Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Nursing Home Resident Assessment

Resource Utilization Groups

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EXECUTIVE SUMMARY

PURPOSE

To provide an initial review of the integration of the prospective payment system with the resident assessment.

BACKGROUND

The Office of Inspector General undertook a series of nursing home inspections examining the quality of care in nursing homes. This report is a part of that series. A companion report, "Nursing Home Resident Assessment, Quality of Care," provides a more detailed analysis of the components of the minimum data set.

The Nursing Home Reform Act mandates that nursing facilities use a clinical assessment tool known as the Resident Assessment Instrument to identify residents' strengths, weaknesses, preferences, and needs in key areas of functioning. The assessment is an integral part of the residents' medical record. It is designed to help nursing facilities thoroughly evaluate residents and provides each resident with a standardized, comprehensive, and reproducible resident assessment. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident. The minimum data set (MDS) is a component of the resident assessment which contains a standardized set of essential clinical and functional status measures.

The prospective payment system for a Medicare Part A skilled nursing facility stay was phased into nursing homes between July of 1998 and January of 1999. This has raised a new dimension of issues and concerns and changed the significance of the resident assessment. Under the prospective payment system, skilled nursing facilities are required to classify residents into one of forty-four Resource Utilization Groups (RUGs-III) based on assessment data from the resident assessment.

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records for a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators.

FINDINGS

Coding differences exist: both upcoding and downcoding

The RUGs flow from the MDS and drive Medicare reimbursement to nursing homes under the prospective payment system. Residents are initially assigned to one of seven

major categories of RUGs and then are further classified into 1 of 44 minor RUG categories based on a MDS assessment. For 46 percent of the residents the nursing home coded the resident in a RUG that was higher than our reviewer. For the remaining 30 percent, the nursing home coded the residents in a RUG that was lower than our reviewer. We tested the potential effect on reimbursement; it was not statistically significant.

Therapy minutes and activities of daily living are keys to RUG differences

There are 108 MDS elements that are used in developing the RUG category for each Medicare resident. The minutes of therapy given to the residents is a key driver of the RUG reimbursement. The nursing home completes the MDS by recording the time the beneficiary spent receiving therapy. The therapy log includes both the time the beneficiary spent receiving therapy and other related activities. Our reviewers compared the number of minutes on the MDS to the time in the therapy logs and determined a difference to exist when the therapy time did not match. Thus, some difference is anticipated between the log and the MDS. One would expect the log to be higher than the MDS. However, we found that in most cases the MDS is higher. The nursing home more often coded the resident with more therapy minutes on their copy of the MDS than the therapy logs indicate. More specifically, we found that minutes of both occupational and physical therapy given in the last seven days show rates of difference between 39 and 46 percent respectively. Thirty-one percent of the occupational therapy records and 34 percent of the physical therapy records were coded in the MDS with more minutes.

Further, Section G of the MDS, "Physical Functioning and Structural Problems" has a higher total rate of difference (37 percent) than any other section used to develop RUGs. Each field in Section G used in the RUG computation has a difference rate of at least 28 percent.

Concerns were raised regarding PPS training and additional staff responsibility

Ninety-three percent of MDS coordinators and 98 percent of nursing home administrators report that the introduction of PPS has given additional responsibilities to existing staff. However, about 40 percent of administrators and MDS coordinators note that new staff has been hired to handle PPS.

Almost all MDS coordinators and nursing home administrators state that the staff received initial PPS training. However, 28 percent of MDS coordinators and administrators feel that their staff were inadequately trained about the Medicare PPS. Some cite that there was confusion and misunderstanding in the initial training sessions and express a need for additional training. Twenty-seven percent of MDS coordinators note that they receive on-going training and 60 percent of administrators say they have plans for additional PPS training sessions.

RECOMMENDATIONS

This is an early alert raising concerns about the accuracy of the RUG codes. The fact that coding differences are both higher and lower indicates confusion or difficulties in implementing the MDS rather than an effort to "upcode" the RUGs to increase Medicare reimbursement. However, such a practice cannot be ruled out and our study demonstrates how vulnerable Medicare is to such a practice.

There are apparently differences in how people perceive the MDS. Some see it as a primary document that does not need to be validated by medical documentation. Others feel it must be consistent and validated with the medical record. Clearly, there are variations in interpretation in the way people are using the system. We believe any inability to validate the resident assessment through the medical record would expose the Medicare program to billing abuses. For these reasons, we recommend that HCFA:

- more clearly define MDS elements, especially section G;
- provide enhanced and coordinated training to nursing homes to be sure that similar and accurate MDS and RUG information is being disseminated; and
- require that nursing homes establish an audit trail to validate the 108 MDS elements that drive the RUG code from other parts of the medical record, paying particular attention to therapy minutes and activities of daily living.

The problems we describe in this report will require continuing attention. We plan to revisit the prospective payment system in nursing homes after it has been implemented for a while.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration. They concur with the first two recommendations and describe a number of important steps they are taking to improve understanding and implementation of resident assessment, particularly the MDS.

However, HCFA does not concur with our third recommendation to establish an audit trail to validate the 108 MDS elements. Instead, they plan to fund a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. They hope to combine data validation and program integrity approaches.

We are certainly open to approaches other than the one used in this study to validate the

RUG codes and are ready to work with HCFA in analyzing any such alternate methods. However, for the time being we see no alternative to relying on a medical record review, not just the MDS, to assure correct reimbursement for SNF services.

We appreciate HCFA's thoughtful consideration of our report. We wish to emphasize again that our work was intended to be an early look to identify potential vulnerabilities and issues for further work.

The Health Care Financing Administration also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix G.

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INTRODUCTION

PURPOSE

To provide an initial review of the integration of the prospective payment system with the resident assessment.

BACKGROUND

The Senate Special Committee on Aging held hearings in the summer of 1998 following reports by the Health Care Financing Administration (HCFA) and the General Accounting Office (GAO) of serious concerns about nursing home residents' care and well-being. Subsequently, the Office of Inspector General (OIG) undertook a series of nursing home inspections examining the quality of care in nursing homes. They include trends in reported abuse among residents, the role of the ombudsman in protecting residents, the capacity of the State survey and certification program, the trends in the Online Survey Certification and Reporting System (OSCAR) data, the access of nursing home survey results, and access to nursing homes. This report is a part of that series. A companion report, "Nursing Home Resident Assessment Quality of Care," has a more detailed analysis of the components of the minimum data set (MDS).

Generally a nursing home is a residential facility which offers daily living assistance to people who are either physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, and, in most cases, some medical treatment for those residents who require it.

Medicare Part A can help pay for skilled nursing facility (SNF) care for up to 100 days in a benefit period when a beneficiary meets certain conditions. These conditions include a requirement of daily skilled nursing or rehabilitation services, a prior three consecutive day stay in a hospital, admission to the SNF within a short period of time after leaving the hospital, treatment for the same condition that was treated in the hospital, and a medical professional certifying the need for daily skilled nursing or rehabilitation care. In 1990 Medicare paid $1.7 billion to nursing homes. In 1998 this amount had increased to $10.4 billion[1]. Medicare pays only a small portion of the nation's nursing home bills. Most bills are paid by personal funds, purchased long-term care insurance, and Medicaid.

