

CH.	Sect.	Pg.	March 2007 Revision
NA	Title Page	NA	Change the revised date to March 2007
CH 3	H3a	3-124	Revise the definition of "Any Scheduled Toileting Plan" by adding the words shown below: A plan for bowel and/or bladder elimination whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes bowel habit training and/or prompted voiding.
	Plac	3-182	Delete the words "or biological (e.g., contrast material)" from the following sentence: Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port.
	W2b	3-243	After number 6, add: If none of the above reasons apply, enter a dash (-).
	W3b	3-246	After number 3, add: If none of the above reasons apply, enter a dash (-).
CH 5	5.6	5-7	In the last sentence, change "March 2000" to "September 2000" and change the website reference as shown below: Detailed instructions concerning completion of the Correction Request form and examples of the correction process are included in the final <u>Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form</u> (March September , 2000), which may be accessed at http://www.gtso.com/download/mds/prMn1002.pdf . http://www.cms.hhs.gov/NursingHomeQualityInits/20_NH_QIMDS20.asp
CH 6	6.1	6-1	Change all occurrences of "nursing facility" to "nursing home" and "nursing facilities" to "nursing homes".
	6.2	6-2	Change "nursing facilities" to "nursing homes" in the fourth paragraph.
	6.4	6-4	Change "Nursing facilities" to "Nursing homes" in the third paragraph.
	6.5	6-7	Change two occurrences of "nursing facility" to "nursing home" in the last paragraph.
	6.5	6-8	Delete the "NOTE" at the end of Section 6.5: NOTE: These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.
	6.6	6-14	Change the first sentence as follows: Rehabilitation therapy is any combination of the disciplines of physical therapy , occupational therapy , or speech therapy language pathology .

	Appendix	Page	March 2007 Revision
	B	B-1	Add new revision date
		B-2 through B-4	Update contact information for MDS RAI Coordinators for the following states: Alaska, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maryland, Minnesota, Missouri, North Carolina, North Dakota, New Mexico, Nevada, New York, Puerto Rico, Vermont, Virginia, Wisconsin, and West Virginia.
		B-5 through B-7	Update contact information for MDS RAI Automation Coordinators for the following states: Alaska, California, Colorado, and South Dakota.
		B-8	Update contact information for Region V.
		B-9	Move three lines from B-8 to B-9 to keep Region VI information on one page.

**Centers For Medicare &
Medicaid Services**



**Revised
Long-Term Care
Facility Resident
Assessment
Instrument
User's Manual**

Version 2.0

December 2002

Revised March 2007

H3. Appliances and Programs (14-day look back)

- Definition:**
- a. **Any Scheduled Toileting Plan** - A plan for **bowel and/or bladder elimination** whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes **bowel** habit training and/or prompted voiding.
 - b. **Bladder Retraining Program** - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.
 - c. **External (Condom) Catheter** - A urinary collection appliance worn over the penis.
 - d. **Indwelling Catheter** - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.
 - e. **Intermittent Catheter** - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder-emptying program (e.g., every shift in a resident with an under active or a contractile bladder muscle).
 - f. **Did Not Use Toilet Room/Commode/Urinal** - Resident never used any of these items during the last 14 days, nor used a bedpan.
 - g. **Pads/Brief Used** - Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.
 - h. **Enemas/Irrigation** - Any type of enema or bowel irrigation, including ostomy irrigations.
 - i. **Ostomy Present** - Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.
 - j. **NONE OF ABOVE (Not Used on the MPAF)**

SECTION P.

SPECIAL TREATMENTS AND PROCEDURES

P1. Special Treatments, Procedures, and Programs

Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.**

a. SPECIAL CARE (14-day look back)

TREATMENTS - The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc.

- Definition:**
- a. **Chemotherapy** - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
 - b. **Dialysis** - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
 - c. **IV Medication** - Includes any **drug given** by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy.

