
- Foot Infection, diabetic foot ulcer, or other open lesion of foot with drg

Radiation/Dialysis Therapy (while resident)

### Cat. VI-Clinically Complex

**ADL = 0 - 16**

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>End Split</th>
<th>RUG-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 16</td>
<td>Depression</td>
<td>CEa</td>
</tr>
<tr>
<td>15 - 16</td>
<td>No Depression</td>
<td>CEb</td>
</tr>
<tr>
<td>11 - 14</td>
<td>Depression</td>
<td>CDa</td>
</tr>
<tr>
<td>11 - 14</td>
<td>No Depression</td>
<td>CDb</td>
</tr>
<tr>
<td>8 - 10</td>
<td>Depression</td>
<td>CCa</td>
</tr>
<tr>
<td>8 - 10</td>
<td>No Depression</td>
<td>CCb</td>
</tr>
<tr>
<td>2 - 5</td>
<td>Depression</td>
<td>CBa</td>
</tr>
<tr>
<td>2 - 5</td>
<td>No Depression</td>
<td>CBb</td>
</tr>
<tr>
<td>0 - 1</td>
<td>Depression</td>
<td>CAa</td>
</tr>
<tr>
<td>0 - 1</td>
<td>Depression</td>
<td>CAb</td>
</tr>
</tbody>
</table>

- Residents with ES, SC, or SC Low with ADL = 0 - 1
- Hemiplegia/hemiparesis and ADL >5
- Surgical wounds or open lesion Tx
- Burns
- Chemotherapy, while resident
- CPAP, while resident
- IV medications, while a resident
- Transfusions, while a resident

Depression criteria is met if Total Severity Score ≥ 20
Cat. VII-Behavior SX-Cog Performance

**ADL = 0 - 5**

- Cognitive Impairment BIMS score 9 or CPS > 3
- Hallucinations
- Delusions
- Physical behavior sx to others
- Verbal behavior sx to others
- Other behavioral sx not desired to others
- Rejection of Care
- Wandering
- Restorative Nursing Services

**ADL Score** | **End Split** | **RUG-IV**
--- | --- | ---
2 - 5 | > Restor. Nsg | BB1

Cat. VIII-Reduced Physical Function

**ADL = 0 - 16**

- Behavioral Symptoms & Cognitive Performance = ADL 6 - 16
- Residents who do not meet the conditions in any of the previous categories
- Restorative Nursing Services

**ADL Score** | **End Split** | **RUG-IV**
--- | --- | ---
15 - 16 | > 2 Restor. Nsg | PE2
15 - 16 | > 2 Restor. Nsg | PE2
11 - 14 | > 2 Restor. Nsg | PD1
6 - 10 | > 2 Restor. Nsg | PB2
2 - 5 | > 2 Restor. Nsg | PB1
2 - 5 | > 2 Restor. Nsg | PB1
0 - 1 | > 2 Restor. Nsg | PA1
0 - 1 | < 2 Restor. Nsg | PA1

Critical MDS Sections continued and...

- Section I: Active Diagnoses
- Section K: Swallowing/Nutritional Status
- Section M: Skin Conditions
- Section N: Medications
Most Critical MDS Sections

The following seven sections are have the greatest impact of rehab:

- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section G: Functional Activities

Rehab Minutes Count

- Individual
- Concurrent
- Group

Individual

Individual (Robin's rule of one)

- The services are provided by one therapist to one resident at one time.
Concurrent
Concurrent (Robin’s rule of two)
➢ These services are provided to two residents at the same time while performing up to two different activities while in line of sight of the therapist providing the documented treatment.

Group
Group (Robin’s rule of grouping)
➢ These services are provided to a group of two, three, or four residents at a time who are performing activities that may be similar while being supervised by their treating therapist who is not supervising anyone else other than the group.

Time Spent
➢ What is new, is the requirement of separate identification of the resident’s time spent noting:
  1. 1:1
  2. Concurrent
  3. Group
Minute Counting Rules

- Start—when the resident begins 1st activity, task, or treatment.
- End—when the resident ends the final treatment, task, or intervention

Note any bathroom breaks or other non-care planned therapeutic interruptions as they are not counted in the total minutes.