Medicaid coverage varies among States. Medicaid eligible beneficiaries who require custodial care such as help with eating, bathing, taking medicine and toileting, as well as

[1]U.S. Department of Health and Human Services, Health Financing Administration, Office of the Actuary, National Health Statistics Group: http://www.hcfa.gov/stats/nhe-oact/tables.

those who require skilled care may have a nursing home stay paid by Medicaid. Medicaid payments to nursing homes in 1996 totaled $40.6 billion. Despite the increase in Medicare and Medicaid payments, concern remains about the quality of care in nursing homes.

In 1986 the Institute of Medicine conducted a study on nursing home regulation and reported prevalent problems regarding the quality of care for nursing home residents and the need for stronger Federal regulations. In 1987, the GAO reported that over one-third of nursing homes were operating under the Federal minimum standards. This report, along with widespread concern regarding nursing home conditions, led Congress to pass the Omnibus Budget Reconciliation Act (OBRA 1987). As a part of OBRA 1987, Congress passed the comprehensive Nursing Home Reform Act (P.L. 100-203), expanding requirements that nursing homes have to comply with prior to Medicare or Medicaid certification.

The Resident Assessment

The Nursing Home Reform Act mandates that nursing homes use a clinical assessment tool known as the Resident Assessment Instrument (RAI) to identify residents' strengths, weaknesses, preferences, and needs in key areas of functioning. The RAI is designed to help nursing homes thoroughly evaluate residents and to provide each resident with a standardized, comprehensive, and reproducible assessment. "With consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities. Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably."[2]

The RAI was developed by a research consortium under contract with the HCFA and consists of three key components: the Minimum Data Set (MDS), Triggers and Resident Assessment Protocols (RAPs), and Utilization Guidelines. Most States required nursing homes to begin implementing the RAI in 1991. It was intended that the RAI be a dynamic tool, and HCFA began developing version 2.0 of the RAI in early 1993 which is now in use. The HCFA is committed to continuous reviews and updates.

The RAI is intended to be completed by an interdisciplinary team of nursing home staff who gather facts about the residents' strengths and needs. The interdisciplinary team should ideally include dieticians, speech, physical and occupational therapists, social workers, pharmacists, and nurses. The attending physician is also an important participant in the RAI process providing valuable input on sections of the MDS and RAPs. Federal regulations require each individual who completes a portion of the RAI to sign, date, and certify its accuracy. Regulations also require that a registered nurse sign and certify that

[2]U.S. Department of Health and Human Services, Health Care Financing Administration, *Long Term Care Resident Assessment Instrument User's Manual Version 2.0* October, 1995.

the assessment is complete. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident.

The Minimum Data Set

The MDS 2.0, a component of the RAI, contains a standardized set of essential clinical and functional status measures. It must be collected on every resident in the nursing home at regular intervals during their nursing home stay regardless of the method of payment. Nursing homes are required to "conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." [3] All residents must be completely assessed in the first 14 days after admission, promptly after a significant change in their physical or mental condition, and at least once every 12 months. Additionally, all MDS assessments must be reviewed at least every 3 months to assure continued accuracy. Since the implementation of the prospective payment system there is a more frequent MDS schedule for those residents reimbursed by Medicare Part A.

Resource Utilization Groups and the Prospective Payment System

A new dimension of issues and concerns was layered upon the resident assessment with the advent of the prospective payment system. Effective June 23, 1998, nursing homes participating in the Medicare and Medicaid programs are required to electronically submit, at least monthly, MDS data to the State for all assessments conducted during the previous month. Under the prospective payment system for a Medicare Part A skilled nursing facility (SNF) stay, SNFs are required to classify residents into one of 44 Resource Utilization Groups (RUGs-III) based on assessment data from the MDS. Each SNF must complete the assessments according to a schedule designed for Medicare payment. This schedule requires residents, upon admission to a SNF, be assessed on the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of the resident's stay.

Under the new prospective payment system, SNFs will know in advance how much HCFA will pay for each Medicare patient. The prospective payment system was phased into nursing homes in July of 1998, and all nursing homes were expected to comply with the new system in January of 1999. Some States are currently using a PPS system for Medicaid reimbursement, while others are considering adopting it in lieu of their existing systems.

The RUG-III classification is based on residents' resource needs and is divided into seven major categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function. Payment rates are

[3]U.S. Department of Health and Human Services, Health Care Financing Administration, *Long Term Care Resident Assessment Instrument User's Manual Version 2.0* October, 1995

further differentiated between and within the seven major categories. Facility differences in case-mix and for geographic variations in wages are also incorporated into the payment rates. The HCFA conducted a demonstration project to determine the appropriate payment rates.

In a memorandum released in May 1999, HCFA gives instructions to the fiscal intermediaries which outlines the process to be used for medical record review for PPS claims. All fiscal intermediaries are to review Medicare SNF PPS claims. The goal is to identify inappropriate payments. It states that the Medicare bill must be supported by the appropriate provider documentation including "the MDS, the medical record including physician, nursing, and therapy documentation, and the beneficiary's billing history." [4] This requirement is reinforced by another memorandum released in March 2000 which refers to proper documentation including "hospital discharge summaries and transfer forms; physician orders and progress notes; patient care plans; patient assessment instrument (MDS); nursing and rehabilitation therapy notes; and treatment and flow charts and vital sign records; weight charts and medication records." [5]

MDS Coordination

When Medicare reimbursement became linked to resident assessments, the role of the MDS coordinator became more vital to nursing homes. MDS coordinators are generally registered nurses who oversee the assessments and paperwork in order to guarantee proper completion. The MDS coordinators are able to mesh a combined effort of an interdisciplinary staff to produce the written and electronic documents necessary for Medicare reimbursement. The MDS coordinator is also responsible for ensuring that each resident's MDS is coded accurately so that the nursing home is financially able to provide all necessary services.

In addition, MDS coordinators affect the quality of care of the residents. Completing a thorough and accurate comprehensive assessment enables the nursing home to provide appropriate plans of care for each resident. The MDS coordinators can provide a global picture of each resident and can spot weaknesses in their plans of care.

Prior Studies

The Research Triangle Institute completed a study in 1995 entitled "Evaluation of the Nursing Home Resident Assessment Instrument" that examined the effect of the resident assessment instrument on quality of care in nursing homes. One finding suggested that

[4] Program Memorandum Intermediaries, transmittal No. A-99-20. Department of Health and Human Services, Health Care Financing Administration, May 1999.

[5] Program Memorandum Intermediaries, transmittal No. A-00-08. Department of Health and Human Services, Health Care Financing Administration, March 2000.

administrators and directors of nursing positively accepted the RAI and believed it helped individualize the plans of care. Another key finding suggested that overall quality of care and care planning improved in nursing homes when the RAI was implemented. In addition, the study indicated that the RAI significantly reduced hospitalization rates and improved resident outcomes in certain areas.

