Management Minutes Questionnaire

Professional Development Seminar

4.23.18

Harmony Healthcare International (HHI)

HHI **C.A.R.E.S.** About Care

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Management Minutes Questionnaire

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Date

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About Kris

Kris Mastrangelo OTR/L, LNHA, MBA

President and CEO

Owns and operates

Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S. There are no nonfinancial disclosures to share.

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About Joyce

Joyce Sadewicz PT, RAC-CT

VP of HarmonyHelp

Employed by Harmony Healthcare International (HHI) for over 10 years, managing a diversified team of HealthCARE Specialists with extensive knowledge in the areas of MDS 3.0, PDPM, Compliance, Documentation, Therapy Program development, as well as expertise in Medicare and Medicaid Reimbursement and Documentation.

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Educational Activity Completion

Requirements for Successful Completion

1 contact hour will be awarded for this continuing nursing education activity. **Criteria for successful completion includes:**

Attendance for 100% of the 1-day course or individual, 3 hour module (2 and 3 day trainings requires at last 80% attendance). Contact hours will be awarded for time

Must complete post course exam within 2 weeks of the course and course/teacher evaluation.

Clearly demonstrate the learning outcome of the program.

Participants will receive a certificate of completion immediately following completing the above requirements.

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- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose. Please visit https://www.harmony-healthcare.com/hhi-team for all speaker's financial and nonfinancial disclosures
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  - Pamela Duchene, PhD, APRN-BC, NEA, FACHE
- **Presenter:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA

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Objectives

1. Summarize MMQ Scheduling Requirements.
2. State MMQ item Definitions.
3. List MMQ associated MDS Definitions.
4. Summarize MMQ ADL requirements
5. Identify medical record documentation to support MMQ coding.
6. Identify a Significant Change in Status MDS and impact on MMQ completion.

Minute Management Questionnaire (MMQ)

- Precise time frames, coding and criteria/definitions with documentation by the direct caregiver versus assessor
- Nurse that completes the summary cannot complete the MMQ
- 50% Rule or ½ of the assessment time frame required
- Assistance is related to identified dysfunction with little room for interpretation
- Lower score prevails in presence of conflicting data (nursing vs. CNA)

Minimum Data Set (MDS)

- Specified look back periods per coding item based on ARD: 5, 7, 14, 30, 60 and 180 days
- MDS codes actual self performance and staff support and includes all disciplines
- Measures Resource Utilization
- Skilled nursing procedures, rehabilitation, and complex medical conditions reflected in RUG score
- MDS develops care plan, reported in Quality Indicators, Quality Measures , directs surveyors, SNF QRP, SNF VBP and Five Star Rating
- All sources of data may be interpreted by assessor (with supportive documentation)

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MDS AND MMQ

- Be prepared to respond to any coding discrepancies between the MDS and MMQ- as there are very different definitions and coding criteria. Apples and Oranges
  - MMQ: 15 days (50% days) related to a valid dysfunction/disability. Assist can be verbal, visual or physical for same points
  - MDS/ADL: 7 day look back with very specific coding definitions and break down in assist with number of support to yield points

In all cases

- Continuous education with staff in the clinical and financial impact of accuracy
- Foster environment of resident status discussion with CNA staff
- Establish policy for timely corrections
- Communicate status change via SCSA (MDS) for permanent change in status
- Proactively case manage services with upcoming MDS and MMQ assessments
- Routinely monitor/review documentation
- Actively obtain supportive documents
- Equates to Accurate Reimbursement

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Documentation Impact

- If care is not documented accurately, the facility will not receive the appropriate level of funding to support the level of care that is required by the resident resulting in significant lost revenue
- MMQ pays for the next 6 months unless the resident has experienced a Significant Change in Status that supports a new MMQ.
- Establish communication process

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Financial Impact

- Quality care yields good financial and clinical outcomes. For example:
  - CNA documents resident not dressed (0)
  - CNA documents resident not transferred out of bed (0)
- Good standard of care (when not medically contraindicated) would include getting resident dressed daily and out of bed/room to a meal or activity for a positive quality of life impact
  - Resident now assist dressing/depend (30)
  - Resident now wheelchair w/ assist (32)
  - MMQ now with 62 point increase

Financial Impact

- Semiannual MMQ: yields “L” however would qualify for “R” with documentation
  - R (225.1)vs. L (140) = $160.83 – $123.50 = $37.33/day
    - x 180 days = $6,719.40
    - x 10 patients = $67,194.00 over the next 6 months

    or
    - $134,388.00 annually

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Supportive Documentation

- ADL Flowsheet
- Positioning Sheets (separate/part of flow sheet)
- Behavior Sheets identifying specific behavior and interventions
- Norton Plus/Braden Scale within 90 days (MDS)
- Skilled Nursing Observations
- Nursing Summary: MMQ
- MAR/TAR: documentation of findings

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Supportive Documentation

- Wound Sheets with measurements and progress report
- Respiratory Flow Sheet with outcomes
- MDS and Care Plan- address all dysfunction in care plan
- Dietary Notes- validate no conflict with feeding etc.
- MD Orders and Progress Notes

MMQ Score is Comprised of

- Dispensing Meds and Charting
- ADL- personal care, mobility, positioning and incontinence
- Skilled Procedures related to Pressure Ulcer with preventative care
- Skilled Procedures- other
- Skilled Observations
- Special Attention: immobility, contracture, isolation, behavior problems
- Restorative Nursing Rehabilitation Program

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Examples of Minutes

- Mobility:
  - Independent – 0
  - Assist -32 (supervised, cueing and physical assist)
  - Bed Bound – 0
- Eating:
  - Independent – 0
  - Assist (supervised/cued or physical)– 20
  - Total Dependent – 45
  - Tube Fed – 90
  - Tube Fed and Assist – 110
  - Tube Fed and Total Dependent - 135

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Update CNA Care Profiles

- Communicates with staff the level of assist care planned and clinically appropriate
- Guides documentation-MMQ rules no cueing in flow sheets. Kardex is a care plan for CNA
- Educate staff that Profile identifies the minimum level of support/care that must be provided based on IDT assessments

