Quality Rehab Management

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PDPM
Restorative Nursing ~ Why All the Buzz?
NHCA Sept 25th, 2019

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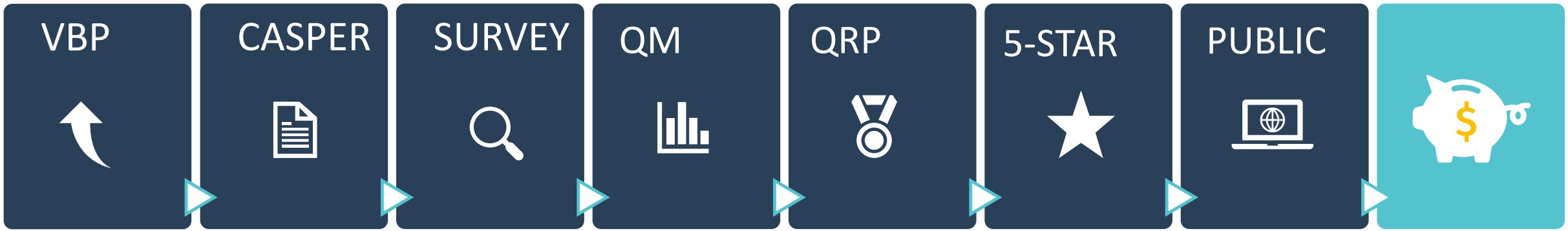
Agenda

- CMS' Drive For Quality of Life in the Value Equation
- Restorative Nursing's role in the Value Equation
- PDPM: Re-awakening the restorative discussion
- Care Strategies incorporating Restorative for Short Stay Resident
- What's being discussed within the Industry
- New Skills/ Competencies
- Discussion

CMS' Move Towards Value



CMS Monitoring of Quality Outcomes

- “Any significant shifts in care provision between RUG-IV and PDPM could draw significant scrutiny from CMS review entities”
- Quality measured through:
  - SNF Quality Reporting Program
  - SNF Value Based Purchasing (re-hospitalization)
  - Nursing Home Compare Star Ratings
- QRP Assessment Based Measures at “High Likelihood of Audit”; 10/1/18 data collection start date
  - Skin Integrity
  - Change in mobility and self care score
  - Discharge mobility and self care score
- QRP Claims Based Measures at “Moderate to High Likelihood of Audit”
  - DC to Community
  - Potentially Preventable 30- day Post DC Readmission Measure
- 5 Star Short Stay Measures at “Low-Moderate Likelihood”
  - % of short stay residents self reporting mod to severe pain
  - % of short stay residents who have had an outpatient emergency dept visit

Surveyors Questions.....

Our Documentation holds the answers

- What was your baseline
- What are your reassessments showing
- What is the natural history of the underlying medical problem
- Is there an avoidable decline
- Was the appropriate care plan developed and followed to treat or prevent potential or actual problems

How can Restorative Help?

CMS' Emphasis on Quality of Life –
Restorative Nursing Rationale

- Restorative Nursing Item Rationale from the RAI manual O0500:
  - "Maintaining independence in activities of daily living and mobility is critically important to most people."
  - "Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers."
  - "Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible….achieving and maintaining optimal physical, mental, and psychosocial functioning."
  - "A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, …is not a candidate for formalized rehabilitation therapy,…when restorative needs arise during the course of a long-term stay, or in conjunction with formalized rehabilitation therapy."

10/1/19 – CMS rolls out the Medicare Part A Patient Driven Payment Model "PDPM"

- Impacting Who:
  - Skilled Nursing Facilities' Medicare Part A
- What:
  - Reimbursement model complete re-write
  - Skilled criteria remains unchanged (3-day hospital admission)
  - Medically necessary daily skilled intervention in a SNF level of care
  - No impact to eligible requirements or available days
- Why:
  - Drive towards 'Value' vs 'Volume' (better outcomes = less cost)
- Intent: Focus solely on residents unique, individualized needs, characteristics and goals of each patient. We must know our patients to care for them.
- Introducing the biggest change in Medicare Part A SNF reimbursement in over 20 years…….