However, recent reports by the Office of Inspector General[6] and another researcher[7] found that the failure to provide comprehensive assessments was among the 10 most frequently cited deficiencies in nursing homes. A 1996 study for HCFA reported that between 25 and 30 percent of nursing homes were deficient in their development of comprehensive assessments and/or comprehensive care plans.

METHODOLOGY

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records from a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators. We conducted our field work between June and August 1999.

Sample Selection

We selected Medicare, Medicaid, and private pay nursing home residents using a three-stage stratified, cluster sample. First, we selected a stratified sample of eight States to include the four States with the most certified nursing home beds (California, New York, Texas, and Illinois), two States randomly selected from the four currently using a prospective payment system for Medicaid reimbursement in a HCFA demonstration project (Mississippi and Maine), and two States randomly selected from the remaining 40 States (Connecticut and Virginia).

Skilled nursing facilities refers to nursing homes that participate in Medicare. Nursing facilities refers to nursing homes certified to participate in Medicaid. For the purposes of this study, we will refer to Medicare, Medicaid, and private pay facilities as nursing homes because we included all payor types for the sample selection.

Next, we randomly chose eight nursing homes in each of the eight sample States, excluding nursing homes with a bed count of less than 60 to ensure a sufficient number of residents who fit the selection criteria. Finally, we randomly selected 10 residents in each

[6] Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, *Nursing Home Survey and Certification: Deficiency Trends OEI-02-98-00330,* March 1999.

[7] Charlene Harrington, Ph.D. *The Regulation and Enforcement of Federal Nursing Home Standards, 1991-1996* University of California, Department of Social and Behavioral Sciences, March 1998.

nursing home for a total of 640 residents. This selection was made from all nursing home residents who were in the 64 sample nursing homes in December 1998, regardless of payment source. These residents were admitted to the nursing home between July 1998 and December 1998. We selected the 14 day admission assessment completed for the resident from July to December 1998 and reviewed all the medical records prior to this assessment. Data for all samples were weighted and projected to the universe.

Medical Review and Analysis

Comparison with the medical record. We obtained the services of a medical review contractor who employed nurses with experience in completing the MDS in nursing homes and in consulting and training on the MDS process to conduct the review. These nurses visited each nursing home and completed a 14 day assessment based on the resident's medical record for the same 14 day time period. In doing so, our reviewers did not refer to the original MDS during their review nor did they contact the residents or the staff to complete their assessments. They were instructed to complete each field of the assessment only if there was sufficient and reliable information in the medical record to warrant a determination. Subsequently, we made a comparison of the results for each field. In this way, we were able to determine if the nursing homes' resident assessment was consistent with the rest of the medical record.

Nine residents did not fit our selection criteria, thus leaving a sample of 631 residents. All but three completed copies of the MDS were forwarded to us by the nursing home. The nurses were unable to complete some fields in the MDS due to lack of information in the medical record[8]. Most of these fields required information that was inappropriate for a 14 day assessment. All other fields had sufficient information for our reviewers to complete the MDS.

The methodology is useful to identify differences between what our reviewers would have entered in the MDS based on a review of the other medical records, versus what the facility nurses observed in the actual physical assessment of the patient. Our method does not permit a specific determination of why the differences occurred -- e.g., an error in the MDS review by the observing nurse, an error or omission in the medical record, or simply an honest difference of opinion given a similar set of facts. However, overall such differences might highlight the need to take steps to ensure greater consistency.

Generation of RUGs. In addition, the reviewers generated a RUG based on their prepared MDS to compare to the RUG generated by the facility. Because we included all payer sources in our sample, we were able to compare RUGs for 228 beneficiaries. The remaining 403 beneficiaries had no RUG information on the copy of the MDS forwarded to us. Medicaid and private pay residents are not required to be grouped in a RUG. In

[8]These fields include B6, C7, E3, E5, G3a, G9, H4, I3, K3, N5a, R1a, R1b, and R1c.

addition, some nursing homes had yet to begin using PPS for reimbursement. In order to compare differences in reimbursement rates between our reviewers and the nursing home, we calculated RUG rates of our reviewers and the nursing homes based on case-mix adjusted Federal rates for northeast, urban nursing homes.

Surveys

We sent a self-administered questionnaire to each MDS coordinator in the 64 nursing homes in our sample and asked questions regarding the implementation of the resident assessment and plans of care. We had a 100 percent response rate from the MDS coordinators. We obtained information regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. In addition, we looked at the structures and processes the staff use to perform the resident assessment and their satisfaction with the process.

Interviews

We conducted structured telephone interviews in July 1999 with nursing home administrators in each of the 64 sample nursing homes. We had a 100 percent response rate. We asked them questions regarding the implementation of the resident assessment and plans of care. During these interviews, we also obtained information from them regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. We also looked at the structures and processes the staff used to fulfill the resident assessment instrument requirements and their satisfaction with the process.

Limitations

The results of this analysis are limited by the information available in the medical record. In some cases, the nursing home completes the MDS based on observation of or discussion with the resident about which there may not be any other information in the medical record.

For Section P: Special Treatment and Procedures, which includes minutes of occupational and physical therapy given in the last 7 days, the reviewer compared the therapy logs to the MDS. In some cases, the logs were kept in units of 15 minutes. The reviewers converted the units to minutes.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

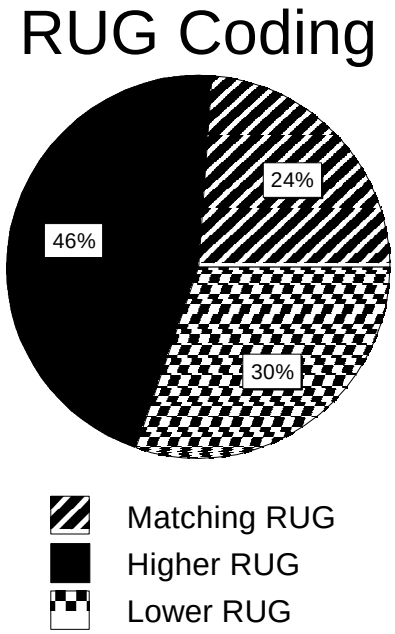
FINDINGS

Coding differences exist: both upcoding and downcoding

Resource Utilization Groups, or RUGs, flow from the Minimum Data Set (MDS) and drive Medicare reimbursement to nursing homes under the Prospective Payment System (PPS). A resident is initially assigned to one of the seven major categories of RUGs based on their clinical characteristics and functional abilities. Upon completion of the MDS, Medicare residents are further classified into 1 of 44 minor RUGs categories. See Appendix A for a complete listing of RUGs.

For 46 percent of the residents, the nursing home coded the resident in a RUG that was higher than our reviewer. For the remaining 30 percent, the nursing home coded the residents in a RUG that was lower than our reviewer. See Chart 1. See Appendix B for confidence intervals.