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MMQ Category and Minutes

H	30.0
J	30.1 → 85.0
K	85.1 → 110
L	110.1 → 140
M	40.1 → 170
N	170.1 → 200.0
P	200.1 → 225
R	225.1 → 245
S	245.1 → 270
T	270.1 +

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Time Frames for MMQ

- An initial Management Minutes Questionnaire (MMQ) must be submitted for each new MassHealth member at the end of the admission month, or at the end of the conversion month from private or Medicare coverage to MassHealth coverage
- An MMQ must also be submitted on a semiannual basis for all MassHealth members who are residents of a nursing facility.
  - Cycle: A: July and January
    - Documentation: June and December
  - Cycle: B: August and February
    - Documentation: July and January
  - Cycle: C: September and March
    - Documentation: August and February
- Semi annual submission due 15th of the month in MMIS

Time Frames for MMQ

- 15 days to complete corrections done from time nursing summary is done
- Norton Assessment must be within the last 90 days of effective date (TD)
- Events for skilled observations last 60 days- must be occurrence within past 60 days to continue to capture

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Preparing for the MMQ

- Two months before turnaround, house audit. Review level of care clinically appropriate and correct forms are in place.
- The month before turnaround, alert all staff that this is an audit month. Post it on units.
- Have solid system of assigning the Nursing Summary including Medicare residents with MassHealth back up that may be converting in the future
- Increase intensity in documentation review

Preparing for the MMQ

- Confirm that preventative measures, skilled observations and documentation in place and completed. Pull in the team.
- The Monthly Nursing Summary should begin on the 16th of the month and completed by the 5th of the following month.
- Enter an addendum on the Nursing Summary for changes that occurred following completion of the Nursing Summary.
- Audit Norton Assessments to verify that they have been done within 90 days and are coded correctly when positioning is captured

Preparing for the MMQ

- Audit and compare CNA flow sheets with last MMQ
- Audit behavior sheets
- Audit treatment sheets
- Audit skilled observation sheets
- Audit IDT documentation for potential conflicting documentation of status:
  - Activities
  - Dietary
  - Social Services
  - Therapy Treatment Documentation

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Preparing for the MMQ

- Check MD orders for skilled interventions
- Check Nursing Summaries
- Check Norton/MDS/Care Plans
- Review Dietary Notes- supervision or assist with feeding can be conflicting

Preparing for the MMQ

- Make a documentation packet to include:
  - Nursing Summary
  - CNA Flowsheet
  - Positioning Records
  - Norton Plus/Braden
  - Behavior Flow Sheets
  - Skilled Flow Sheets
  - MAR
  - TAR

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Preparing for the MMQ

- Set up system for creating packets for review. (by unit/alphabetical order)
- Print off last MMQ to use as worksheet to use completing current MMQ
- Use an audit tool for notes and required follow up

Preparing for the MMQ

- Review all documentation with a focus on conflicting information- all must match
- Verify accuracy before taking points
- Make changes on last MMQ worksheet
- Note corrections needed and responsible staff member
- Note opportunities with the next turnaround

Preparing for the MMQ

- Corrections
  - Set up time with nurse responsible for summary to review corrections
  - Set up time with CNA for flow sheet corrections using correction sheets
  - Corrections must be within 15 days of Summary completion
  - All corrections must be dated and initialed (full)

Preparing for the MMQ

- Obtain list from BOM for all residents who stay is paid for by Medicaid on the 1st of the month
- Print listing of needed MMQ
- Make note as completed/status
- Identify increase/decrease in score on listing report
- Stack MMQ's as completed or in need of corrections
- Keep track of correction status- stay on top of staff in completing corrections

Preparing for Submission

- Data Entry
  - Have all units completed and set up for computer time to enter changes into system
  - Check file for submission
  - Check effective date is correct
  - View submission list
  - Make sure the MMQ is the most recent
  - Use the MMQ worksheet for data entry
  - View submission pending first and print out
  - Validate information is correct, number and names accurate
  - Make corrections and save and view list again
  - Include discharge information on residents not in this submission that were in the last submission

Preparing for Submission

- Print submission list
- Print batch MMQs
- Review for correct number and residents
- Upload EDS file to MMIS
- Check status of file within 48 hours

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The Audit

- Audits are scheduled **q 6 months** after the MMQ submitted (semi-annually)
- Conversions and Significant Change in Status MMQ's are completed in between semi-annual audits
- **Auditor reviews** CNA Flow Sheets, Nursing Summary, Positioning Sheet, MD Orders, Treatment and Medication Records, Behavior Sheets, Dietary Notes, Care Plans and the MDS
- **Appeals Process** exists with justification for request and supporting documentation within 30 days of receiving audit findings- final decision by DMA with additional appeal for judicatory hearing
- Be confident in claims to avoid leaving money on table

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The Audit

- Provide the charts in timely fashion
- Take charge of chart audit review
- Ask auditor to discuss any concerns or considerations for down coding during the audit
- Have worksheet with you for reference for any discussion

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General Instructions - MMQ

- For new members, codes must reflect the care provided on the effective date forward to the end of the month
- For established residents codes must reflect the care provided during the previous month
- A temporary condition may not be claimed. A temporary condition is one that requires a service for less than 50 percent of the month.

