Advanced Medicaid Case Mix Management: A MDS Coordinator’s Perspective to Accurate Reimbursement

Presented by:
HARMONY UNIVERSITY
The Provider Unit of
Harmony Healthcare International, Inc.
HHI

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“We Care About Care”
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Disclosure: The planners and presenters of this education activity have no relationship with commercial entities or conflicts of interest to disclose

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About Elisa
Elisa Bovee, MS OTR/L

Elisa Bovee is the Vice President of Operations at Harmony Healthcare International, (HHI), an industry leader in Long Term Care consulting.

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About Kim

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- Over 28 years experience in Long-term Care and Cardiac CCU
- Shift Supervisor
- MDS and Care Plan Coordinator for 5 years
- Director of Nursing for 18 years
- Trained staff in IV-Certification, MDS 2.0, MDS 3.0, PPS, ADLs and Regulatory Compliance, Infection Control and OSHA
- Specialty in Wound Care and Survey Compliance for both Standard and OIS Surveys
- Provides education in all aspects of Therapy and Nursing Medicare Documentation Requirements, completing CAAs and Care Plan Development, Wound Assessment and Documentation
- Expert in NY State Medicaid/CMI Reimbursement and Documentation and training for Successfully Preparing for the NY State OMIG Audit

Objectives

- The learner will be able to identify the specific components of NY RUG-III 53 categories
- The learner will be able to identify high risk NY RUG-III 53 categories
- The learner will be able to identify documentation requirements to support the RUG components
- The learner will be able to identify strategies for organization of the Medical Record in preparation for OMIG Audits

Component of a RUG

RUG-III Grouper Qualifications:
- Identification of Qualifiers and Extensive
Component of a RUG

- Know qualifiers of the RUG
- Documentation must be in the medical record to support each component or qualifier of the RUG

Extensive Component of RUG

- Non-Therapy Extensive
  - SE1
  - SE2
  - SE3
- Rehab Extensive
  - R_X
  - R_L

Extensive Defined

- Extensive Services qualification based on ADL Sum 7 or greater and one of the following services:
  - IV feeding in last 7 days
  - IV medications in last 14 days
  - Suctioning in last 14 days
  - Tracheostomy care in last 14 days
  - Ventilator/respirator in last 14 days
- Special Care with ADL score 6 or less
Extensive Defined

- While a Resident
  - Treatments, procedures, and programs received or performed by the resident after admission/re-entry to the facility and within the 14-day look-back period
- While not a Resident
  - Treatments, procedures, and programs received or performed by the resident prior to admission/reentry to the facility and within the 14-day look-back period

IV Parenteral/IV Feeding Defined

- K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration
- "Supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy."

IV Parenteral/IV Feeding Defined

- DO:
  - Administered for nutrition or hydration
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy
  - Prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration
IV Parenteral/IV Feeding Defined

- **DO NOT:**
  - IV fluids **NOT** administered for *nutrition* or *hydration*
  - IV fluids administered solely as flushes
  - In conjunction with Dialysis, Chemotherapy, Surgical procedure or Diagnostic procedure
  - IV fluids used to reconstitute and/or dilute IV medications

IV Medication Defined

- Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item
- Do not include IV medications of any kind that were administered during:
  - Dialysis
  - Chemotherapy
  - Surgical procedure
  - Diagnostic procedure

IV Medication Defined

- Do not code flushes to keep an IV access port patent
- Do not code IV fluids without medication here.
  - Dextrose 50% and/or Lactated Ringers given IV are **not** considered medications
  - Epidural, intrathecal, and baclofen pumps may be coded
  - Subcutaneous pumps may **not** be coded
### Extensive Defined

- May code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff in Section O
  - Tracheostomy care
  - Suctioning

### RUG-III: Extensive Services Count

**RUG III Non-Therapy SE Count:**
- Parenteral IV – K5A = 1
- IV Medication – P1ac = 1
- Special Care = 1
- Clinically Complex = 1
- Impaired Cognition = 1

### RUG-III: Extensive Services Count

<table>
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</table>
Extensive Services Documentation

- Facility Medication Administration Records for IV Medication and IV Hydration
- Hospital Medication Administration Records for IV Medication and IV Hydration
- Emergency Room Records
- Hospital documentation evidencing actual administration of for IV Medication and IV Hydration