The > Patient Driven Payment Model "PDPM"

PDPM: October 1, 2019

- NEW Reimbursement drivers: (No longer days/minutes of therapy)
  - Primary Reason for SNF stay (ICD 10 Diagnosis with specificity requirements)
  - Surgery resulting in SNF care
  - Functional scores (Self Care and Mobility)
  - Clinical conditions and comorbidities (ICD 10 Diagnosis)
  - Depression (PHQ-9)
  - Cognition (BIMs / CPS)
  - Diet modifications and Swallowing disorders
  - Restorative Nursing

- 5 Clinical Categories scored individually assigning Case Mix Groups and reimbursement rates for each: PT/ OT/ ST/ Nursing/ NTA

- Initial MDS establishes reimbursement for entire stay based on total of the 5 clinical categories as determined no later than day 8 of the stay

- Intended to Strengthen Care Delivery Process and Care Team Collaboration

- New Core Competencies Required

New MDS Schedule

TABLE 33: Proposed PPS Assessment Schedule under PDPM

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

Interdisciplinary Communication: Collaborative Assessments and Care Delivery

- Day 1-3 Gathering of GG Performance & Patient Specific Goals
- Restorative Nursing Initiation
- Initial IDT PDPM Component Review
- Determine care delivery needs by Discipline
- Baseline care plan
- GG 1st 3 days "Usual Performance" & DC goals
- IDT Review of Patient Response to Intervention & progress towards capturing of active conditions, Dx and characteristics
- PDPM Component Review Leading to Accurate Admission Assessment by day 8 (161 items on MDS impact reimbursement)
- BIMs / CPS completion

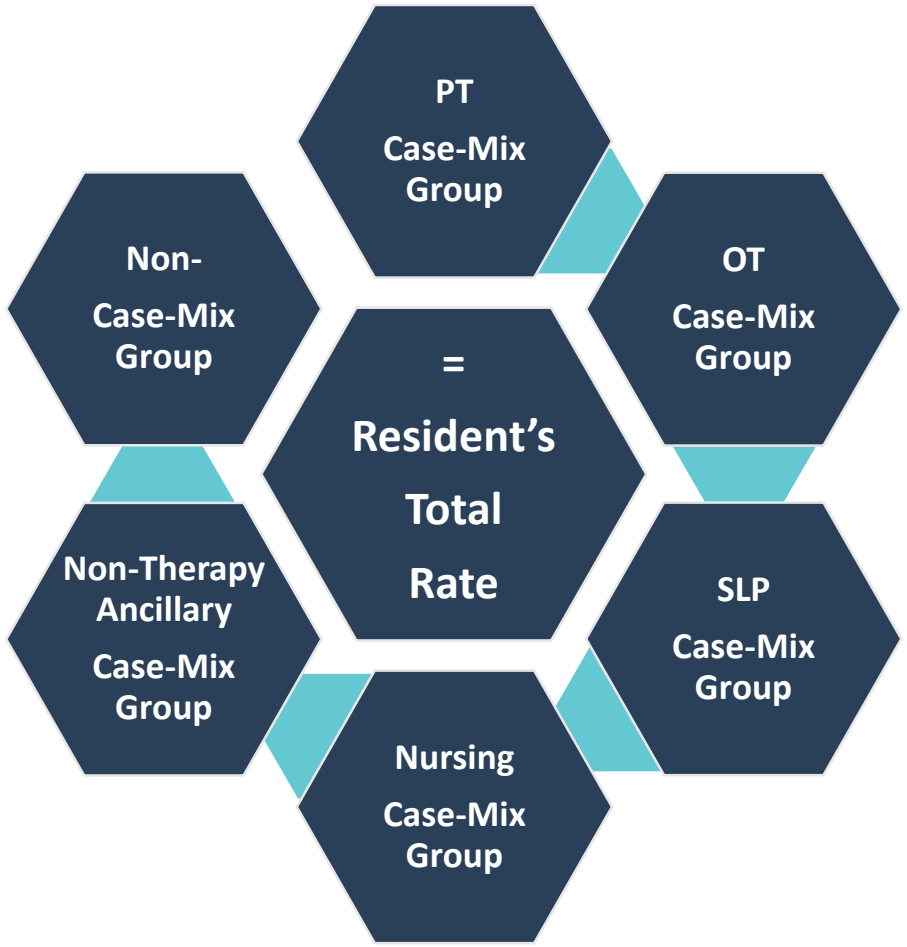
Pre-Admission	Day 1, (Day of Admission)	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9<