Chart 1



Source: Medical Record Review

In order to determine the potential effect of these differences on reimbursement, we created a model based on assumptions. We assumed that the prospective payment system was fully implemented and all nursing homes in the sample were in the urban northeast. Using the case-mix adjusted Federal rates for the northeast, we found no statistically significant effect. See Appendix C.

We looked at some characteristics that might explain the variation in coding. Nursing homes that are not a member of a chain organization are more likely than those that are a part of a chain organization to have RUG determinations different from our reviewers. Eighty-two percent of non-chain nursing homes, compared to 72 percent of chain nursing homes had differences between the nursing homes and our reviewers in the RUG codes. There was not a significant difference between rural or urban nursing homes. See Appendix D. Seven of the eight states in our sample had at least one nursing home that coded all of their residents in a different RUG than our reviewer.

Special rehabilitation, the largest of the 7 major RUG categories, is composed of 14 of the 44 RUGs. Physical, speech, or occupational therapy are clinical indicators that identify residents in the Special Rehabilitation category. Each RUG is given a number value that corresponds to the complexity of the diagnosis, symptoms, and treatment.
Nursing homes are more likely than our reviewers to code the residents in the Special Rehabilitation RUGs. Thirty-seven percent of all residents coded in a higher reimbursement level were assigned to the Special Rehabilitation RUG category. While the remaining 9 percent of all other residents who were coded higher by the nursing home fell into the remaining 6 major RUG categories: Extensive Care, Special Care, Clinically Complex, Cognitively Impaired, Behavior Problems, and Reduced Physical Functions.

In addition to this RUG group being the largest and generating the highest payments, "Special Rehabilitation" is notable because a previous OIG study found that nursing homes prefer special rehabilitation patients[9]. Discharge planners who were interviewed said that patients who require rehabilitation therapy are easier to place. They explained that these patients generally have short stays and become independent in activities of daily living quickly. In another report, 46 percent of nursing home administrators report that special rehabilitation patients such as physical, occupational, or speech therapy recipients are more likely to be admitted for care[10].

[9] Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities (OEI-02-99-00400),* August 1999

[10] Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, *Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Administrators' Perspective (OEI-02-99-00401),* October 1999

Therapy minutes and activities of daily living are keys to RUG differences

Minutes of therapy given to the residents is a key driver of the rehabilitation RUG reimbursement. Minutes of both occupational and physical therapy given in the last 7 days are two fields that are included in Section P: Special Treatment and Procedures. The nursing home completes the MDS by recording the time the beneficiary spent receiving therapy. The therapy log includes both the time the beneficiary spent receiving therapy and other related activities. Our reviewers compared the number of minutes on the MDS to the time in the therapy logs and determined a difference to exist when the therapy time did not match. Thus, some difference is anticipated between the log and the MDS. One would expect the log to be higher than the MDS. However, we found that in most cases the MDS is higher. The nursing home more often coded the resident with more therapy minutes on their copy of the MDS than the therapy logs indicate.

More specifically, of the 39 percent difference rate in occupational therapy, 31 percent of the records were coded with higher rates than the therapy logs while only 9 percent were coded lower. Of the 46 percent difference rate in physical therapy, 34 percent were coded higher with only 12 percent coded lower. The overall difference rates of occupational and physical therapy are well above the 15 percent difference rate average of all 108 elements. See Appendix B for confidence intervals.

A resident's functional status is measured by an index of activities of daily living (ADLs) and the number and types of services used. The ADL index is based on scores in MDS Section G, Physical Functioning and Structural Problems. This includes bed mobility, transfer, eating, and toilet use.

Section G has a 37 percent difference rate making it the highest difference rate of all sections used to develop the RUGs. All seven fields in Section G used in the RUG computation have a difference rate of at least 28 percent. Section G includes assessments for both self-performance and support. The self-performance section assess the degree to which a resident can perform an activity independently. The support assessment describes the nature and extent of the support provided. Some specific examples include the self-performance assessment of bed mobility which has a 36 percent difference rate and the support assessment of bed mobility which has a 33 percent difference rate. The self-performance difference rate for transfers is 40 percent, and the support difference rate is 36 percent.

Forty percent of the nursing home MDS coordinators report Section G is the most difficult to complete. When asked to indicate which section they would change, 20 percent report they would change Section G. Some explained that the "staff views capabilities differently [and the capabilities] remain subjective" and they "would like

more well-defined levels."

Concerns were raised regarding PPS training and additional staff responsibility

Ninety-three percent of MDS coordinators and 98 percent of nursing home administrators report that the introduction of PPS has given additional responsibilities to existing staff. Further, about 40 percent of administrators and MDS coordinators note that new staff has been hired to handle PPS.

Twenty-eight percent of MDS coordinators and administrators feel that the staff was inadequately trained about the Medicare PPS. Some cite that there was confusion and misunderstanding in the initial training sessions and express a need for additional training. Twenty-seven percent of MDS coordinators note that they receive on-going training and 60 percent of administrators say they have plans for additional PPS training sessions. Almost all MDS coordinators and administrators state that the staff received initial PPS training. Most MDS coordinators include formal workshops outside the nursing homes as part of their initial training. Other initial training includes informal on-the-job training, reading and referring to the manual, and formal training provided in the nursing home.

Administrators and MDS coordinators state that they receive training from private consultants, corporate offices, HCFA, and the fiscal intermediary. Eighty-seven percent of administrators feel that they have adequate resources available about PPS. They cite corporate offices, consultants, the fiscal intermediary, and magazines and books as resources used when they have questions.

RECOMMENDATIONS

This is an early alert raising concerns about the accuracy of the RUG codes. The fact that coding differences are both higher and lower indicates confusion or difficulties in implementing the MDS rather than an effort to "upcode" the RUGs to increase Medicare reimbursement. However, such a practice cannot be ruled out and our study demonstrates how vulnerable Medicare is to such a practice.

There are apparently differences in how people perceive the MDS. Some see it as a primary document that does not need to be validated by medical documentation. Others feel it must be consistent and validated with the medical record. Clearly, there are variations in interpretation in the way people are using the system. We believe any inability to validate the resident assessment through the medical record would expose the Medicare program to billing abuses. For these reasons, we recommend that HCFA:

- more clearly define MDS elements, especially section G;
- provide enhanced and coordinated training to nursing homes to be sure that similar and accurate MDS and RUG information is being disseminated; and
- require that nursing homes establish an audit trail to validate the 108 MDS elements that drive the RUG code from other parts of the medical record, paying particular attention to therapy minutes and activities of daily living.

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AGENCY COMMENTS

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However, HCFA does not concur with our third recommendation to establish an audit trail to validate the 108 MDS elements. Instead, they plan to fund a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. They hope

to combine data validation and program integrity approaches.