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General Instructions - MMQ

- The medical record is the source for information to complete the MMQ. Documentation must be accurate, dated, and signed by the person performing the care.
- The licensed nursing summary, daily licensed nursing notes, physician's orders and progress notes, ADL flow sheets, medication administration records, treatment records, and care plans should all be reviewed to complete the MMQ
- Documentation for assistance with activities of daily living must be associated with resident dysfunction, and the reason given for assistance must relate to this dysfunction as described in the medical plan. (Care planned)

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General Instructions - MMQ

- The following terms should **not** be used in documentation since they are not specific:
  - frequently
  - almost always
  - often mostly dependent
  - almost total assist

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General Instructions

- If a member has been in the facility for less than a month, the score is based on 50 percent of the days the resident has been in the facility
- When MassHealth is secondary, a MMQ conversion will be completed for temporary bed hold status while in hospital and MLOA on Medicare Part A benefits

General Instructions

- Initial MMQs and semiannual MMQs must be signed by a Registered Nurse
- Clinical records must document the activity before the information is prepared for electronic submission of MMQ data

General Instructions

- **Medicare:** When a member's stay is covered by Medicare, the facility does not need to complete an MMQ
- When Medicare coverage terminates, the member is eligible for conversion to MassHealth. The facility must submit an MMQ (Reason Code 2 for Conversion) with an effective date of the first day of MassHealth eligibility.
- The MMQ is submitted at the end of the month following the issuance of the member’s 10-digit recipient identification number

Completing the Semiannual MMQ

- A semiannual MMQ must be submitted for every MassHealth member who is a resident of the facility on the first day of the reporting period
- The semiannual MMQ must be completed from documentation for the previous month. It is essential to obtain semiannual MMQ information at the same time each reporting period
- With each semiannual MMQ, indicate the discharge of a resident who is no longer a MassHealth member as of the first day of the current reporting period

Code 1 — Admission

- The resident is a new MassHealth admission to the facility
  - Submit the MMQ at the end of the month following the issuance of the member's 10-digit member identification number

Code 2 — Conversion

- The resident is a new conversion to MassHealth
  - Submit the MMQ at the end of the month following the issuance of the member's 10-digit recipient identification number

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Code 3 — Category Change

- The member's category has changed from the last semiannual assessment. Indicate the changes on the MMQ and submit. In the case of a Significant Change in Status, the nursing facility must have submitted an MDS 3.0 for a Significant Change in Status Assessment.
  - Indicate changes on an MMQ and submit the MMQ with an effective date of the first of the month following the event
  - There must be at least 15 days of documented change during the previous month to warrant a significant change submission

Code 4 — Code Score Change

- The scoring or coding for this member changed since the last assessment but the change did not result in a change in category.
  - Indicate changes on the MMQ and submit upon semiannual review

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Code 5 — No Change

- No code or score changes for resident since last assessment

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Code D — Discharge

- The resident has been discharged from the facility

Item by Item Coding

- **Admission Date:** date admitted to facility
- **Effective Date:** Start date for the category. Includes:
  - New MassHealth Admission
  - Conversion- first day of MassHealth eligibility
  - Semiannual Update- the first day of the new period; or
  - Significant Change – the first of the month following the significant change

Item by Item Coding

- To justify the member's Case Mix Score and Category, the member's condition and care requirements must be documented for at least 15 days of the month during which the MMQ assessment takes place
- If the individual has been a MassHealth member in the facility for less than a month, the score is based on 50 percent of the MassHealth eligible days the member has been in the facility

Item by Item Coding

- In completing the MMQ, information from the physician's orders, monthly nursing summary, nursing progress and daily notes, MDS, care plan, ADL flow sheets, medication record, treatment record, and all pertinent documentation must be reviewed

- A licensed nursing summary must be completed monthly (or no later than five days after the end of the month), summarizing all of the care provided to the member

Documentation

- All documentation must be accurate, dated, and signed by the person performing the care. **Prompting or predetermining documentation is unacceptable**. For example, licensed nurses may not indicate how nurse's aides are to complete an ADL flowsheet by highlighting, circling, or otherwise marking items.
- Only the original writer who made the original entry may change that entry
- **Late entries, corrections**, and **addendums** must be made **within 15 days** of the original entry or before the MMQ is submitted, whichever is sooner

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Documentation

- To correct an error, draw a single line through the error, leaving the original entry legible, then initial and date the entry
- The member's score and category are based upon the services provided and recorded through the nurse’s and nurse's aide’s documentation. When conflicting documentation exists, the lower score will be applied.
- Justification for assistance with activities of daily living and special attention must be associated with the member’s clinical and functional status as documented by the licensed nurse according to the member’s care plan

Documentation

- A service may be claimed as either an intermittent PRN service or a continuous service and only as ordered by the physician and documented in the clinical record

- For example, oxygen PRN may be claimed under Item 2 ("Skilled Observation Daily"), or continuous or daily oxygen may be claimed under Item 12 ("Skilled Procedure Daily/Other"). Both items must not be claimed on the same MMQ.

Nursing Summary

- To ensure accuracy and objectivity, the monthly nursing summary must be completed by a licensed nurse who provided **direct member care** or was **directly responsible** for the care provided

- The licensed nurse who completes the monthly nursing summary must not complete the MMQs. The MMQ must be completed by a licensed nurse (RN, LPN) and must be signed by a Registered Nurse

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1. Dispense Medications and Chart includes all routine documentation

- Pouring, delivering, and charting all medications, including psycho-actives (see exclusion under Skilled Observation), intermittent I.V. antibiotics, routine injections, PRN medications, eye drops, eye ointments, inhalation aerosols, topical medications, suppositories, miscellaneous brief services such as vital signs that must be taken in conjunction with various medications, routine vital signs, and routine sugar and acetone.
- All residents receive 30 points since it reflects the necessary presence of a licensed nurse on duty at the nursing unit. The Code and Score data field is pre-filled on the data-entry screen.

2. Skilled Observation Daily

- No Documented Observations Required — Code 1, Score 0
- Daily Skilled Observations — Code 2, Score 15
- A skilled observation must be:
  - specifically ordered with parameters in writing by a physician,
  - performed by a licensed nurse, and recorded at least daily (for example, neurological signs, B/P, and TPR) over and above any vital signs that must be taken and recorded as a prerequisite for the administration of certain medications.
  - This also includes any non-routine measurement of a resident's condition, such as the need for suctioning a resident with a tracheostomy,
  - observation of the edema and/or congestion in a resident with congestive heart failure,
  - the need for oxygen,
  - and blood tests for insulin administration.

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Skilled Observation

- **Example:** observe for edema daily and prn; notify MD if edema 4+
  - Initial treatment sheet
  - Document on back: edema 3+ lower extremities, legs elevated with noted decrease in edema to 2+
  - Document **physician notification** and **outcome**.

