Medicare Manual

Volume I

6.6.18

We C.A.R.E. About Care

- Compliance
- Audit & Analysis
- Reimbursement & Regulatory
- Education & Efficiency

Medicare Manual
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Harmony Healthcare International (HHI)
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Philosophy of Harmony Healthcare International

The mission of Harmony Healthcare International (HHI) Inc. is to provide the long-term care industry with the tools to obtain accurate reimbursement and ultimately to provide better care to its residents. Through seminars, consulting and management services, Harmony (HHI) educates, trains and advises its customers with a user-friendly customer-first approach.

Kris Mastrangelo, president and CEO, has more than 18 years of experience in the long-term care industry. An Occupational Therapist degree from Tufts University followed by a Master's in Business Administration and a Nursing Home Administrator's License affords Kris an in-depth perspective into the nursing home industry.

Initially providing direct care as an occupational therapist, Kris became familiar with the Medicare reimbursement system. Her position evolved into the management of in-house rehabilitation programs to Vice President of Operations for a national consulting company to Vice President of Reimbursement.

Her experience includes the development and presentation of training modules (clinical, financial, operational and reimbursement) for large healthcare corporations, implementation of in-house rehabilitation programs, management of Medicare and Medicaid cost reporting, change of ownership applications, budgeting, skilled nursing facility clinical and financial analysis along with vendor contracting.

"We Care About Care."
www.harmony-healthcare.com

Purpose of The Manual

The Harmony Healthcare Medicare Manual (Volume I) is to be used as a tool for understanding the Medicare Program. This manual contains guidelines, regulations and recommended systems for ensuring the appropriate coverage for Medicare beneficiaries. The goal of Harmony (HHI) is to keep all participants informed of any changes in the Medicare system in order to enhance the overall Medicare decision-making process. If you would like a copy of this manual or if you have questions or suggestions, please contact:

Harmony Healthcare International, Inc.
430 Boston Street, Suite 104
Topsfield, MA 01983
1-800-530-4413

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Medicare Program

Overview: Rates/Entitlement/Eligibility

Medicare Title XVIII of the Social Security Act is a Federal health insurance program for people 65 or older and certain disabled people. It is administered at the Federal level by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS). The Social Security Administration administers certain Medicare matters, such as "entitlement" to benefits (as opposed to determination of the amount of benefits) and the provision of Administrative Law Judges for certain hearings. Local Social Security Administration offices take applications for Medicare and provide information about the program.

Medicare has two parts: hospital insurance and medical insurance. Hospital insurance can help pay for inpatient hospital care, inpatient care in a skilled nursing facility and home health care. Medical insurance can help pay for medically necessary doctors' services, outpatient hospital and nursing home services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Medical insurance also can pay for home health services.

Medicare does not pay the full cost of some covered services. As general health care costs rise, the amount Medicare does not cover may increase. For people with very low incomes, the Medicaid program in their State may pay all or a part of the amount Medicare does not pay and may pay some health care expenses not covered by Medicare.

Medicare payments are handled by private insurance organizations under contract with the Government. Organizations handling claims from hospitals, skilled nursing facilities and home health agencies are called intermediaries/Medicare Administrator Contractor (MAC). Organizations handling claims from doctors, PEN supplies for skilled nursing homes and other suppliers of services covered under the medical insurance part of Medicare are called carriers.

SNF Inpatient Care

Medicare Part A can help pay for certain inpatient care in a Medicare participating skilled nursing facility following a hospital stay. The condition must require daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care the patient receives must be based on the orders of a medical professional.

What is a Skilled Nursing Facility?

A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. In some facilities, only certain portions participate in Medicare.

Payment Conditions

Medicare Part A can help pay for a beneficiary's care in a Medicare participating skilled nursing facility if he/she meets all six of the following conditions:

1. The condition resulting from hospitalization requires **daily skilled nursing or skilled rehabilitation** services which, as a practical matter, can only be provided in a skilled nursing facility;

2. He/she has been admitted in a **hospital at least three days** in a row (not counting the day of discharge) before being admitted to a participating skilled nursing facility;

3. He/she is admitted to the facility within **30 days** after leaving the hospital;

4. The care in the skilled nursing facility is for a **condition** that was **treated** in the **hospital**, or for a condition that **arose** while he/she was receiving care in the skilled nursing facility for a condition which was treated in the hospital;

5. For hospital swingbed units a physician certifies the need for skilled care. For Skilled Nursing Facility (SNF) PPS **a physician, nurse practitioner, physician assistant or clinical nurse specialist certifies** the need for skilled care or the correctness of the Resource Utilization Groups (RUG) category; and,

Covered Days

In each benefit period, Medicare Part A pays for all covered services for the first 20 days in a skilled nursing facility. A daily coinsurance amount is assessed to the beneficiary from the 21st through the 100th day.