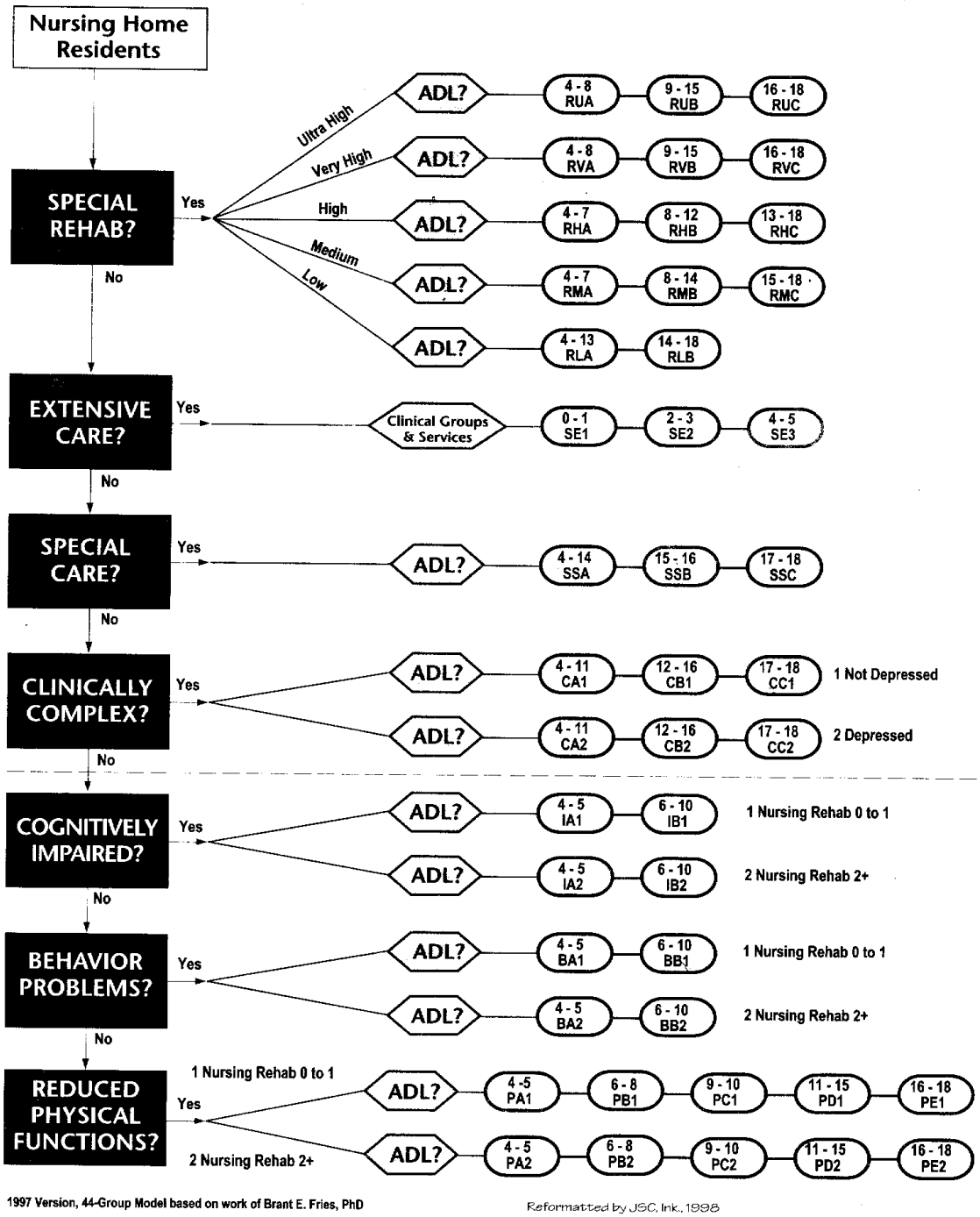
We are certainly open to approaches other than the one used in this study to validate the RUG codes and are ready to work with HCFA in analyzing any such alternate methods. However, for the time being we see no alternative to relying on a medical record review, not just the MDS, to assure correct reimbursement for SNF services.

We appreciate HCFA's thoughtful consideration of our report. We wish to emphasize again that our work was intended to be an early look to identify potential vulnerabilities and issues for further work.

The Health Care Financing Administration also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix G.

APPENDIX A

RUG-III Classification System



1997 Version, 44-Group Model based on work of Brant E. Fries, PhD

Reformatted by JSC, Ink., 1998

APPENDIX B

Confidence Intervals for Key Findings

We calculated confidence intervals for the key findings. The point estimate and 95 percent confidence interval are given for each of the following findings. The point estimates and confidence intervals for the findings vary based on the standard error for each individual finding.

KEY FINDINGS	POINT ESTIMATE	CONFIDENCE INTERVAL
Percent of matched RUGs	24%	+/-9%
Percent of mismatched RUGs	76%	+/-9%
NH coded higher and coded Special Rehabilitation	37%	+/-14%
Difference rate of physical therapy	46%	+/-5%
Difference rate of occupational therapy	39%	+/-11%
Difference rate of 108 MDS elements	15%	+/-4%

APPENDIX C

Statistical Tests for RUG Payment

It is not possible to make a precise dollar projection without using a model based on assumptions. The prospective payment system for nursing homes is in transition until 2002. Currently, nursing homes are reimbursed using a mixed rate composed of part federal rates and part rates based on individual nursing homes' previous cost base. In addition, at the time we pulled our sample, December 1998, not all nursing homes had converted to PPS, and billing information was not widely available.

In order to determine the potential difference in reimbursement, we constructed a payment model based on assumptions. We used urban, northeast case-mix adjusted federal rates for residents in all nursing homes and assumed that PPS was fully implemented for all of our nursing homes. We then projected reimbursement based on the RUG and payment associated with that RUG. See Appendix E for payment rates. At the 95 percent confidence level, the difference is not statistically significant.

Dollar Projections of Coding	**Dollar Projection**	**Confidence Interval**
Nursing Home	$27,388,798	$17,902,544 - $36,875,052
Our Reviewer	$25,005,872	$18,142,667 - $31,869,077

APPENDIX D

Statistical Tests for Key Findings

We computed Chi-square values for differences in urban and rural nursing homes and the differences in RUG determinations different from our reviewers. We also looked at the differences between chain and non-chain nursing homes and the differences in RUG determinations. As shown in the table below, some variables are statistically significant and some variables are not.