2. Skilled Observation Daily

- This may include the introduction and/or titration of a psychoactive medication for a resident with a diagnosis of a major mental disorder that is defined as one or more of the following:
  - schizophrenia;
  - major affective disorder;
  - atypical psychosis;
  - schizoaffective disorder;
  - bipolar depression;
  - unipolar depression; or
  - organic mental syndrome with associated psychotic and/or agitated behavior;

2. Skilled Observation Daily

- Specifically to:
  - titrate the dose for **maximum effectiveness**
  - **manage unexpected harmful behaviors** that cannot be managed without a psychoactive medication

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2. Skilled Observation Daily

- **Note:** The resident's condition must indicate the **clinical complexity** and justify the need for skilled observation, with documentation of a **current or recent episode within the past 60 days**. Document the.
- date and type of episode
- **Documentation:** Daily licensed nursing documentation must be specific to the observation, including the nursing action and effect. Specific observations must be noted daily on a treatment sheet. Each episode must be documented and dated.

2. Skilled Observation Daily

- **Exclusions:**
  - Routine PRN use or tapering of psychoactive medications
  - aspiration precautions (except in clinically complex situations); and
  - monitoring of temperature and signs and symptoms of infection while on antibiotic therapy.

3. Personal Hygiene

- Independent — Code 1, Score 0
  - The resident is independent, assisted only for weekly bath/shower or on a "Restorative Bathing/Grooming" program
  - Score 0 if both bathing and grooming are Code 1

3. Personal Hygiene

- **Assist — Code 2, Score 18**
  - Nursing procedures by staff to maintain personal cleanliness and good grooming including attending and/or assisting with bathing, shaving, and brushing teeth
  - Attending means continual supervision while the resident performs the personal hygiene task to ensure completion of the task. Includes routine skin care and the use of all bathing products.
  - **Note:** Any degree of resident involvement is considered an assist

3. Personal Hygiene

- Totally Dependent -Code 3, Score 20
  - Bathing and/or grooming completed entirely by nursing staff without assistance from the resident
  - "Bath“ may take place at bedside, or in a bathing system, shower, or regular tub

3. Personal Hygiene

- **Note:** Score is based on the highest level of need in either grooming or bathing
- **Example:** If the resident is independent in grooming but needs assistance in bathing, the codes are Bathing — 2, Grooming — 1, and the score is 18
- **Documentation:** The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.
- **Note:** If points are scored for bathing or grooming, points may not be scored under "Restorative Bathing or Grooming" program

4. Dressing

- Independent - Code 1, Score 0
  - This item includes setting out the resident's clothes. Code 1 if the resident is on a "Restorative Dressing“ program.

4. Dressing

- **Assist — Code 2, Score 30**
  - The resident cannot dress and undress without direct physical, or continual instructional, or continual motivational assistance
  - This item includes application of all splints (for example, MultiPodus or L'Nard boots), braces, binders, anti-embolism stockings, and cervical collars
  - Assistance only with socks and shoes may not be claimed
  - **Note:** Any degree of resident involvement is considered an assist

4. Dressing

- **Totally Dependent - Code 3, Score 30**
  - The resident cannot dress and undress
- **Socks and Shoes Only - Code 4, Score 0**
  - The resident needs assistance with socks, shoes, buttons, bra hooks, or zippers only
- **Not Dressed - Code 5, Score 0**
  - The resident wearing night clothes only is "not dressed”

4. Dressing

- **Documentation:** The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

- **Note:** If points are scored for dressing, points may not be scored under "Restorative Dressing“ program

5. Mobility

- Mobility describes how the resident walks indoors, once in a standing position, or wheels once in a wheelchair. Transfer (Item 16) describes how the resident gets to the standing or sitting position.

5. Mobility

- Independent — Code 1, Score 0
  - The resident is independent if no staff intervention is necessary. This includes the resident who walks with the assistance of equipment (e.g., uses a walker or a cane or wears a Wanderguard).
  - Code 1 if the resident is on a "Restorative Ambulation" program

5. Mobility

- Independent w/wheelchair — Code 2, Score 0
- Walks with assist — Code 3, Score 32
  - The resident can bear own weight but must be physically steadied (one on one) or guided (standby guard) in ambulation by nursing staff, or the resident must be continually monitored, supervised, and given verbal instructions

5. Mobility

- **Wheelchair with assist — Code 4, Score 32**
  - Wheelchair resident who cannot move or propel alone, or appropriately, because of mental or physical state, or the resident must be continually monitored, supervised, and given verbal instructions
- **Non-ambulatory/bed bound — Code 5, Score 0**
  - The resident does not move out of his or her bed (non-mobile, bed-bound, **or bed-to-chair only**)

5. Mobility

- **Documentation:** The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident.

- **Note:** If points are scored for mobility/ambulation, points may not be scored under "Restorative Ambulation" program

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6. Eating

- Independent — Code 1, Score 0
  - A resident requiring standard tray preparation (uncover all items on tray, open milk carton) but needs no help eating, is independent. Cutting up meat is considered standard tray preparation.
  - Code 1 if the resident is on "Restorative Feeding" program

6. Eating

- Assist — Code 2, Score 20
  - The resident can bring food to mouth. The resident requires intervention by caregiver, including direct physical assistance, or continual individual or small-group supervision (at a ratio no greater than one staff to eight residents) during the entire mealtime
  - **Note:** Any degree of resident involvement is considered an assist

6. Eating

- **Totally dependent -Code 3, Score 45**
- The resident is fed by the nursing staff.
- This item includes syringe feeding when approved in writing by the physician

6. Eating

- Tube fed — Code 4, Score 90
  - This applies to the resident who is being tube fed only
- I.V. — Code 5, Score 90
  - This applies to the resident receiving I.V. therapy, or TPN for total nutrition and hydration. I.V. may be scored if required for more than five days of the month.