Skilled Care

The only type of "nursing" home care Medicare covers is skilled nursing facility care. Medicare does not cover custodial care when that is the only type of care required.

Custodial Care

Care is considered custodial when it is primarily for the purpose of helping the patient with daily living or meeting personal needs, and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

Covered Services

The following services are covered under Medicare Part A when in a skilled nursing facility:

- A semi-private room (two or four beds in a room);
- All meals, including special diets;
- Regular nursing services;
- Physical therapy, occupational therapy, and speech-language pathology;
- Pharmacy costs during the stay;
- Blood transfusions furnished during the stay;
- Medical supplies (such as splints and casts furnished by the facility); and,
- Use of appliances (such as a wheelchair furnished by the facility).

Physician's services while in a skilled nursing facility are not covered under Medicare Part A. These services may be billed to the carrier.

Services Not Covered

The following services are considered non-covered under the Medicare Part A benefit when a patient is in a skilled nursing facility:

- Personal convenience items that are requested (such as a television in patient's room);
- Private duty nurse; and,
- Charges for a private room, unless determined to be medically necessary.

SNF Items and Services Covered Under Medicare Part B

Payment may be made under Medicare Part B using a 22X type of bill for certain medical items and services when furnished by a participating SNF (either directly or under arrangements) to an inpatient of the SNF, if payment for these services cannot be made under Medicare Part A in the following situations:

- The beneficiary does not have Medicare Part A eligibility;
- The beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Medicare Part A in his/her current spell of illness;
- He/she is determined to be receiving a non-covered level of care; or,
- The three day prior hospitalization or the transfer requirement is not met.

SNF Medicare Part B Items and Services

The following items and services are billable under Medicare Part B furnished to inpatients of a SNF:

1. Diagnostic X-ray tests (including portable X-ray), diagnostic laboratory tests and other tests;
2. X-ray, radium and radioactive isotope therapy, including materials and services of technicians;
3. Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations;

SNF Medicare Part B Items and Services

4. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices;

5. Leg, arm, back and neck braces, trusses and artificial legs, arms, and eyes, including adjustments, repairs and replacement required because of breakage, wear, loss, or a change in the patient's physical condition;

6. Outpatient physical therapy, outpatient occupational therapy, or outpatient speech pathology services;

7. Immunizations for Influenza Virus, Pneumococcal Pneumonia and Hepatitis B (high and intermediate risk);

8. Pulse Oximeter reading with specified MD order;

9. Hemophilia Clotting Factors; and,

10. Some Ambulance Services.

Self administered drugs and biologicals (except as provided in the seventh and eighth bullets above) and blood are not covered by Medicare Part B when furnished by a SNF.

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Benefits Overview With Rates
Medicare Part A

Medicare Part A (Hospital Insurance) Helps Pay For:	What the Beneficiary Pays in 2013* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies (this includes care in critical access hospitals). This does not include private duty nursing, or a television or telephone in your room. It also does not include a private room, unless medically necessary. Inpatient mental health care coverage in an independent psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period the beneficiary pays:** • A total of $1,216 for a hospital stay of 1-60 days. • $304.00 per day for days 61-90 of a hospital stay. • $592 per day for days 91-150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: * Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day inpatient hospital stay).	**For each benefit period the beneficiary pays:** • Nothing for the first 20 days. • Up to $152.00 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Intermediary or MAC.
Home Health Care:* Part-time skilled nursing care, physical therapy, occupational therapy, speech language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	**Beneficiary pays:** • Nothing for home health care services. • 20% of the Medicare-approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary.
Hospice Care:* Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**Beneficiary pays:** • A co-payment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary.
Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.	**Beneficiary pays:** For the first 3 pints of blood, unless you or someone else donates blood to replace what you use.
* You must meet certain conditions in order for Medicare to cover these services.	