Practices

- All minutes count for Individual Services (rule of one)
- Half of the minutes count for Concurrent (rule of two)
- Up to 25% of the total group can count towards Group (based on total number of residents...rule of grouping)

Recording of Minutes

- Record all minutes separately (by individual, concurrent, and/or group—note time spent on each intervention is not required to be broken down).
- Record each discipline separately on the MDS.
- Record the total time for each category is entered on the MDS in Section O.
Key Minutes Considerations
Below lists some key considerations for management of rehab minutes:

➢ Thou shall **not** round minutes

➢ Thou shall **not** convert units to minutes

AND...

➢ Thou shall include the minutes to prepare the resident in set up.

➢ Thou shall include the minutes to adjust equipment for the resident usage.

AND...

➢ Thou shall record of actual minutes of service only

➢ Thou shall record and count minutes spent on subsequent re-evaluations which is conducted as part of the treatment process
Short Stay v. Projection

Short Stay is a new term that was:
- Designed for residents that have not achieved the minimally required days.
- Used to replace MDS 2.0 Section T projection which means even in a short stay period you can achieve Ultra High or Very High RUG levels.

Short Stay Allows

Therefore, the use of the Short Stay category will allow:

Allocation into any RUG level.

By:

Counting the days and the minutes provided for the calculation.

Short Stay Calculation

Take the Average Daily Minutes (number of minutes) and divide them by the number of the days:

- Rehab low (RL) 15 to 29
- Rehab Medium (RM) 30 to 64
- Rehab High (RH) 65 to 99
- Rehab Very High (RV) 100 to 143
- Rehab Ultra High (RU) 144 or greater
Supporting Documentation

Documentation to reflect the Rehab Services is successful is an important aspect of the Nursing department progress notes.

What systems do you currently have in place to support the nurses to be aware of what results in the resident skill level therefore what is important to document?

Skill Documentation System

It is critical that the MDS Coding on the MDS does not contradict progress. This is not new and should be occurring now and often not in most facilities.

Physical Functioning

Looking at Physical Functioning for the 3.0 and comparing to the rehab language, are you speaking the same language? Do you need a bridge? Consider making/adding to the following with three examples per discipline:
Section G
Section G: Physical Functioning

Refer to the ADL Flow Chart in the RAI Manual to facilitate accurate coding.

Section G

Instructions for the “Rule of 3”

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).

Instructions “Rule of 3” Continued

- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - when there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - when there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.
ADL Self-Performance

1. ADL Self-Performance
   
   Code for the resident’s performance over all shifts—not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent—except for total dependence which requires full staff performance every time.

2. ADL Support Provided
   
   Code for most support provided over all shifts; code regardless of the resident’s self performance classification.

ADL Self-Performance

1. ADL Self-Performance
   
   Coding:
   
   Activity occurred 3 or More Xs
   0. Independent
   1. Supervision
   2. Limited Assistance
   3. Extensive Assistance
   4. Total Dependence

   Activity Occurred 2 or Fewer Xs
   7. Activity occurred once/twice
   8. Activity did not occur

2. ADL Support Provided
   
   Coding:
   
   0. No setup or phys. Staff help
   1. Setup help only
   2. One person physical assist
   3. Two + persons physical assist
   8. ADL activity itself did not occur during the entire period

Balance During Transitions & Walking

**Coding:**

Coding Choices are:

0. Steady at all Times
1. Not Steady, but able to stabilize without human assistance.
2. Not Steady, only able to stabilize with human assistance.
8. Activity did not occur

**Code most dependent**

Enter Codes in Boxes

[] A. Moving from seat-standing
[] B. Walking w assistive device if used
[] C. Turning around & facing opposite direction while walk
[] D. Moving on and off toilet
[] E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)
Functional Status Activities

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

**Transfer** - how the resident between surfaces including to and from: bed, chair, wheelchair, standing position excluding to and from the bath/toilet.