Variable	Degrees of Freedom	Chi-Square	Significant Difference in RUG coding
Urban vs. Rural	1	.57	No
Chain vs. Non-chain	1	8.50	Yes

APPENDIX E

RUG Rates: Case-Mix Adjusted Rates for Northeast Urban Nursing Homes

RUG Category	Rate
RUC	$384.21
RUB	$345.90
RUA	$327.28
RVC	$296.15
RVB	$286.30
RHC	$271.53
RMC	$267.34
RVA	$261.12
SE3	$252.91
RHB	$249.64
RMB	$238.87
RHA	$228.84
RMA	$224.64
SE2	$218.97
RLB	$212.95
SE1	$194.88
SSC	$190.50
CC2	$189.41
SSB	$181.74
RLA	$179.01

SSA	$177.36
CC1	$175.18
CB2	$166.42
CB1	$158.75
CA2	$157.66
PE2	$153.28
PE1	$151.09
CA1	$148.90
PD2	$145.62
PD1	$143.43
IB2	$142.33
BB2	$141.24
IB1	$140.14
BB1	$137.95
PC2	$137.95
PC1	$136.86
IA2	$129.19
BA2	$128.10
IA1	$124.81
PB2	$122.62
PB1	$121.53
PA2	$120.44
BA1	$119.34
PA1	$117.15

APPENDIX F

Minimum Data Set

In this appendix we have included a complete copy of the Minimum Data Set.

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME
a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) — Month — Day — Year

5. MARITAL STATUS
1. Never married 3. Widowed 5. Divorced
2. Married 4. Separated

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(*Billing Office to indicate; check all that apply in last 30 days*)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT
[*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed.*]

a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***
1. Medicare 5 day assessment
2. Medicare 30 day assessment
3. Medicare 60 day assessment
4. Medicare 90 day assessment
5. Medicare readmission/return assessment
6. Other state required assessment
7. Medicare 14 day assessment
8. Other Medicare required assessment

9. RESPONSIBILITY/ LEGAL GUARDIAN
(*Check all that apply*)

Legal guardian	a.	Family member responsible	e.
Other legal oversight	b.	Patient responsible for self	f.
Durable power of attorney/health care	c.	*NONE OF ABOVE*	g.
Durable power of attorney/financial	d.		

10. ADVANCED DIRECTIVES
(*For those items with supporting documentation in the medical record, check all that apply*)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes **(If yes, skip to Section G)**

2. MEMORY (*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY (*Check all that resident was normally able to recall during last 7 days*)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the last 7 days.*) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.***]
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS
Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING (*With hearing appliance, if used*)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES (*Check all that apply during last 7 days*)
a. Hearing aid, present and used
b. Hearing aid, present and not used regularly
c. Other receptive comm. techniques used (e.g., lip reading)
d. *NONE OF ABOVE*

3. MODES OF EXPRESSION (*Check all used by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
American sign language or Braille	c.	Other	f.
		NONE OF ABOVE	g.

4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY (*Code for speech in the last 7 days*)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING
Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter [a] = When letter in box, check if condition applies

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Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(*Code for indicators observed in last 30 days, irrespective of the assumed cause*)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

4. BEHAVIORAL SYMPTOMS

(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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Resident _____ Numeric Identifier _____

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*		
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* Cane/walker/crutch (a.); Wheeled self (b.); Other person wheeled (c.); Wheelchair primary mode of locomotion (d.); *NONE OF ABOVE* (e.)		
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* Bedfast all or most of time (a.); Bed rails used for bed mobility or transfer (b.); Lifted manually (c.); Lifted mechanically (d.); Transfer aid (e.g., slide board, trapeze, cane, walker, brace) (e.); *NONE OF ABOVE* (f.)		
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs (a.); Direct care staff believe resident is capable of increased independence in at least some ADLs (b.); Resident able to perform tasks/activity but is very slow (c.); Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings (d.); *NONE OF ABOVE* (e.)		
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)*

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*

1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly

2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week

3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week

4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days (a.); Constipation (b.); Diarrhea (c.); Fecal impaction (d.); *NONE OF ABOVE* (e.)		

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan (a.); Bladder retraining program (b.); External (condom) catheter (c.); Indwelling catheter (d.); Intermittent catheter (e.); Did not use toilet room/commode/urinal (f.); Pads/briefs used (g.); Enemas/irrigation (h.); Ostomy present (i.); *NONE OF ABOVE* (j.)		
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*		
		ENDOCRINE/METABOLIC/NUTRITIONAL		
		Diabetes mellitus	a.	
		Hyperthyroidism	b.	
		Hypothyroidism	c.	
		HEART/CIRCULATION		
		Arteriosclerotic heart disease (ASHD)	d.	
		Cardiac dysrhythmias	e.	
		Congestive heart failure	f.	
		Deep vein thrombosis	g.	
		Hypertension	h.	
		Hypotension	i.	
		Peripheral vascular disease	j.	
		Other cardiovascular disease	k.	
		MUSCULOSKELETAL		
		Arthritis	l.	
		Hip fracture	m.	
		Missing limb (e.g., amputation)	n.	
		Osteoporosis	o.	
		Pathological bone fracture	p.	
		NEUROLOGICAL		
		Alzheimer's disease	q.	
		Aphasia	r.	
		Cerebral palsy	s.	
		Cerebrovascular accident (stroke)	t.	
		Dementia other than Alzheimer's disease	u.	
		Hemiplegia/Hemiparesis	v.	
		Multiple sclerosis	w.	
		Paraplegia	x.	
		Parkinson's disease	y.	
		Quadriplegia	z.	
		Seizure disorder	aa.	
		Transient ischemic attack (TIA)	bb.	
		Traumatic brain injury	cc.	
		PSYCHIATRIC/MOOD		
		Anxiety disorder	dd.	
		Depression	ee.	
		Manic depression (bipolar disease)	ff.	
		Schizophrenia	gg.	
		PULMONARY		
		Asthma	hh.	
		Emphysema/COPD	ii.	
		SENSORY		
		Cataracts	jj.	
		Diabetic retinopathy	kk.	
		Glaucoma	ll.	
		Macular degeneration	mm.	
		OTHER		
		Allergies	nn.	
		Anemia	oo.	
		Cancer	pp.	
		Renal failure	qq.	
		NONE OF ABOVE	rr.	
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*		
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	
		Clostridium difficile (c. diff.)	b.	
		Conjunctivitis	c.	
		HIV infection	d.	
		Pneumonia	e.	
		Respiratory infection	f.	
		Septicemia	g.	
		Sexually transmitted diseases	h.	
		Tuberculosis	i.	
		Urinary tract infection **in last 30 days**	j.	
		Viral hepatitis	k.	
		Wound infection	l.	
		NONE OF ABOVE	m.	
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____ b. _____ c. _____ d. _____ e. _____		

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*		
		INDICATORS OF FLUID STATUS		
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	
		Inability to lie flat due to shortness of breath	b.	
		Dehydrated; output exceeds input	c.	
		Insufficient fluid; did **NOT** consume all/almost all fluids provided during **last 3 days**	d.	
		OTHER		
		Delusions	e.	
		Dizziness/Vertigo	f.	
		Edema	g.	
		Fever	h.	
		Hallucinations	i.	
		Internal bleeding	j.	
		Recurrent lung aspirations in **last 90 days**	k.	
		Shortness of breath	l.	
		Syncope (fainting)	m.	
		Unsteady gait	n.	
		Vomiting	o.	
		NONE OF ABOVE	p.	