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Medicare Benefits
Medicare Part B

Medicare Part B (Medical Insurance) Helps Pay For:	What the Beneficiary Pays in 2013* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also, covers second surgical opinions. Also covers outpatient physical and occupational therapy including speech-language therapy. Outpatient mental health care.	**Beneficiary pays:** • $147 deductible (pay once per calendar year). 20% of Medicare-approved amount after the deductible, except in the outpatient setting. • Beginning 1/1/11 monthly premium will be based on individual and joint tax return with income >$85,000 and $170,000. • 20% for all outpatient physical, occupational, and speech-language therapy services. • 45% for outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**Beneficiary pays:** • Nothing for Medicare-approved services.
Home Health Care: * Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare-covered home health care, and other supplies and services.	**Beneficiary pays:** • Nothing for Medicare-approved services. • 20% of Medicare-approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**Beneficiary pays:** • A coinsurance or fixed co-payment amount which may vary according to the service.
Blood: Prints of blood you get as an outpatient, or as part of a Part B covered service.	**Beneficiary pays:** • For the first 3 pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless you or someone else donates blood to replace what you use.
* You must meet certain conditions in order for Medicare to cover these services or equipment.	

Pre/Post PPS at a Glance
Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
100 Day Spell of Illness	Requirement the same
3 Day Qualifying Hospital Stay	Requirement the same
30 Day Transfer Rule	Requirement the same
Physician Certification and Re-certification	Requirement the same
Medical Predictability	Requirement the same
Resident is being **treated for a condition which was treated during qualifying hospital stay OR** a condition **which arose while in a SNF** for a treatment of a condition, for which the resident previously was treated in hospital.	Requirement the same
Daily Skilled Care	Requirement the same (Service is based upon MDS observation period and documentation to support coverage and services being reasonable and necessary.)
Physician Supervision	Requirement the same
Management and Evaluation of Plan of Care and/or Skilled Observation and Assessment of Plan of Care	Reinstated in the Final Rule.
Suprapubic Catheters	Reinstated in the Final Rule.
Teaching and Training Activities • Self injection • Newly diagnosed diabetic insulin – injections, diet, foot care precautions • Gait training and prosthesis care • Recent colostomy/ileostomy care • Self catheterization • Self G-tube feedings • Care & maintenance of CVP lines/Hickman • Care of catheter, braces, splints and orthotics, and any associated skin care. • Specialized dressings or skin treatments	Modified under nursing rehabilitation.

Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
IV, IM, SC Injections	Eliminated subcutaneous injections (Special Care High captures diabetics with daily injections requiring physician insulin order changes on 2 or more days).
Hypodermoclycis, IV Feedings	Eliminated hypodermoclysis. (Hypodermoclysis is the medical equivalent of IV infusions.)
Tube Feedings, NG, Gastrostomy, Jejunostomy	Modified to: must receive at least 51%or more of total calories **OR** 26% of daily calories and minimum of 501 ml of fluid per day.
Naso-Pharyngeal Tracheotomy Aspiration	Requirement the same
Catheters – Insertion, sterile irrigation, replacement catheters/care of suprapubic cath and insertion/care of catheter adjunct to active treatment of a disease.	Requirement the same
Dressing Changes – Dressings with prescription meds and aseptic techniques.	Requirement the same
Pressure Ulcers – Severity of grade 3 or worse or wide spread skin disorder and daily skilled treatment.	Requirement the same : Ulcers with 2 or more skin treatments; 2 or more stage II, 1 or more stage III or IV, Unstageable secondary to eschar, slough, 2 or more venous/arterial ulcers or 1 stage II pressure ulcer and 1 venous/arterial ulcer.
Heat treatments ordered by physician requiring skilled observation.	Requirement the same
Rehabilitation nursing procedures included related teaching adaptive aspects of nursing & part of active treatment necessitating skilled nursing (e.g. institution of bowel and bladder training program).	Requirement the same
Administration of Medical Gases – Initial Regimen	Requirement the same
Colostomy Care – Care of during early post-op phase with associated complications.	Requirement the same

Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
Physical Therapy • Directly related written plan of treatment • Required knowledge/skills/judgment of qualified professional. • Services must be considered under acceptable standards of practice. • Expectation of improvement of restorative potential in a reasonable and predictable period of time…or… • Establishment of a safe and effective maintenance program. **Skilled Services** • Assessment • Infra-red Treatment, Paraffin Baths only in presence of complicating condition (open wounds), Whirpool Baths • Gait Training • Ultrasound, Short-wave iathermy Treatment • Range of Motion • Therapeutic exercises	Requirement the same