Dx capturing of Primary Reason for SNF stay begins preadmission – continually reassess for accuracy and supportive documentation

- Ongoing Dx Specificity > Clinical Category (68,000 ICD10 codes, 24,000 RTP)

- Gathering of Clinical Conditions and Characteristics - including Pre Admission
  - Consequence of incomplete assessment = default category

6 Components of PDPM



Every resident is assigned a CMG for each Component (Non-Case Mix Payment is excluded).

PDPM Calculator (Per Diem Rate)

Component	Urban Base Fed Rate *	Rural Base Fed Rate *		Case Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	$60.75	$69.25	X		X		X		=	
OT	$56.55	$63.60	X		X		X		=	
SLP	$22.68	$28.57	X		X		X		=	
Nursing	$105.92	$101.20	X		X	1.00**	X		=	
NTA	$79.91	$76.34	X		X		X		=	
Non-Case Mix Component	$94.84	$96.59	X		X		X		=	
* Non-wage index adjusted								Total Payment		
** Except when the resident has HIV/AIDS, then variable per diem adjustment equals 1.18										
*** Rates are for FY 2020, from final rule										

Section I0020B

Section I	Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

Section J – Surgical Procedures

J2100. Recent Surgery Requiring Active SNF Care

Enter Code ☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. **No**
1. **Yes**
8. **Unknown**

Surgical Procedures - Complete only if J2100 = 1

↓ **Check all that apply**

	Major Joint Replacement
☐	**J2300. Knee Replacement** - partial or total
☐	**J2310. Hip Replacement** - partial or total
☐	**J2320. Ankle Replacement** - partial or total
☐	**J2330. Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400. Involving the spinal cord or major spinal nerves**
☐	**J2410. Involving fusion of spinal bones**
☐	**J2420. Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**
	Other Orthopedic Surgery
☐	**J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520. Repair but not replace joints**
☐	**J2530. Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800. Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐	**J2899. Other major genitourinary surgery**

PT/OT Classification Groups & Case-Mix Weights

Collapsed Clinical Categories for PT and OT Classification	
PDPM Clinical Category	**Collapsed PT and OT Clinical Category**
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

Using Section GG

Section GG Items Included in PT, OT & Nursing Functional Measure		
Section GG Item		**Score**
GG0130A1	Self-care: Eating	0 - 4
GG0130B1	Self-care: Oral Hygiene*	0 - 4
GG0130C1	Self-care: Toileting Hygiene	0 - 4
GG0170B1 GG0170C1	Mobility: Sit to lying Mobility: Lying to sitting on side of bed	0 - 4 (average of 2 items)
GG0170D1 GG0170E1 GG0170F1	Mobility: Sit to stand Mobility: Chair / bed-to-chair transfer Mobility: Toilet transfer	0 - 4 (average of 3 items)
GG0170J1 GG0170K1	Mobility: Walk 50 feet with 2 turns* Mobility: Walk 150 feet*	0 - 4 (average of 2 items)

**Not included in Nursing Functional Score*

Section GG: Functional Abilities and Goals (PT/OT & Nursing Component)

Section GG	**Functional Abilities and Goals** - Interim Payment Assessment

GG0130. Self-Care (Assessment period is the last 3 days)

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

Section GG: Functional Abilities and Goals - GG0130. Self-Care (PT/OT & Nursing)

5. Interim Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Section GG: Functional Abilities and Goals - GG0170. Mobility (PT/OT & Nursing)

5. Interim Performance Enter Codes in Boxes ↓	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100, Appliances
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