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2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)*			
		a. **FREQUENCY** with which resident complains or shows evidence of pain 0. No pain *(skip to J4)* 1. Pain less than daily 2. Pain daily		b. **INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3.	PAIN SITE	*(If pain present, check all sites that apply in last 7 days)*			
		Back pain	a.	Incisional pain	f.
		Bone pain	b.	Joint pain (other than hip)	g.
		Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
		Headache	d.	Stomach pain	i.
		Hip pain	e.	Other	j.
4.	ACCIDENTS	*(Check all that apply)*			
		Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Fell in **past 31-180 days**	b.	Other fracture in **last 180 days**	d.
				NONE OF ABOVE	e.
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)			a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem			b.
		End-stage disease, 6 or fewer months to live			c.
		NONE OF ABOVE			d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem			a.
		Swallowing problem			b.
		Mouth pain			c.
		NONE OF ABOVE			d.
2.	HEIGHT AND WEIGHT	*Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) b. WT (lb.)			
3.	WEIGHT CHANGE	a. **Weight loss**—5 % or more in last **30 days**; or 10 % or more in last **180 days** 0. No 1. Yes			
		b. **Weight gain**—5 % or more in last **30 days**; or 10 % or more in last **180 days** 0. No 1. Yes			
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Leaves 25% or more of food uneaten at most meals	c.
		Regular or repetitive complaints of hunger	b.	*NONE OF ABOVE*	d.
5.	NUTRITIONAL APPROACHES	*(Check all that apply in last 7 days)*			
		Parenteral/IV	a.	Dietary supplement between meals	f.
		Feeding tube	b.	Plate guard, stabilized built-up utensil, etc.	g.
		Mechanically altered diet	c.	On a planned weight change program	h.
		Syringe (oral feeding)	d.	*NONE OF ABOVE*	i.
		Therapeutic diet	e.		
6.	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section L if neither 5a nor 5b is checked)*			
		a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%			
		b. Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day			

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	g.

SECTION M. SKIN CONDITION

				Number at Stage
1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]*		
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.		
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.		
2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)*		
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue		
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in **LAST 90 DAYS** 0. No 1. Yes		
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during last 7 days)*		
		Abrasions, bruises		a.
		Burns (second or third degree)		b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)		c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster		d.
		Skin desensitized to pain or pressure		e.
		Skin tears or cuts (other than surgery)		f.
		Surgical wounds		g.
		NONE OF ABOVE		h.
5.	SKIN TREATMENTS	*(Check all that apply during last 7 days)*		
		Pressure relieving device(s) for chair		a.
		Pressure relieving device(s) for bed		b.
		Turning/repositioning program		c.
		Nutrition or hydration intervention to manage skin problems		d.
		Ulcer care		e.
		Surgical wound care		f.
		Application of dressings (with or without topical medications) other than to feet		g.
		Application of ointments/medications (other than to feet)		h.
		Other preventative or protective skin care (other than to feet)		i.
		NONE OF ABOVE		j.
6.	FOOT PROBLEMS AND CARE	*(Check all that apply during last 7 days)*		
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems		a.
		Infection of the foot—e.g., cellulitis, purulent drainage		b.
		Open lesions on the foot		c.
		Nails/calluses trimmed during **last 90 days**		d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)		e.
		Application of dressings (with or without topical medications)		f.
		NONE OF ABOVE		g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
		(If resident is comatose, skip to Section O)			
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	**(When awake and not receiving treatments or ADL care)** 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None			
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	b.	*NONE OF ABOVE*	e.
		Inside NH/off unit	c.		
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Trips/shopping	g.
		Crafts/arts	b.	Walking/wheeling outdoors	h.
		Exercise/sports	c.	Watching TV	i.
		Music	d.	Gardening or plants	j.
		Reading/writing	e.	Talking or conversing	k.
		Spiritual/religious activities	f.	Helping others	l.
				NONE OF ABOVE	m.

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5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(*Record the number of different medications used in the last 7 days; enter "0" if none used*)	
2.	NEW MEDICATIONS	(*Resident currently receiving medications that were initiated during the last 90 days*) 0. No 1. Yes	
3.	INJECTIONS	(*Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used*)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(*Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)	
		a. Antipsychotic	
		b. Antianxiety	
		c. Antidepressant	
		d. Hypnotic	
		e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*	
		TREATMENTS	
		Chemotherapy	a.
		Dialysis	b.
		IV medication	c.
		Intake/output	d.
		Monitoring acute medical condition	e.
		Ostomy care	f.
		Oxygen therapy	g.
		Radiation	h.
		Suctioning	i.
		Tracheostomy care	j.
		Transfusions	k.
		Ventilator or respirator	l.
		PROGRAMS	
		Alcohol/drug treatment program	m.
		Alzheimer's/dementia special care unit	n.
		Hospice care	o.
		Pediatric unit	p.
		Respite care	q.
		Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
		NONE OF ABOVE	s.
		b. **THERAPIES** - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **(A) = # of days** administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A) / MIN (B)
		a. Speech - language pathology and audiology services	
		b. Occupational therapy	
		c. Physical therapy	
		d. Respiratory therapy	
		e. Psychological therapy (by any licensed mental health professional)	
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(**Check all interventions or strategies used in last 7 days**—no matter where received)	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in **last 90 days**	b.
		Group therapy	c.
		Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		Reorientation—e.g., cueing	e.
		NONE OF ABOVE	f.
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for **more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive)	
		b. Range of motion (active)	
		c. Splint or brace assistance	
		TRAINING AND SKILL PRACTICE IN:	
		d. Bed mobility	
		e. Transfer	
		f. Walking	
		g. Dressing or grooming	
		h. Eating or swallowing	
		i. Amputation/prosthesis care	
		j. Communication	
		k. Other	

4.	DEVICES AND RESTRAINTS	(*Use the following codes for last 7 days.*) 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. — Full bed rails on all open sides of bed	
		b. — Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)	
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)	
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change* (*Enter 0 if none*)	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes	
		b. Family: 0. No 1. Yes 2. No family	
		c. Significant other: 0. No 1. Yes 2. None	
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:		
		a. Signature of RN Assessment Coordinator (sign on above line)	
		b. Date RN Assessment Coordinator signed as complete — Month — Day — Year	
		c. Other Signatures — Title — Sections — Date	
		d. — Date	
		e. — Date	
		f. — Date	
		g. — Date	
		h. — Date	

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. **RECREATION THERAPY**—*Enter number of days and total minutes of recreation therapy administered (**for at least 15 minutes a day**) in the **last 7 days** (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = **# of days** administered for 15 minutes or more		
(B) = **total # of minutes** provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. **ORDERED THERAPIES**—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if **ADL self-performance score for TRANSFER** (***G.1.b.A*) *is 0, 1, 2, or 3 AND at least one of the following are present:***

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS***)

a. **Furthest distance walked** without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ State _____

APPENDIX G

Comments on the Draft Report

In this appendix, we present in full the comments from the Health Care Financing Administration.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

RECEIVED
2000 NOV -8 PM 3:38
OFFICE OF INSPECTOR GENERAL

The Administrator
Washington, D.C. 20201

DATE: NOV - 3

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Nursing Home Resident Assessment, Quality of Care," (OEI-02-99-00040) and "Nursing Home Resident Assessment, Resource Utilization Groups (RUGs)," (OEI-02-99-00041)

Thank you for the opportunity to review and comment on the above-referenced draft reports. Nursing home residents deserve and expect access to safe, quality care. In 1998, the Health Care Financing Administration (HCFA) began an aggressive initiative to promote quality care and to strengthen the enforcement process for the 1.6 million beneficiaries who reside in nursing homes. HCFA now requires States to crack down on nursing homes that repeatedly violate health and safety standards and has strengthened the inspection process to increase its focus on preventing bedsores, malnutrition, and resident abuse. In addition, HCFA has created Nursing Home Compare, a searchable database available at www.medicare.gov, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents. HCFA is taking these actions to make sure that residents get the quality care and safe environment that they deserve.