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Functional Status Activities

**Walk in Room** - how the resident walks between locations in his/her room.

**Walk in Corridor** - how the resident walks in corridor on unit.

**Locomotion on Unit** - how the resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self sufficiency once in chair.

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Functional Status Activities

**Locomotion off Unit** - how the resident moves and returns from off-unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, how resident moves to and from distinct areas on the floor. If in wheelchair, self sufficiency once in chair.
Functional Status Activities

**Eating**—how the 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).

Functional Status Activities

**Toilet use**—how the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes paid; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

Functional Status Activities

**Personal Hygiene**—how the resident maintains personal hygiene, including combing hair, brushing their teeth, shaving, applying make-up, washing/drying face and hands (*excludes* baths and showers).
Rehab Reports

➢ Minimum Assist bed mobility...then nursing documentation should evidence

➢ Mod Assist in Lower body dressing...then nursing documentation should evidence

Nursing Documents

➢ Resident bed mobility improving moves self...

➢ Resident needs extensive assist dressing

What have we Learned?

Select [ ] True or [ ] False for the following:

1. The new Rehab RUG IV minute values are the same as RUG III? _____

2. Start of Rehab should be seen per CMS when the resident is stable enough to fully participate? _____
What have we Learned?

3. Group Rehab consists of 2 to 4 residents who are similar activities supervised by a therapist who is not supervising others? _____

4. CMS permits Group Rehab when in the treatment plan? _____

What we have Learned?

5. The re-evaluation/re-assessment time can be included on the MDS? _____

6. Concurrent Rehab is defined under Medicare Part A as 2 residents doing activities at the same time, activities can be different? _____

What we have Learned?

7. Medicare has stated that student therapists may complete billable treatments when they are under the direct line of sight of a therapist? _____

8. The purpose of Grace Days is to gain the most accurate assessment of the residents need? _____
Corporate Compliance Question?
- Have you looked at your corporate compliance program as of late?
- When and how is it reported on?
- What follow-up actions are taken?

Compliance Program
- Consider content and quality audit system.
- Initial emphasis on legibility, adherence to physician orders/certification, completeness, plan of care and billing compliance.
- Document what is skilled and ensure appropriate allocation.
- Consider types of review (automated – no medical record needed & complex – requires use of medical record).

Increased Scrutiny
There is increased scrutiny through the Federal & State Governments.
- Recovery Audit Contractor (RACs) are:
  - paid on a % of overpayment recovery
  - looking for administrative errors
- Zone Program Integrity Contractor (ZPIC)
  - Detect fraudulent claims
More on RACs

- Demand Letter issued by the RAC
- RAC will offer an opportunity for the provider to discuss improper payment determination outside the normal appeal process
- Issues to be reviewed by the RAC are to be approved by CMS PRIOR to widespread review
- Approved issues will be posted to a RAC website before widespread review
- Detailed review results letter following all complex reviews

RAC Preparation is Key

To best prepare, review posted improper payments found during the RAC demonstration findings website is:

www.cms.hhs.gov/rac

Top Reasons for Denials

**Documentation Insufficient**
1. Requested documentation was not sent in timeframe.
2. Illegible Documentation (esp. signatures).
3. No documentation for date of service.
4. Incomplete documentation and or unofficial terms or abbreviations used.

**Recommended Corrective Measures**
1. Create your compliance program with minimum of 10% of current PPS billing.
2. Complete content/quality audit per monthly schedule.
3. Perform quantitative as well as qualitative audit.
4. Establish and audit to confirm documentation guidelines followed.
More on Denials

5. Treatment provided but not supported by the treatment plan.
6. No documentation of Physician approval of treatment plan.
7. Duplication of services.
8. No documentation of functional progress in a 'reasonable' period of time.
10. Time/days on MDS does not match other doc.

Thank You

Robin A. Bleier has presented nationally on Resident Assessment, Clinical Risk, as well as Disaster Management since 1996.

She speaks nationally on risk which includes disaster Management, clinical operations, MDS, and PPS. Robin is the Principal of RB Health Partners, Inc. 1st Vice President of FADONA and Chair FHCA Disaster Council since 2003. To contact Robin, email robin@rbhealthpartners.com or call 727.744.2021.