PDPM Functional Scoring

PT / OT Function Score Construction		
Response		**Score**
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial / moderate assistance	2
02	Substantial / maximal assistance	1
01, 07, 09, 10, 88	Dependent, Refused, N/A, Not Attempted	0
** Coded based on response to GG0170H1 (does the resident walk?)*		

PT/OT Classification Groups & Case-Mix Weights

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.70	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.69
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.60
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.18
Medical Management	6-9	TJ	1.42	1.45
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.50
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

SLP Comorbidities & Cognitive Measure Methodology

SLP Related Comorbidities	
✓ Aphasia	Laryngeal Cancer - I8000
✓ CVA, TIA or Stroke	Apraxia – I8000
✓ Hemiplegia or Hemiparesis	Dysphagia – I8000
✓ Traumatic Brain Injury	ALS – I8000
✓ Tracheostomy Care *	Oral Cancers – I8000
✓ Vent or Respirator Care *	Speech & Lang Deficits – I8000

** while a resident*

PDPM Cognitive Measure Classification Methodology		
Cognitive Level	**BIMS Score**	**CPS Score**
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severly Impaired	0	5-6

Section C: Cognitive Patterns (SLP & Nursing)

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: *"Please tell me what year it is right now."*

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask resident: *"What month are we in right now?"*

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask resident: *"What day of the week is today?"*

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

CMS Training Videos

Section K: Swallowing Disorder (SLP)

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Mechanically Altered Diet

QRM

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last **7 days**		
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	**1. While NOT a Resident**	**2. While a Resident**
	↓ **Check all that apply** ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☐
Z. None of the above	☐	☐

SLP Classification Groups & Case-Mix Weights

Presence of acute Neurologic, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	Case-Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.67
Any one	Neither	SD	1.46
Any one	Either	SE	2.34
Any one	Both	SF	2.98
Any two	Neither	SG	2.04
Any two	Either	SH	2.86
Any two	Both	SI	3.53
Any three	Neither	SJ	2.99
Any three	Either	SK	3.70
Any three	Both	SL	4.21

Nursing CMI

- Each resident is Assigned to 1 of 25 Groupings each with its own CMI based on

  - Diagnosis grouping – MDS Section I
  - Functional Status – MDS Section GG
  - Extensive Services – MDS K,M & O
  - Depression – MDS
  - Restorative Nursing– MDS

Nursing Case Mix Under PDPM

Nursing Section GG Item		ADL Score
GG0130A1	Self-care: eating	0-4
GG0130C1	Self-care: toileting hygeine	0-4
GG0170B1 GG0170C1	Mobility: sit to lying Mobility: lying to sitting on side of bed	0-4 (average of two items)
GG0170D1	Mobility: sit to stand	0-4 (average of three items)
GG0170E1	Mobility: chair bed-to-chair transfer	
GG0170F1	Mobility: toilet transfer	

RN Classification Groups & Case-Mix Weights

Extensive Services			
Functional GG Score = 0 -14			**PDPM/ CMI**
Tracheostomy care AND ventilator or respirator (while a resident)		*Extensive Services HIPPS* *ES3 A* *ES2 B* *ES1 C*	ES3 / 4.06
Tracheostomy care OR ventilator or respirator (while a resident)			ES2 / 3.07
Infection Isolation (while a resident)			ES1 / 2.93
Special Care High			
Functional GG Score = 0 -14	**GG Score**	**Depression**	**PDPM / CMI**
Comatose and dependent /activity did not occur	0-5	Depression	HDE2 / 2.40
Septicemia	0-5	No Depression	HDE1 / 1.99
Diabetes with both:	6-14	Depression	HBC2 / 2.24
- daily injections - insulin order changes on 2+ days	6-14	No Depression	HBC1 / 1.86
Quadriplegia with Functional Score <=11 COPD and SOB when lying flat Fever with one of the following: - pneumonia - vomiting - weight loss - feeding tube with intake requirement Parenteral/IV feedings – while not or while a resident Respiratory therapy = 7 days	*Special Care High HIPPS* *HDE2 D* *HDE1 E* *HBC2 F* *HBC1 G*		
Depression criteria is met if the Total Severity Score = or > 10 but not 99			