We have carefully reviewed your two reports on minimum data set (MDS) accuracy, and we agree that both highlight the need for HCFA to integrate the findings into our ongoing training and accuracy improvement efforts. HCFA has always been attentive to matters concerning the accuracy of MDS information, given its uses for the development of care plans, for quality monitoring, payment, consumer and provider feedback, policy development and research. We have dedicated significant resources and have sponsored a variety of projects aimed at monitoring and ensuring the accuracy of MDS information.

We are concerned, however, about the conclusions that might be drawn based on the OIG's comparisons of RUG-III classification of cases between their reviewers and the skilled nursing facility (SNF) staff. We believe that too limited data were analyzed (very

few facilities were paid under the prospective payment system (PPS) at the time of the study) and there were limitations associated with the methodology (recognized in both reports). As noted in our manuals and repeated in our training programs, the MDS is an integral part of the medical record; it is not an abstraction form. The OIG's methodology relies in part on an erroneous interpretation of certain language from HCFA's medical review Program Memoranda (cited on page 10 of the RUG report). While this language was intended to make clear that the MDS is an integral part of the medical record, there is no expectation that all information found in the MDS will be duplicated elsewhere in the medical record, as the OIG's report suggests. Rather the MDS, in conjunction with other clinical documentation, provides a full view of the beneficiary's clinical course in a given time period. Vital information must be obtained from a variety of sources. Therefore, an item-by-item validation of the MDS using other entries in the medical record cannot be assumed. The OIG's interpretation of the language in these Program Memoranda points to the need for HCFA to clarify the subject instructions.

HCFA believes that these are important areas for examination and looks forward to working closely with the OIG in designing a methodology for the next phase of its study of the RUG-III system and MDS accuracy. We appreciate the effort that went into these reports. Our detailed comments on the OIG's recommendations follow.

OIG Recommendation
We recommend that HCFA more clearly define MDS elements, especially Section G.

HCFA Response
We concur. Since the MDS was first implemented, we have made efforts on an as needed, ongoing basis to clarify item definitions and coding instructions. We recognize the need to make Section G, in particular, easier to understand and code. In addition, we are evaluating a new coding methodology for capturing activities of daily living (ADL) information, for possible implementation with version 3.0 of the MDS.

OIG Recommendation
We recommend that HCFA work with the nursing home industry to provide enhanced and coordinated training to nursing homes to be sure that similar and accurate information about the MDS and RUG is being disseminated.

HCFA Response
We concur. HCFA has an ongoing responsibility for the development and dissemination of educational programs and materials that will promote a uniform understanding of MDS requirements and improve the accuracy of MDS information. Some of our projects aimed at monitoring and ensuring the accuracy of MDS information have been carried

out since initial implementation of MDS requirements in 1991. Most recently for example, we provided training and clarification on items in the Activities sections of the MDS (Sections F and N) via a national Satellite Broadcast for Nursing Home Activities surveyors and providers on September 29. We also have additional short- and long-range plans for training that include the following:

- HCFA is planning further national SNF PPS training for early 2001 to update the fiscal intermediaries and providers on changes in the payment system and clarify existing policy and processes. The use of the MDS and RUG information by providers and medical reviewers will be a significant topic addressed during this training.

- By spring 2001, we plan to develop and release MDS policy and item coding clarifications for areas of the MDS that are considered most confusing and most in need of clarifications, such as Section G. The MDS items addressed will be prioritized based on feedback from a variety of MDS accuracy studies, including those completed by the OIG and Abt Associates, and feedback solicited from the industry via formal requests for comments and focus group meetings. These clarifications will be posted on HCFA's MDS web site. Wide dissemination of these clarifications will provide updated MDS coding information to State agencies and others who train providers. We are also pursuing the possibility of disseminating this information directly to facilities via State MDS information "bulletin boards" that are part of a facility computer interface with States in the MDS submission process.

- We will review clarifications of policy and coding instructions and provide accompanying training materials at HCFA's annual, national resident assessment instrument (RAI) conference in May of 2001. This conference is attended by State and regional office RAI and MDS Automation Coordinators, and representatives of national provider organizations.

- We plan to revise the Long Term Care Resident Assessment Instrument User's Manual for the MDS version 2.0, to incorporate Questions & Answers and clarification information published since the last publication of the User's Manual (October 1995). In addition, the revised manual will include new chapters relative to new policies implemented since 1995, including MDS Automation and Electronic Transmission, SNF PPS and MDS Correction Policy. We will develop and disseminate a draft, revised manual for comments and anticipate that a final manual will be published following a comment period, by the end of calendar year 2001.

- We plan to develop a standard MDS training program, for use by State agencies, fiscal intermediaries, providers and others in MDS training programs to achieve uniformity and consistency in terms of MDS training across the country. We will begin by developing training programs for those areas of the MDS identified as high priorities for clarification, as mentioned above. We hope to be able to expand this training program to cover the entire RAI instrument and process.

In addition, HCFA maintains ongoing communication with State, regional, technical staff and contractors by hosting standing, monthly phone conferences with combined State and regional MDS and RAI Coordinators, and separately with regional office MDS and RAI Coordinators. We also host standing, bimonthly phone conferences with State MDS technical staff, and separately with HCFA's MDS system contractors. Further, communication with providers through their trade organizations is an ongoing activity.

OIG Recommendation

We recommend that HCFA require that nursing homes establish an audit trail to validate the 109 MDS elements that drive the RUG code from other parts of the medical record paying particular attention to therapy minutes and the ADL.

HCFA Response

While we do not concur with this specific approach to validation, future HCFA plans for validating and ensuring the accuracy of the MDS data do include proposed funding of a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. Given the importance of MDS data accuracy to the assignment of Medicare SNF patients to appropriate RUG categories, we will begin approaching this verification function from both a data validation and a program integrity perspective. In addition, such an arrangement provides HCFA with a valuable external mechanism to evaluate individual State performance regarding the accuracy of data being reported. Accuracy protocols will be provided to the PSC for implementation in 2001.

Attachment