Additional Documentation to Support

- IV Hydration facility administered
  - Dietary notes to support administration for hydration
  - Care Plan supporting Dehydration risk
  - MDS Notes indicating location of the data
  - MDS System may allow MDS Note in MDS
  - Staple a copy of documentation to support to printed MDS or MDS Signature
  - Scan document into Electronic Medical Record

Component of a RUG

RUG-III Grouper Qualifications: Depression, Diagnosis and Rehab
Depression Component of a RUG

- End Split for Clinically Complex:
  - CD2 versus CD1
  - 2= Positive Depressive Indicator

Depressive Indicator Defined

- Depression End Splits: Signs and symptoms of depression are used as a third-level split for the Clinically Complex category
  - D0300 PHQ-9 Total Severity Score is greater than or equal to 10 but not 99
  - or
  - D0600 PHQ-9 Total Severity Score is greater than or equal to 10

Depressive Indicator Documentation

- Section D of the associated MDS
  - D0300 PHQ-9 Resident Interview
  - D0600 PHQ-9 Staff Interview
Addisonal Documentation to Support

- Care Planning for Depression
- Verification of Completion of the PHQ on the ARD or the Day before
  - "If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed"

Diagnosis Coding Component of a RUG

- Special Care
  - Multiple Sclerosis
  - Cerebral Palsy
  - Quadriplegia
- Clinically Complex
  - Coma
  - Hemiparesis
  - Diabetes (with daily injections and order changes)

Diagnosis Coding Component of a RUG

- Special Care
  - Dehydration (with Fever)
  - Pneumonia (with Fever)
- Clinically Complex
  - Septicemia
  - Dehydration
  - Pneumonia
  - Internal Bleed
Diagnosis Coding Defined

- Require a physician-documented diagnosis
- Active diagnosis:
  - Direct relationship to the resident’s current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period

Medical record sources for physician diagnoses include:
- Progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available
- If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered

Hemiparesis: Includes Hemiplegia
Must have a specific diagnosis
Weakness due to CVA is not supportive

Quadriplegia: Excludes Quadripareisis
Clarified on Open Door Forum
February 2013: Must be related to spinal cord injury. Excludes Functional Quadriplegia.
Diagnosis Coding Defined

- **Dehydrated** (two or more present)
  1) Intake less than 1,500 ml of fluids daily
  2) Clinical indicators: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity, etc.
  3) Resident’s fluid loss exceeds intake

Diagnosis Coding Defined

- **Internal Bleed**: Frank Bleeding or Occult (such as guaiac positive stools). Vomiting “coffee grounds,” hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing.
  - *Excludes* Menses or a urinalysis that shows a small amount of red blood cells

Diagnosis Coding Defined

- **Coma** (Persistent Vegetative State): Diagnoses by a Physician
  - *Excludes* progressive neurologic disorders or severe cognitive impairment as they are usually not comatose or in a persistent vegetative state
Diagnosis Coding Defined

- Active Diagnosis: Do not include conditions that have **been resolved**, do not affect the resident’s current status, or do not drive the resident’s plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.
- Medical treatments
- Medication
- Symptoms

Diagnosis Component Documentation

- Physician Orders (Monthly/ Interim)
  - Physician Signed in the last 60 days
- Physician Progress Notes
- Emergency Department Report
- History and Physical
  - Documentation must support diagnosis is active
- Diagnosis list must be supported by Physician
  - Physician Order or Signature
  - Supported by relationship in the Care Plan

Accurate Diagnosis Coding Tips

- What is the facility process for adding and resolving diagnosis to the medical record?
  - Supported by Physician
  - Physician Orders
- Diagnosis lists alone do not support if not signed and dated by the physician
- What is the facility process for identifying resolvable diagnosis
  - Pneumonia
Rehabilitation Component of a RUG:

- Extensive Rehab
  - “X” or “L” in last position
- Combination of Rehab and the Extensive service
- Based on actual minutes of Physical, Occupational and Speech Therapy minutes combined during the 7-Day Look-back period

Rehabilitation RUG Levels Defined

- Ultra High Intensity Criteria:
  - 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
- Very High Intensity Criteria: In the last 7 days:
  - 500 minutes or more (total) of therapy per week AND
  - At least 1 discipline for at least 5 days

Rehabilitation RUG Levels Defined

- High Intensity Criteria (either (1) or (2) below may qualify)
  - 325 minutes or more (total of therapy per week AND At least 1 discipline for at least 5 days
- Medium Intensity Criteria (either (1) or (2) below may qualify)
  - 150 minutes or more (total of therapy per week AND at least 5 days of any combination of the 3 disciplines
Rehabilitation RUG Levels Defined

- **Low Intensity Criteria** (either (1) or (2) below may qualify):
  - 45 minutes or more (total) of therapy per week **AND** at least 3 days of any combination of the 3 disciplines **AND** 2 or more nursing rehabilitation services received for at least 15 minutes each with each administered for 6 or more days.