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Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
Occupational Therapy • Must be ordered by a physician to Improve or Restore Function • Directly related written plan of treatment • Required knowledge/skills/judgment of qualified professional. • Services must be considered under acceptable standards of practice. • Expectation of improvement of restorative potential in a reasonable and predictable period of time…or… • Establishment of a safe and effective maintenance program. **Skilled Services** • Evaluation /Re-Evaluation of function • Teaching task oriented therapeutic activities • Plan/implement/supervise individualized therapeutic activities and sensory integration functions • Testing of compensatory techniques. • Design/fabrication and fitting orthotic or self help devices • Vocational/pre-vocational assessment and training	Requirement the same

Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
Speech Therapy • Directly related to written plan of treatment • Required/knowledge/skills/judgment of qualified professional. • Services must be considered under acceptable standards of clinical practice. • Expectation of improvement of restorative potential in a reasonable and predictable period of time OR • Establishment of a safe and effective maintenance program. • Services must be necessary for diagnosis and treatment of speech and language disorders **Skilled Services** • Restoration therapy • Diagnostic and Evaluation services • Therapeutic Services • Treatment of dysphagia.	Requirement the same
MDS Assessments – Previously not required.	On days 5, 14, 30, 60, 90, Unscheduled and OMRAs.
Tracking Skilled Days Resident assessed on a daily basis to determine if skilled care continues and if Medicare Part A billing is justified.	Resident assessed on a daily basis to determine if skilled care continues and if Medicare Part A billing is justified. Assessed on a mandated schedule and each assessment predetermines the number of Medicare Part A days that can be billed. Predetermined assessed days are altered when: • There is a change in the resident's level of care (medical

Tracking Skilled Days Resident assessed on a daily basis to determine if skilled care continues and if Medicare Part A billing is justified.	condition) thus requiring a new assessment. • There are no benefits available to the resident upon admission. • Discharge and/or readmission to SNF • Death of the resident • Late or missed assessment Maximum number of Medicare Part A days allowed per each assessment cannot exceed a resident's technical eligibility.

Medicare Entitlement, Eligibility and Coverage Criteria Overview of PPS Impact

Pre-PPS Requirements	Post PPS Requirement
Leave of Absence (LOA)	Requirement the same. If a resident does not meet the midnight census criteria, they are considered to be on a leave of absence. Residents temporarily sent outside the SNF for only a brief period to receive a service offsite (outpatient visit to a hospital or clinic) are not considered discharged unless admitted to the hospital. LOA days do not interrupt the unscheduled assessment schedule and modify the scheduled assessment schedule.
Notices of Non-Coverage	SNFs are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries to alert them that Medicare covered item(s) and/or service(s) are ending and give beneficiaries the opportunity to request an expedited determination from a QIO. A Detailed Notice is given when the QIO review is requested in order to provide more explanation on why coverage is ending.
Demand Bills	Requirement the same
New Spell of Illness	Requirement the same

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Entitlement (Part A & B)

Medicare Part A

Most people 65 and older can get premium-free Medicare Part A benefits, based on their own or their spouses' employment, i.e., they or their spouse have paid into the Social Security System through payroll taxes for a minimum of 40 quarters or 10 years. (Premium-free means there are no premium payments for Medicare Part A.) The individual is eligible at 65 years of age if he or she:

- Receives Social Security or Railroad Retirement benefits or,
- Is not receiving Social Security or Railroad Retirement benefits, but have worked long enough to be eligible for them or,
- Would be entitled to Social Security based on their spouse's (or divorced spouse's) work record, and that spouse is at least 62 years of age or,
- Has worked long enough in a Federal, State, or local government job to be insured for Medicare.

If the individual is under 65, they may qualify for premium-free Medicare Part A benefits if he or she:

- Has been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months or,
- Has worked long enough in a Federal, State, or local government job **and** meets the requirement of the Social Security disability program.

Certain aged or disabled people who do not qualify for Medicare Part A under the above rules may be able to get Medicare Part A by paying a monthly premium. For information individuals can contact their local Social Security office.

Medicare Part B

Most people 65 and older who can get premium-free Medicare Part A benefits, based on work as described above can enroll for Medicare Part B, pay the monthly Medicare Part B premiums, and get Medicare Part B benefits.

Medicare Part B

Aliens who are 65 or older and are not eligible for hospital insurance must be lawfully, admitted permanent residents and must live in the United States for 5 years before they can enroll for medical insurance.