6. Eating

- Tube fed and assist — Code 6, Score 110
  - In those documented instances where a resident is tube fed and needs assistance with eating
- Tube fed and totally dependent — Code 7, Score 135
  - In those documented instances where a resident is tube fed and is totally dependent in eating

6. Eating

- Tube fed and I.V. — Code 8, Score 135
  - This covers the rare instance of a resident receiving both tube feeding and an I.V. (Do not also take points as a "Skilled Procedure," Item 12)
  - Note: I.V. therapy refers to nutrition and hydration
  - Documentation: The licensed nursing summary must verify ADL status at least monthly and specify the reason for assistance. The ADL flow sheet must document the daily functional status of the resident and the amount of supervision required.
  - Note: If points are scored for feeding, points may not be scored under "Restorative Feeding" program

7. Continence/Catheter

- Continent — Code 1, Score 0
  - The resident is continent or able to request assistance with toileting. Includes the resident who is dependent for transfers but is able to request assistance in advance of need
- Incontinent Occasionally — Code 2, Score 0
  - "Occasionally" is defined as less than 15 days of the month. Use this code for the residents on bowel and bladder retraining

7. Continence/Catheter

- **Incontinent and Toileted- Code 3, Score 48**
  - This applies to the resident whose continence is maintained only through regular staff assistance in advance of need. The resident is not able to request assistance but is toileted at least every two hours. Includes incontinent care.

7. Continence/Catheter

- Incontinent — Code 4, Score 48
  - This applies to regular incontinence due to the resident's inability to control micturition or bowels, or to notify staff of need, and includes incontinent care. (Cannot claim bladder incontinence if the resident is on a bladder-retraining program. Cannot claim bowel incontinence if the resident is on a bowel retraining program.)
  - This service may be claimed if the resident is regularly incontinent at any time during the 24-hour period or requires routine colostomy, ileostomy, or urostomy care

7. Continence/Catheter

- Indwelling Catheter — Code 5, Score 20
  - Prescribed by a physician. Includes insertion, maintenance, catheter care, and cystostomy care and irrigation, if less than daily. (Cannot claim if the resident is on bladder-retraining program, Item 8).
  - Please note that when catheter is irrigated at least daily the service may be claimed as a "Skilled Procedure" in Item 12

7. Continence/Catheter

- **Bowel Incontinent & Bladder Retraining - Score 18**
  - Enter Code 2 for bladder and Code 6 for bowel. Points for Bladder Retraining should be taken in Item 8.
  - Documentation: The licensed nursing summary must verify ADL status at least monthly.
  - The ADL flow sheet must document daily functional status of the resident.
  - Score for continence is based on the highest level of need in either Bladder or Bowel.

7. Continence/Catheter

- **Example:** If Bladder is Code 4, Incontinent, and Bowel is Code 2, Incontinent Occasionally, Score 48
- **Exception:** If Bladder is Code 5, Indwelling Catheter, and Bowel is Code 3, Incontinent and Toileted, or Code 4, Incontinent, Score 38

8. Bladder/Bowel Retraining

- No Retraining Received — Code 1, Score 0
- Bladder Retraining — Code 2, Score 50
  - A planned and documented program designed to reduce incontinence of urine. Include intermittent catheterization or clamping procedure for bladder retraining here, not to exceed 90 days.
  - Routine toileting to prevent incontinence does not constitute a retraining program.
  - Cannot claim in combination with "Bladder Incontinence," Item 7.

8. Bladder/Bowel Retraining

- **Bowel Retraining — Code 3, Score 18**
  - A planned and documented program designed to reduce incontinence of feces, not to exceed 90 days
  - Cannot be claimed in combination with "Bowel Incontinence," Item 7
- **Bladder and Bowel Retraining — Code 4, Score 68**
  - Residents on both a bladder and bowel retraining program must meet the requirements listed above

8. Bladder/Bowel Retraining

- **Documentation:** The monthly licensed nursing summary must verify the start date, the goal of the program, the resident's progress or lack thereof, and any revisions to the plan of care.
- The ADL flowsheet must document the daily functional status of the resident.
- **Note:** The clinical record must contain evidence that the patient has the capacity to comprehend and to participate in a program of bladder and bowel retraining

9. Positioning

- Independent — Code 1, Score 0
- Assist — Code 2, Score 36
  - The resident is essentially helpless to assist himself or herself and must be positioned every two hours while in bed or chair. Adjustment of restraints and routine skin care are provided in conjunction with position change.
- Documentation: The monthly must specify the resident's functional status and frequency of positioning and must indicate a reason for the assistance. Daily documentation must specify frequency and position on a positioning sheet or a restraint sheet.

10. Pressure Ulcer Prevention

- No Preventive Measures — Code 1, Score 0
- Preventive Measures — Code 2, Score 10
  - Pressure ulcer prevention includes routine diabetic foot care or the use of elbow or heel protectors or handrolls
  - It may include the use of over-the-counter (nonprescription) creams such as: Desitin, Eucerin, A&D, Vaseline, Aloe Vesta, and Sween Cream, which are used to provide an extra increment of care
  - There must be documentation of a previous pressure ulcer and/or a current risk assessment using the Braden or Norton scale to indicate moderate or high risk of skin breakdown

10. Pressure Ulcer Prevention

- **Note 1:** Points cannot be taken for the use of an air/water mattress, egg-crate pad, sheepskin, or foot cradles
- **Note 2:** Incontinent treatment does not necessitate the need for preventive measures, unless the resident has had documented previous skin breakdown
- **Note 3:** This item is concerned solely with preventive measures. The following item applies to the treatment of an existing condition.

10. Pressure Ulcer Prevention

- **Documentation:** The daily nursing documentation must be specific to indicate the type of care, frequency, and site of application
- The monthly licensed nursing summary must specify the reason for preventive measures (previous skin breakdown or current risk assessment)
- Only the Braden or Norton scale, which must have been completed within the previous 90 days, will be accepted, or the **skin breakdown** must have been documented within the previous **90 days**

11. Skilled Procedure Daily/ Pressure Ulcer

- Code the daily frequency of procedure(s) administered (maximum of nine). Enter 0 if no treatments are ordered.
  - Procedures must be specifically ordered by a physician in writing and must be performed by a licensed nurse.
  - Multiple pressure ulcers at the same or different locations are considered one procedure if the same treatment is provided.
  - A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing.