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Rehabilitation RUG Documentation

- Actual minutes supported by therapy logs
  - Actual minutes not units
  - Legible
  - Patient name
- Rehabilitation Nursing (Restorative) minutes provided for Rehabilitation Low
- Minutes signed by the therapist that provided care
- Physician Orders for therapy

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Additional Documentation to Support

- Reason for Referral Supported by Nursing and or Physician Documentation
- Prior Level of Function supported by Medical record
- Change in status supported by medical record:
  - Nursing
  - ADL
Component of a RUG

RUG-III Grouper Qualifications:
Restorative Nursing,
Procedures, Treatments and Conditions

Rehab Nursing Component of RUG
- End Split is restorative nursing rehab/restorative 6 days in 2 areas
- Reduced Physical/Behavioral /Cognitive
  - BB2 versus BB1
  - PB2 versus PB1
- Rehab Low
  - RL A
  - RLB

Rehab Nursing Component of RUG
- 2 areas for 15 or more minutes a day for 6 or more of the last 7 days:
  - H0200C, H0500** Urinary toileting program and/or bowel toileting program
  - O0500A,B** Passive and/or active ROM
  - O0500C Splint or brace assistance
  - O0500D,F** Bed mobility and/or walking training
Rehab Nursing Component of RUG

- Restorative (Cont.)
  - O0500E  Transfer training
  - O0500G  Dressing and/or grooming training
  - O0500H  Eating and/or swallowing training
  - O0500I  Amputation/prostheses care
  - O0500J  Communication training

Rehab Nursing Documentation

- Signed logs supporting days 15 minutes provided
- Signed logs supporting 2 areas provided 6 days

Additional Documentation to Support

- RAI criteria for rehabilitation nursing must be met:
  - Measurable objective and interventions must be documented in the care plan and in the medical record
  - Evidence of periodic evaluation by the licensed nurse must be present in the medical record
Additional Documentation to Support

- Nursing Supervision
- State specific
- Minimum 30 Days
- Does not include groups with more than four residents per supervision helper or caregiver
- Evidence of Restorative Nursing Aid training

Skin Component Defined

- Special Care
  - 2 Stage I or II Pressure Ulcers or Venous/Arterial ulcers (crosswalk)
  - Stage III, IV or Unstageable Pressure Ulcer with slough or eschar
  - Open lesion
  - Surgical wound
  - Clinically Complex
  - Burns
  - Foot infection/wounds

Skin Component Defined

- Pressure Ulcers require 2 or more skin treatment
  - Documented in Section M – Care Plan and/ or treatment sheets support items coded
  - Surgical wounds and open lesions require 1 treatment
Documentation to Support Skin

- Weekly sizing and staging reports or nursing note evidencing present in the 7-day look-back period
- Treatment sheets to support treatment administered in the 7-day look-back period
- Documentation to support the highest stage the pressure ulcer was if healing
- Wound Care Consult Reports

Skilled Procedures and Treatments

- Special Care
  - Tube feeding and Fever or Aphasia
  - Radiation treatment
  - Respiratory therapy =7 days
- Clinically Complex
  - Dialysis
  - Oxygen therapy
  - Transfusions

Skilled Procedures and Treatments

- While a Resident
  - Treatments, procedures, and programs received or performed by the resident after admission/re-entry to the facility and within the 14-day look-back period
- While not a Resident
  - Treatments, procedures, and programs received or performed by the resident prior to admission/reentry to the facility and within the 14-day look-back period
Skilled Procedures and Treatments

- **Oxygen: 14-Day Look-back**
  - Oxygen actually administered in the Look-back Period
  - PRN order must have documentation to support actual administration
  - Continuous oxygen with documentation evidencing administered

Skilled Procedures and Treatments

- **Tube Feeding:**
  - 7-Day Look-back
  - **Actual intake** through parenteral or tube feeding routes
  - Proportion of total calories received
  - 51% or more or 26% to 50% and greater than 501 cc Average Fluid Intake per Day
  - Documentation in the Look-back period to support for patients eating and receiving tube feed

Respiratory Therapy

- Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing and deep breathing, heated nebulizers, aerosol treatments, incentive spirometry and mechanical ventilation.