5. Not offered – Resident or responsible party/legal guardian not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

6. Inability to obtain vaccine – Vaccine unavailable at the facility due to declared vaccine shortage; however, the resident should be vaccinated once the vaccine is received. The annual supply of inactivated Influenza vaccine and the timing of its distribution cannot be guaranteed in any year.

If none of the above reasons apply, enter a dash (-).

W3. Pneumococcal Immunization

Intent: To determine the rate of vaccination and causes for non-vaccination.

Section W3 must be completed for all residents on all assessment types (OBRA and/or PPS) and all discharge tracking forms.

- The CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm^{2,3}. If the resident is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.
- Persons less than 65 years of age who are living in environments or social settings (e.g. nursing homes and other long-term care facilities) in which the risk for invasive pneumococcal disease or its complications is increased should receive the PPV².
- All adults 65 years of age or older should get the PPV. PPV is given once in a lifetime, with certain exceptions¹.

Enter “1” for a ‘Yes’ response and skip item W3b

- If the resident's PPV status is up to date

W3b

If the resident has not received a PPV, code the reason from the following list:

- 1. Not eligible** – Due to contraindications including:
 - allergic reaction to vaccine component(s)
 - a physician order not to immunize
 - an acute febrile illness is present; however, the resident should be vaccinated after contraindications end
- 2. Offered and declined** – Resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.
- 3. Not offered** - Resident or responsible party/legal guardian were not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

If none of the above reasons apply, enter a dash (-).

In summary, the facility must then take the following actions:

1. Correct the original assessment,
2. Submit the corrected assessment, and
3. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment if the error was major, and update the care plan as necessary.

If the MDS (MPAF) is performed for Medicare purposes only (AA8a = 00, AA8b = 1, 2, 3, 4, 5, 7 or 8), no Significant Change in Status or Significant Correction of a Prior assessment is required. RAPs and care planning are not required with Medicare assessments.

5.6 Correcting Errors in MDS Records That Have Been Accepted Into The State MDS Database

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. Two processes have been established to correct MDS records (assessments or tracking forms) that have been accepted into the State MDS database:

- **Modification**
- **Inactivation**

A Modification request moves the inaccurate record into the history file in the State MDS database and replaces it with the corrected record in the active database. An Inactivation request also moves the inaccurate record into the history file in the State MDS database, but does not replace it with a new record. Both the Modification and Inactivation processes require an MDS Correction Request form.

The MDS Correction Request form (Prior Record Section and Section AT) contains the minimum amount of information necessary to enable correction of the erroneous MDS data previously submitted and accepted into the State MDS database. A hard copy of the Correction Request form must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. A hard copy of the Correction Request form should also be kept with an inactivated record. (A copy of the Correction Request form can be found at the end of this chapter.)

Detailed instructions concerning completion of the Correction Request form and examples of the correction process are included in the final Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form (September, 2000), which may be accessed at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHOIMDS20.asp.

CHAPTER 6: MEDICARE SKILLED NURSING HOME PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing homes, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for skilled nursing homes under Part A of the program. (Federal Register Vol. 63, No. 91, May 12, 1998, Final Rule.)

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970's, focusing on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of states that developed and implemented similar case mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of State and Federal payment systems for nursing home care is based on the recognition of the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs, but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels would be higher than for those residents with less intensive care needs. In a case mix adjusted payment system the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the MDS. Case mix reimbursement has become a widely adopted method for financing nursing home care. The case mix approach serves as the basis for the PPS for skilled nursing homes, swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

6.2 Utilizing the MDS in the Medicare Prospective Payment System

A key component of the Medicare skilled nursing home prospective payment system is the case mix reimbursement methodology used to determine resident care needs. A number of nursing home case mix systems have been developed over the last 20 years. Since the early 1990's, however, the most widely adopted approach to case mix has been the Resource Utilization Groups (RUG-III). This classification system uses information from the MDS assessment to classify SNF residents into a series of groups representing the residents' relative direct care resource requirements.

The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-III groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency or other conditions will be assigned to higher groups in the RUG-III hierarchy. Providing care to these residents is more costly, and is reimbursed on a higher level.