11. Skilled Procedure Daily/ Pressure Ulcer

- Multiply daily frequency of each procedure by 10 and enter the total score
- **Note:** In rare situations, different treatments may be ordered for multiple pressure ulcers in different locations. This may be claimed as more than one treatment.
  - Identify the number of pressure ulcers in each stage (maximum of nine)
- **Documentation:** Daily licensed nursing documentation must be recorded on the treatment sheet. At least weekly, the licensed nurse must record description, size, stage, treatment, and progress of pressure ulcer or ulcers on the treatment sheet.

11. Skilled Procedure Daily/ Pressure Ulcer

- Clinical stages are described as follows:
  - **Stage 1 Pre-Ulcer:** Characterized by unbroken skin surface. An area of induration, erythema, or blue/black discoloration of the skin that does not fade within 30 minutes after pressure has been removed
  - **Stage 2 Ulcer**: Moist, irregular, partial-thickness ulceration limited to the superficial epidermal and dermal layers
  - **Stage 3 Ulcer:** Full thickness extending into the subcutaneous adipose tissue
  - **Stage 4 Ulcer:** Necrotic ulcer extending into muscle, bone, or joint structure

12. Skilled Procedure Daily/Other

- Skilled procedures are procedures or treatments, other than pressure ulcer treatment, specifically ordered by a physician in writing that must be performed by a licensed nurse. See list of procedures below.
  - Code the daily frequency of skilled procedures in the single box (maximum of 9).
  - Code 0 if no skilled procedures are needed.
  - If more than one procedure is done daily, add the daily frequency for each procedure and enter the code.
- **Example:** If one procedure is done twice a day and another is done three times a day, the code is 5
- Multiply the sum of the daily frequency of each procedure or treatment by 10
  - and enter the total on the score line

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12. Skilled Procedure Daily/Other

- Respiratory therapy, continuous or daily oxygen, oxygen therapy, suctioning, and continuous bladder irrigation may be claimed for a maximum of one time per shift.
- The **same treatment** to different locations is considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing.
- **Topical medications** requiring a prescription may be scored for a maximum of 20 points for a dermatological condition involving epidermal and dermal layers of skin. Top and second layer of skin.
- **Documentation:** Daily licensed nursing documentation must specify treatment, frequency, description, and outcome. Specific observations must be recorded daily on a treatment sheet.

12. Skilled Procedure Daily/Other

- Enter appropriate procedure code(s) in the double boxes provided:
  - 00 — None
  - 01 — Dressing Change
  - 02 — Catheter Irrigation
  - 03 — Intermittent Catheterization
  - 04 — Eye Irrigation
  - 05 — Ear Irrigation
  - 06 — Care of Heparin Locks
  - 07 — Oxygen Therapy (continuous or daily therapy)
  - 08 — Tracheostomy Care
  - 09 — Sterile Dressing
  - 10 — Suctioning
  - 11 — Not in use at this time
  - 12 — Respiratory Therapy
    - includes the use of inhalation aerosols for the management of episodes of bronchospasm)
  - 13 — New Colostomy Irrigation
  - 14 — Other

12. Skilled Procedure Daily/Other

- **Educate** nursing staff the clinical importance of keeping the treatment for at least 15 days, as appropriate.
- Include MMQ nurse in the review for the appropriateness of discontinuing treatments in documentation month
- **Example:** wound appears healed in 2 weeks (14 days) ongoing assessment and treatment may be appropriate to ensure not reoccurred for the additional few days

13. Special Attention

- **Coding:** A code must be entered for each box A through D. (See Note below for Box C.)
  - Code 0 if not applicable
  - Code 1 if special attention was required for 15 days of the month reviewed (or 50 percent of the total days if less than a full month)

13. Special Attention

- **A. Immobility:** Code 1 if the resident is so heavy, helpless, or combative that two or more people are needed to change position, transfer, or ambulate.
- This includes use of mechanical lifting devices, for example, a Hoyer lift.
- The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must record the daily functional status.

13. Special Attention

- **B. Severe Spasticity or Rigidity:** Code 1 if the problem is of such magnitude that it severely limits personal care or ambulation, requiring two or more people
  - The licensed nursing summary must specify the resident's dysfunction and the ADL flow sheet must code the daily functional status.

13. Special Attention

- C. Behavioral Problems: Code 1, 2, or 3 may be used for behavioral problems. The disruptive behavior interferes with staff and/or other residents, causing the staff to stop or change what they are doing to control or alleviate the following disruptive behaviors:
  - Wandering — moves with no rational purpose, appears oblivious to needs or safety.
  - Verbally Abusive — threatens, screams, or curses.
  - Physically Abusive — hits, shoves, scratches, or sexually abuses others.
  - Socially Inappropriate or Disruptive Behavior — performs self-abusive acts, exhibits sexual behavior or disrobes in public, smears or throws food or feces, or rummages through others' belongings.

13. Special Attention

- Note
  - Code 1 if behavior and intervention have been documented for 15-22 days
  - Code 2 if behavior and intervention have been documented for 23-29 days
  - Code 3 if behavior and intervention have been documented for 30 or 31 days

13. Special Attention

- Documentation
  - For Code 1, 2, or 3, a current active treatment plan for behavioral problems must be in the medical record
  - For Code 1, the licensed nursing summary must verify and summarize the daily documented behavior(s), frequency, intervention(s), and the outcome of intervention(s)
  - For Code 2 or 3, the daily nursing documentation must specify behavior(s), frequency, intervention(s), and outcome of intervention(s)
  - For Code 2 or 3, a psychiatric assessment must document the disruptive behavior

13. Special Attention

- **D. Isolation:** Code 1 if gowns and gloves are required due to communicable infection or severely impaired immune status

14. Restorative Nursing

- **Restorative nursing** refers to care procedures that may require relearning after an illness such as a fractured hip or CVA
- Implementation of specific types of resident re-teaching conducted at least five times per week by nursing staff
- Intervention and progress must be well documented daily, with time limits and goals clearly stated. This may only be claimed for a period not to exceed 90 days.