- RAI Manual Appendix A November 2012
Skilled Procedures and Treatments Documentation
- Facility Medication/Treatment Administration Records
- Respiratory Flow Sheets
- Hospital Medication/Treatment Administration Records
- Emergency Room Records
- Consult Reports
- Nursing Notes

Conditions Component of the RUG
- Special Care:
  - Fever in conjunction with any of the following:
    - Dehydration
    - Tube Feed
    - Weight Loss
    - Vomiting

Conditions Defined
- 7-Day Look-Back Period
- Fever: Defined as a temperature 2.4 degrees F higher than baseline. The resident’s baseline temperature should be established prior to the Assessment Reference Date.
- Vomiting: Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic)
Conditions Defined

- **Weight Loss:**
  - Includes weight loss either physician-prescribed or not physician-prescribed
  - Weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days
  - Compare the resident’s weight on the 7-day look-back period to his or her weight in the observation period 30 and 180 days ago.
  - New Admissions ask the resident, family, or significant other and consult. Review transfer information.

Conditions Documentation to Support

- **Weight Records**
- **Vital Signs tracking**
- **Nursing Notes**
- **Facility Medication/Treatment Administration Records**
- **Hospital Medication/Treatment Administration Records**
- **Emergency Room Records**
- **Consult Reports**
- Must support the actual date the condition occurred

Additional Documentation to Support

- **Accuracy of Weight:**
  - Most recent weight measure in the last 30 days
  - If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again.
  - If the resident’s weight was taken more than once during the preceding month, record the most recent weight
Physician Orders and Visits Component

- 14-Day Look-Back Period
- Clinically Complex:
  - 2 Days of Physician Orders and 2 Physician Visits
  - 4 Days of Physician Orders and 1 Physician Visit
  - Diabetes mellitus and injection 7 days and 2 Physician days of order changes

Physician Visits Defined

- Physician Visit:
  - Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law
  - Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit claims processing manual.

- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay)
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay
- Off-site (e.g., while undergoing dialysis or radiation therapy) with documentation of the physician's evaluation
Physician Orders Defined

- **Physician Orders:** 14-Day Look-back Period in Section O:
  - Days of Order changes not the actual number
  - Medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
  - New or altered treatment

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Physician Orders Defined

- **Excludes:**
  - Orders prior to the date of admission or re-entry
  - Orders for activation of a PRN order
  - A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines (Coumadin)
  - Orders for transfer of care to another physician

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Physician Orders Defined

- **Excludes:**
  - Standard admission orders, return admission orders, renewal orders, or clarifying orders without changes
  - Orders on day of admission with unexpected change/deterioration in condition or injury are considered as new
Documentation to Support

- Accurate counting of days (not number of orders)
- Physician orders legibly dated
- Interim and monthly orders sheets
- Physician progress report and consults
- Must evidence at least partial assessment
  - Nursing documentation that a visit occurred is not sufficient

Component of a RUG

RUG-III Grouper Qualifications:
Impaired Cognition and Behavior, ADL

Impaired Cognition Impairment Defined

- ADL=10 or Less
- One of the 3 following criteria:
  1) Cognitive Impairment: A BIMS interview score of less than or equal to 9 will meet the criteria for cognitive impairment.
  2) C1000 Severely Impaired Decision Making (3)
Impaired Cognition Impairment Defined

3) Impaired Cognition

- Two or more of the following impairment indicators are present:
  - C0700 = 1 Short term memory problem
  - C1000 > 0 Cognitive skills problem
  - B0700 > 0 Problem being understood
  - AND
- One or more of the following severe impairment indicators are present:
  - C1000 >= 2 Moderately Impaired
  - B0700 >= 2 Sometimes understood

Additional Documentation to Support

- Care Planning for evidencing impaired cognition
- Verification of Completion of BIMS in the 7-day look-back period
- When signing off on interviews in section Z, the date that the interview was complete must be used
- Interview must be on or before ARD