RN Classification Groups & Case-Mix Weights

Special Care Low			
Functional GG Score = 0 -14	**GG Score**	**Depression**	**PDPM / CMI**
Cerebral Palsy	0-5	Depression	LDE2 / 2.08
Multiple Sclerosis	0-5	No Depression	LDE1 / 1.73
Parkinson's Disease and Functional Score <=11	6-14	Depression	LBC2 / 1.72
Respiratory failure and oxygen therapy while a resident	6-14	No Depression	LBC1 / 1.43
Feeding tube >=51% of calories or 6-50% calories + fluid >=501cc during entire last 7 days (avg across 7 days)	*Special Care Low HIPPS*		
2+ Stage 2 pressure ulcers with 2+ skin treatments	*LDE2 H*		
Stage 3 or 4 pressure ulcer, or unstageable with slough or eschar with 2+ skin treatments	*LDE1 I*		
2+ venous/arterial ulcers with 2+ skin treatments	*LBC2 J*		
Stage 2 pressure ulcer (1) and venous/arterial ulcer (1) with 2+ skin treatments	*LBC1 K*		
Foot infection, diabetic foot ulcer, or other open lesion of foot with dressings			
Radiation therapy while a resident			
Dialysis while a resident			
Depression criteria is met if the Total Severity Score = or > 10 but not 99			

RN Classification Groups & Case-Mix Weights

Clinically Complex			
Functional GG Score = 0 -16	**GG Score**	**Depression**	**PDPM / CMI**
Residents with Extensive Services, Special Care High, or Special Care Low with Functional Score = 15 OR 16	0-5	Depression	CDE2 / 1.87
Pneumonia	0-5	No Depression	CDE1 / 1.62
Hemiplegia/hemiparesis and Functional Score <=11	6-14	Depression	CBC2 / 1.55
Surgical wounds or open lesion with treatments	15-16	Depression	CA2 / 1.09
Burns	6-14	No Depression	CBC1 / 1.34
Chemotherapy while a resident	15-16	No Depression	CA1 / .94
Oxygen therapy while a resident	*Special Care High HIPPS*		
IV medications while a resident	*CDE2 L CA2 O*		
Transfusions while a resident	*CDE1 M CBC1 P*		
	CBC2 N CA1 Q		
Depression criteria is met if the Total Severity Score = or > 10 but not 99			
Behavioral Symptoms & Cognitive Performance			
Functional GG Score= 11-16	**GG Score**	**Restorative**	**PDPM/ CMI**
Cognitive impairment (BIMS score =/ < 9 or CPS =/ >3)	11-16	>2 restorative nursing	BAB2 / 1.04
Hallucinations	11-16	0-1 restorative nursing	BAB1 / .99
Delusions	*Behavioral and Cog HIPPS*		
Physical behavior symptoms toward others	*BAB2 R*		
Verbal behavior symptoms toward others	*BAB1 S*		
Other behavioral symptoms not directed toward others			
Rejection of care			
Wandering			
Restorative Nursing Services Administered for 6 or more days for at least 15 minutes			

RN Classification Groups & Case-Mix Weights

Reduced Physical Function	
Functional GG Score = 0-16	
Restorative Count	****Count as 1 service if both provided**
H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training
Provided at least 15 minutes each on 6 out of last 7 days	

GG Score	Restorative	PDPM / CMI
0-5	>2 restorative nursing	PDE2 / 1.57
0-5	0-1 restorative nursing	PDE1 / 1.47
6-14	>2 restorative nursing	PBC2 1.22
15--16	>2 restorative nursing	PA2 / .71
6-14	0-1 restorative nursing	PBC1 / 1.13
15-16	0-1 restorative nursing	PA1 / .66

Reduced Physical Function HIPPS

PDE2 T
PDE1 U
PBC2 V
PA2 W
PBC1 X
PA1 Y

Non-Therapy Ancillary Services

CMI Components

- Each resident is Assigned to 1 of 6 Groupings each with its own CMI based on
  - Clinical Conditions –MDS Section I
  - Extensive Services Received -MDS K, M & O