14. Restorative Nursing

- May claim points only for the limited time necessary to achieve the stated care plan objective or to prove it impractical, as shown by progress or lack of progress.
- Time limits for such services as ADL training, ostomy teaching, diabetic teaching, and restorative eating participation are those established during the resident-care planning process (maximum of 90 days)
- Code — Enter procedure type(s) in the box(es)
- **Note:** The clinical record must contain evidence that the patient has the capacity to comprehend and to participate in the restorative program

14. Restorative Nursing

- 0 — None Required
- 1 — Activities of Daily Living – Dressing
- 2 — Activities of Daily Living - Personal Hygiene
- 3 — Activities of Daily Living - Restorative Eating
- 4 — Ostomy Care/Teaching
- 5 — Diabetic Teaching
- 6 — Ambulation
- 7 — Range of Motion

14. Restorative Nursing

- **Score** — Enter 30 if any restorative nursing procedures are administered.
- The maximum score for this item is 30, regardless of the number of programs implemented. Enter 0 if none was provided.
- **Documentation:** The monthly licensed nursing summary must verify time limits, not to exceed 90 days, goals, progress, or lack of progress.
- The ADL flow sheet must document the daily functional status of the resident.

Supporting Categories

- No points are connected with the next 10 items
- All items must have entries
- Review for consistency of scored items

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15. Toilet Use
Use of toileting equipment

- Toilet use refers to how the resident uses the toilet, bedpan, urinal, or commode, including transferring, if necessary, or positioning a bedpan/urinal, cleansing after elimination, and adjusting clothes prior to and after using the toilet. The process involved in getting to the toilet may not be included here.
  - Code 1 — Independent
  - Code 2 — Assist
  - Code 3 — Totally Dependent
  - Code 4 — Not Toileted (Includes residents who do not use toileting equipment because of incontinence or because they have a catheter.)

16. Transfer

- Transfer refers to how the resident gets to the standing position or to sitting in a wheelchair.
- Mobility (Item 5) is how the resident walks indoors, once in a standing position, or wheels once in a wheelchair.
  - Code 1 — Independent
  - Code 2 — Assist
  - Code 3 — Totally Dependent
  - Code 4 — Bed bound

17. Mental Status

- Inability to remember dates or time, identify familiar locations or people, recall important aspects of recent events, or make straightforward judgments of such recent events, or make straightforward judgments of such a degree that the resident is impaired nearly every day in performance of basic activities of daily living, mobility, and adaptive tasks. Code as follows:
  - Code 1 — Resident is not disoriented or impaired in memory
  - Code 2 — Resident is disoriented or impaired in memory daily
  - Code 3 — Mental status is not determined (includes only new admissions and those residents unable to communicate)

18. Restraint

- **Code 1** — The resident does **not** have a written order for restraints
- **Code 2** — Restraint is **ordered but not** used on a **regular** daily basis
- **Code 3** — Restraint is **ordered and used daily**

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19. Activities Participation

- Code 1 — Always Active
- Code 2 — Occasionally Active
- Code 3 — Rarely Active or Not Active
- Code 8 — Not Yet Determined

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20. Consultations

- Consultation is defined as a direct visit to a specific resident for reasons other than the required routine visit or admission screening
- **Type:** Note which **type of consultation(s)** occurred by entering the appropriate code(s) in the column marked "Type." (If more than three types apply, list the three that are most frequent.)
- Enter 00 if none and 88 if not determined in the first set of boxes.

20. Consultations

- 00 — None
- 01 — Physician
- 02 — Psychiatrist
- 03 — Dentist
- 04 — Podiatrist
- 05 — Physical Therapy
- 06 — Psychologist
- 07 — Dietitian
- 08 — Social Service
- 09 — Occupational Therapy
- 10 — Audiologist
- 11 — Speech Therapy
- 12 — Other
- 88 — Not determined

20. Consultations

- **Frequency:** Note the respective frequency of each consultation by entering the appropriate code(s) in the column marked "Freq":
  - 0 — None
  - 1 — Daily
  - 2 — 2-3 Times Per Week
  - 3 — Weekly
  - 4 — 2-3 Times Monthly
  - 5 — Monthly
  - 6 — One Time Only (PRN)

21. Medications

- If selected types of medications have been ordered and administered, indicate the type of medication in the row marked "Medications" using codes below. (Enter first code in the first box.) Enter 0 if none.
- Medications administered but that are not listed below should not be counted. Under each medication indicate the frequency using the codes below.
- Only code listed in the instructions should be used.
- If more than four medications are administered, enter the ones administered most frequently.

21. Medications

- Medications (Prescription Only)
  - 0. None
  - 1. Tranquilizers
  - 2. Sedatives/Hypnotics
  - 3. Anti-hypertensives
  - 4. Narcotics
  - 5. Pain Relievers (non-narcotic)
  - 6. Anti-Psychotics
  - 7. Antibiotics
  - 8. Antidepressants

21. Medications

- Frequency
  - 0 — None
  - 1 — Regularly
  - 2 — PRN
  - 3 — One Time Only (includes 10-day order for antibiotics)

22. Accidents/Contractures/Weight Change

- Indicate whether or not the resident has experienced an accident (an accident or incident report was completed) or weight change during the month by entering the appropriate code in each box:
  - 1 — Yes
  - 2 — No

- Note: A weight change is defined as an unplanned gain of eight or more pounds or loss of five or more pounds. (A weight change is considered planned when a resident is on a supplement diet, reduction diet, or diuretic program.)
- Indicate whether the patient has any contractures by entering the following code in the box marked "C“
  - 1 — Yes
  - 2 — No

23. Primary Diagnosis

- Use ICD-10-CM codes to indicate the diagnosis that is the principle reason for the resident's need for long-term-care services