Behavior Problem

- ADL=10 or Less
  - E0900 Wandering (2 or 3)
  - E0200B Verbal Behavior Directed at others (2 or 3)
  - E0200A Behavior Directed at others (2 or 3)
  - E0200C Other Behavior not Directed at others (2 or 3)
  - E0800 Resisted care (2 or 3)
  - E0100C Delusions
  - E0100A Hallucinations
Documentation to Support Behavior

- Documentation supports 4+ Days in Look Back period
- Impact on others
- Behavior Monitoring sheets
  - Nursing
  - CNA
- Social Services notes support
- Daily Nursing notes

Additional Documentation

- Care Planning evidencing behavior intervention
- Psychiatry and Psychological notes support
- Physician documentation

ADL Defining RUG Qualifier

- RUG-III
  - ADL score of 7 or more Extensive and Special Care
  - Coma and ALL ADLs must be Dependent or did not occur (4→8)

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ADL Self Performance

- **Rules of 3**
- Weight-bearing support 3 or more times: Extensive Assist
- Non weight-bearing support 3 or more times: Limited Assist

ADL Self Performance

1. **Supervision**: Encouragement or cueing provided by the staff
2. **Limited Assistance**: The resident received physical help in guided maneuvering of limbs or other non weight-bearing assistance
3. **Extensive Assistance**: The resident performed part of the activity and received assistance of the following types:
   - Weight-bearing support or
   - Full staff assistance in the task/or portion of the task, during part but not all shift

ADL Self Performance

- **7. Occurred**: 1 or 2 times
- **8. Activity Did Not Occur during ENTIRE look back period**
- The activity did not occur or family and/or non-facility staff provided care
- **Examples:**
  - The resident was on bed rest so transfer did not occur
  - The resident is non-ambulatory
Self Performance

**The ENTIRE Look-back period:**

- **0. Independent:** No staff assistance or supervision
  - New in MDS 3.0 Page G-6 Algorithm
- **4. Total Dependence:** Full staff assistance of the entire activity each time it occurs. There was no participation by the resident

ADL Support

- **ADL Support Provided:** Code for the *most support provided over the entire shift*.
  - No Support
  - Set up help only
  - One person physical assist
  - Two or more provided physical assist
  - Activity itself did not occur during entire shift

RUG-III ADL-Step 1

- Calculate for Bed Mobility, Transfer and Toilet Use

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<th>Self-Performance Column 1</th>
<th>Support Column 2</th>
<th>ADL Score</th>
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RUG-III ADL-Step 2

- Calculate for Eating

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Documentation to Support ADL

- CNA Flowsheets
  - Reflect Month and Resident Name
  - Identify specific documentation utilized for 2 assist provided by facility staff if single episode coded in the Look-back period
  - Ensure 3 episodes of assist are provided by facility staff are evident in the Look-back period
  - Ensure Dependent coded only if occurred during the entire look-back period

Case Mix Documentation

- Documentation for the long term care resident is not usually performed on a daily or even weekly basis
- When an acute condition arises it is important for the nursing staff to track and document
- Increase documentation of current status during ARD window
Case Mix Documentation

- Tracking Sheets on each unit
- Therapy referrals
- Therapy Screens

High Risk Areas

- Rehab
  - Treatment logs
  - Orders
  - Signed evaluations
- Special Care
  - Documentation of fever
  - Minutes with respiratory therapy
  - Daily respiratory assessment pre/post treatment

High Risk Areas

- Clinically Complex
  - Orders/Visits
  - Hemiplegia/Hemiparesis
  - Oxygen
  - Skin issues
- Behavior/Cognitive
- Physical Functioning
  - Rule of Three and supporting documentation
Organization

- Medical Record
  - Must have documented proof of the RUG
- Tips
  - Create small file of specific documentation
  - Create list of location of specific documentation
  - If something is unclear, obtain and document clarification prior to coding the MDS

Organization

- Tips: continued
  - Do not code anything that there is not written documentation to support.
  - Ensure all needed documentation is signed by appropriate staff members in a timely fashion to avoid issues at a later date.

Bibliography

- Centers for Medicaid and Medicare Services
- MDS 3.0 RAI Manual v1.11 (October 1, 2013)
Questions/Answers

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