NTA CMI

Conditions and Extensive Services Used for NTA Component

NTA Score Range

12+ Points = NA CMG = 3.24 CMI

9-11 = NB = 2.53

6-8 = NC = 1.84

3-5 = ND = 1.33

1-2 = NE = .96

0 = NF = .72

NTA (1 of 2)

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1

NTA (2 of 2)

Condition/Extensive Service	Source	Points
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

Restorative Criteria for O0500 Capturing

- 7 day look back period, must find 15 minutes of time in a day totaled across 24 – hours per technique, training or skill practice was performed to count as a day – groups are capped to 4 residents per helper
- No physician orders are required
- Documentation of measurable objective and interventions present in the care plan and medical record
- Supervision and periodic evaluation by licensed nurse present in the medical record (progress note written by the restorative aide and countersigned by a licensed nurse is sufficient)
- Nursing assistants/ aides trained in techniques (Rehab staff can provide)
- Others able to provide 'restorative services':
  - 'other staff and volunteers'
  - 'licensed rehab professionals' performing repetitive exercises and other maintenance treatments - time counts as restorative but not as therapy time in O0400

Techniques, Training and Skill Practice

Techniques

(Activities provided by restorative nursing staff)

Passive Range of Motion
Active Range of Motion
Splint or Brace Assistance

Training and Skill Practice

(Repetition, physical or verbal cueing, and/or task segmentation provided by any staff ember under supervision of a licensed nurse)

Bed Mobility
Transfer
Walking
Dressing and/or Grooming
Eating and Swallowing
Amputation, Prosthesis Care
Communication

Example Restorative Program – RAI Version 3.0 Manual, Oct 2019

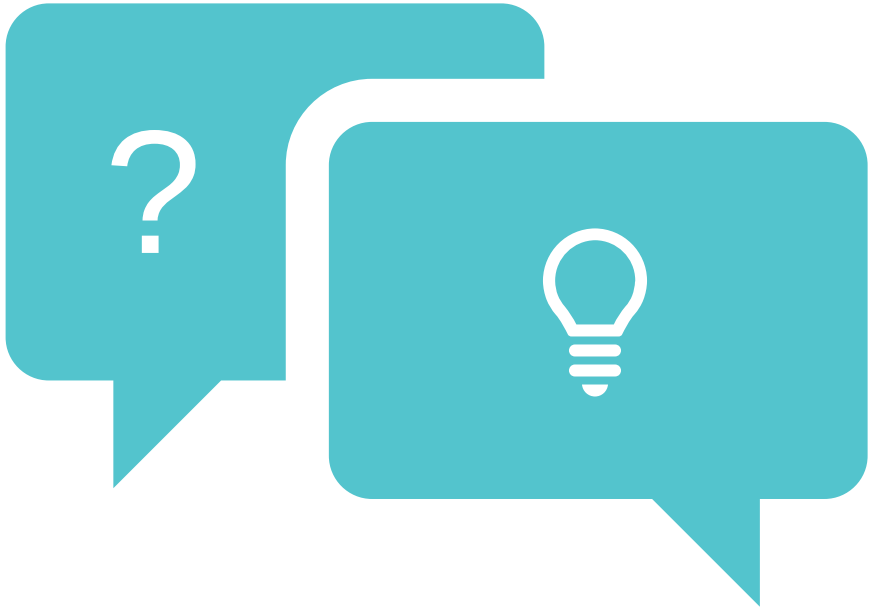
Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. She has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. The charge nurse documented in the nurses notes that in the past 7 days, Mrs. J has been spending approximately 20 minutes per day in completing this task (dressing and undressing).

Coding: Dressing or Grroming item (O0500G) – coded: 7

Rationale: This was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.

Questions / Discussion

- Thoughts on restorative programming for the short stay resident?
- How could restorative help in the GG gathering of “Usual” performance?
- Who will you include in delivery of restorative care – rehab?
- When to initiate?
- New Competency’s Needed?
- Shifting of responsibilities?



References

MDS Manual

- Comprehensive
- IPA – Interim Payment Assessment (Optional)

RAI Manual

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual.html

CMS PDPM Updates:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

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