24. Secondary Diagnosis(es)

- List up to three ICD-10-CM codes for the conditions that have a major relationship to the resident's activities of daily living (ADLs) or cognitive or behavioral status
- Leave blank if no secondary diagnoses are present

25. Registered Nurse Signature

- The name of the facility's registered nurse completing the MMQ form certifies that the information on the questionnaire is complete, valid and accurate

26. Date

- Enter the date the MMQ is completed

27. Signature of Administrator

- The name of the facility's administrator certifies that the information on the questionnaire is accurate, valid and complete

28. Affiliation

- Enter the appropriate code for the person completing the MMQ:
  - Code 1 — Nursing Facility Staff
  - Code 2 — MassHealth
  - Code 3 — RN contractor

Care Plans

Interdisciplinary Care Plan				
Problem/strength	**Goal**	**Target Date**	**Approaches**	**Progress:**
BATHING STATUS				
DRESSING STATUS				
GROOMING STATUS				
TOILETING/ INCONTINENCE				
AMBULATION/ MOBILITY				
PRESSURE ULCER PREVENTION				
SKILLED OBSERVATION				
SKILLED PROCEDURES				

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Care Plans

Interdisciplinary Care Plan				
Problem/strength	**Goal**	**Target Date**	**Approaches**	**Progress:**
Behavior				
Cognition				
Respiratory Therapy				
Positioning Programs				
Care Plan to support the organized program to				
Address dysfunction that Supports intervention				

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Facility MMQ Audit Example

- Provider feedback from recent Facility MMQ Audit (March 2018)
  - It was a 2 day visit with one auditor who exited at 6:30 PM on Friday
  - Reviewed more than the prepared "packets"
  - Auditor requested access to EMR software with review of the medical records to include Interdisciplinary notes, nursing progress notes and Care Plans
- Findings
  - 63 Medicaid Residents
  - 31 rescored
- Audit Issues
  - Corrections to nursing summary did not follow summary correction policy
  - Positioning records with holes in documentation
  - Old or outdated Norton/Braden Scores for pressure ulcer prevention did not support preventative skin care
- Outcome
  - Facility must complete a Corrective Action Plan (CAP)

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Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Regional HealthCARE Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

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HHI
Services and Plans

Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.S.
1 Year Service Plan

A La C.A.R.E.S.
Customized Service Plan

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- Founded in 2000
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- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America **three years in a row**
- Active monthly contracts in 24 states
- Over 1,000 Skilled Nursing Facilities serviced
- Over 3,000 Clinicians Certified on the MDS

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https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a Harmony HealthCARE Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

Manuals I Tools I C.A.R.E.S. Community I Hot Topics I FAQ (Frequently Asked Questions)

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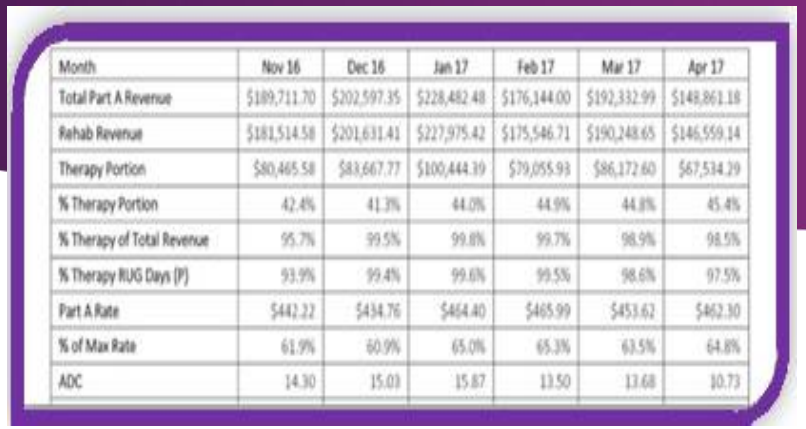
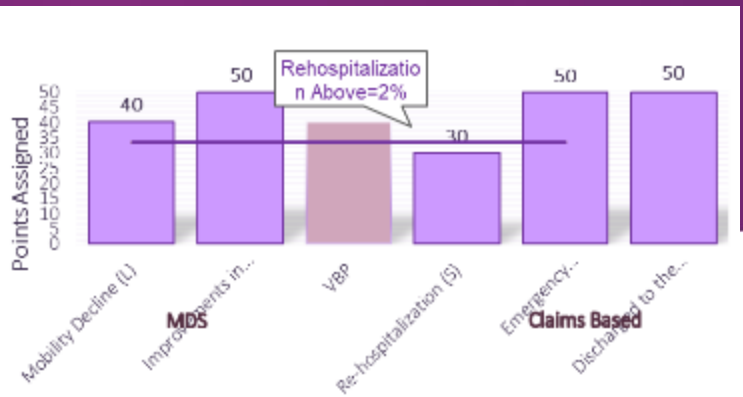
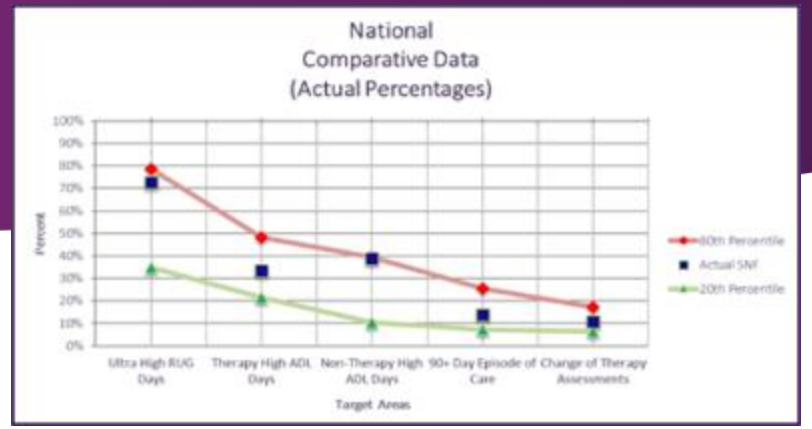


Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73





Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PBJ Analysis
- Staffing Analysis
- PEPPER Analysis

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