6.3 Resource Utilization Groups Version III (RUG-III)

The RUG-III classification system has eight major classification groups: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. The eight groups are further divided by the intensity of the resident's activities of daily living (ADL) needs, and in the Clinically Complex category, by the presence of depression.

One hundred and eight (108) MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the RUG-III Classification system for nursing homes can be found at the end of this section.

EIGHT MAJOR RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP
Rehabilitation Plus Extensive Services	Residents receiving physical, speech or occupational therapy AND receiving IV feeding or medications, suctioning, tracheostomy care, or ventilator/respirator.
Rehabilitation	Residents receiving physical, speech or occupational therapy.

6.4 Relationship Between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

1. ASSESSMENT REFERENCE DATE (ARD)

The ARD must be reported on the Medicare claim. If an MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

2. THE RUG-III GROUP

The RUG-III group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted MDS assessments. **Nursing homes** cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process.

RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
 RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
 SE1, SE2, SE3
 SSA, SSB, SSC
 CA1, CA2, CB1, CB2, CC1, CC2
 IA1, IA2, IB1, IB2
 BA1, BA2, BB1, BB2
 PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
 AAA (the default code)

3. HEALTH INSURANCE PPS (HIPPS) CODES

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement.

The CMS HIPPS codes contain a three position code to represent the RUG-III of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was

6.5 SNF PPS Eligibility Criteria for SNFs

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized below.

TECHNICAL ELIGIBILITY REQUIREMENTS

Technical eligibility remains the same, as outlined below, per the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1 (Pub. 100-1) and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2). The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay.
- Admission for SNF-level services is within thirty days of discharge from an acute care stay.

CLINICAL ELIGIBILITY REQUIREMENTS

A beneficiary is eligible for SNF extended care if all the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition for which the resident:
 - was treated during the qualifying hospital stay, or
 - arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

PHYSICIAN CERTIFICATION

The attending physician or a physician on the staff of the skilled nursing home who has knowledge of the case, or a nurse practitioner (NP) or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician, must certify and then periodically re-certify the need for extended care services in the skilled nursing home.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable. (42 CFR 424.20)
 - The initial certification certifies, per the existing context found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, **or**
 - Validates that the beneficiary's assignment to one of the upper RUG-III (Top 35) groups is correct through a statement indicating the assignment is correct.
- **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 no later than 30 days after the prior re-certification.**

6.6 RUG-III 53 Group Model Calculation Worksheet for SNFs

This RUG-III Version 5.20 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 53-group RUG-III Version 5.20 model. In the 53-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups representing 10 different levels of rehabilitation services. In the 53-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 53-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Function groups.

There are two basic approaches to RUG-III Classification: (1) hierarchical classification and (2) index maximizing classification. CMS has not developed an index maximization worksheet. The worksheet included at the end of this chapter was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below.

CATEGORY II: REHABILITATION

RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical **therapy**, occupational **therapy**, or speech **language pathology**. This information is found in Section P1b. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in Section P3 and H3a,b of the MDS Version 2.0.

► STEP # 1

Determine if the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the resident does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. Ultra High Intensity Criteria

In the last 7 days (section P1b [a,b,c]):

720 minutes or more (total) of therapy per week **AND**

At least two disciplines, 1 for at least 5 days, **AND**

2nd for at least 3 days

RUG-III ADL Score

16 - 18

9 - 15

4 - 8

RUG-III Class

RUC

RUB

RUA

B. Very High Intensity Criteria

In the last 7 days (section P1b [a, b, c,]):

500 minutes or more (total) of therapy per week **AND**

At least 1 discipline for at least 5 days

RUG-III ADL Score

16 - 18

9 - 15

4 - 8

RUG-III Class

RVC

RVB

RVA

APPENDIX B

STATE AGENCY CONTACTS RESPONSIBLE FOR ANSWERING RAI QUESTIONS

STATE AGENCY CONTACTS – MDS RAI COORDINATORS

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