Medicare Card

A copy of the Medicare Card should be made prior to or on the day of Admission and kept in the patient's financial folder and medical record.

Part A & B

Medicare Health Insurance

Social Security Act
Name of Beneficiary
Jane Doe

Medicare Claim Number	Sex
123-45-7890-A	Female

Is Entitled to	Effective Date
Hospital Insurance	3-1-85
Medical Insurance	3-1-85

Sign
Here_____

Part A Only

Medicare Health Insurance

Social Security Act
Name of Beneficiary
Jane Doe

Medicare Claim Number	Sex
123-45-7890-A	Female

Is Entitled to	Effective Date
Hospital Insurance	3-1-85

Sign
Here_____

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Medicare Program

Medicare Card

Part B Only

Medicare Health Insurance

Social Security Act
Name of Beneficiary
Jane Doe

Medicare Claim Number	Sex
123-45-7890-A	Female
Is Entitled to Medical Insurance	Effective Date 3-1-85

Sign Here_____

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Medicare Program

Enrollment (Part A & B)

An individual should contact Social Security about applying for Medicare if:

- He or she is a disabled widow or widower between 50 and 65 but haven't applied for disability benefits because he or she is already getting another kind of Social Security benefit;
- He or she is a government employee and became disabled before 65;
- He or she, their spouse, or their dependent child has permanent kidney failure;
- He or she has Medicare medical insurance in the past but dropped the coverage; or
- He or she has turned down Medicare medical insurance when they became entitled to hospital insurance (Medicare Part A).

Initially, an individual has **seven months to sign up** for medical insurance (Medicare Part B). The seven-month **period** begins **three months before the individual's 65 birthday**, includes the month they turn 65, **and ends three months after their birthday**. If the individual does not enroll during the initial enrollment period, each year they are given another chance to enroll during a general enrollment period which is from January 1 through March 31. If an individual enrolls in the general enrollment period their Medicare coverage would begin in July.

If an individual is 65 or older and does not quality for Medicare, they may buy Medicare Part A coverage for a monthly premium. If they wish to buy Medicare Part A coverage, they must enroll in Medicare Part B and pay a monthly premium for that coverage as well.

If an individual is covered by a group health plan when they are first able to get Medicare, they may be able to delay enrollment in Medicare Part B or premium Medicare Part A without a premium surcharge and without waiting for a general enrollment period to enroll. For more information individuals can contact their local Social Security office.

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Medicare Program

Verification of Enrollment

Verification of Information when the Medicare Card is not available:

If you are unable to obtain a Medicare card on admission, the form on the following page needs to be completed and authorized by the patient. A duplicate card will be sent to the facility.

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Medicare Program

Verification of Enrollment
Request for Information from Social Security Records

Individual's Name: Ima (First) R. (M.I.) Sample (Last)

Social Security Number: 123 – 45 – 6789

Date of Birth: 01 (Month) / 26 (Day) / 1926 (Year)

Medicare Claim Number: 123-45-6789 A

I authorize Social Security to release verification of my Medicare claim number, Medicare eligibility dates, or date of birth to:

Green Valley Ranch
Name of Facility Requesting Information

Ima R. Sample — Signature of Individual

09/15/95 — Date

PLEASE PROVIDE (check appropriate lines)

✓ 1) Verification of eligibility to Medicare

✓ Part A Hospital

✓ Part B Medical

Part A date = _____

Part B date = _____

for SSA use only

✓ 2) Verification of Medicare Claim Number

for SSA use only

✓ 3) Verification of Date of Birth:

for SSA use only

NAME OF PERSON REQUESTING INFORMATION: Mary Bergler *Mary Bergler*

PHONE NUMBER: (909) 999 – 9999

Signature of SSA employee providing information

Medicare Part A & B General Enrollment (January 1 – March 31)

Every year, Medicare offers an open enrollment window (January 1st – March 31st) for potential Medicare Beneficiaries.

Who may be eligible?

- All persons 65 and over who are entitled to monthly Social Security cash benefits or Railroad Retirement cash benefits;
- Persons over 65 who are still employed;
- A dependant or survivor of a person entitled to Medicare Part A; or a dependant of a person under age 65 who is entitled to retirement or disability if the dependent or survivor is at least 65 years old. (Example; a woman aged 65 or older is entitled to spouse or widow's Social Security benefit under Medicare Part A.)
- A Social Security Disability beneficiary after meeting qualifications for disability benefits for 24 months or more (including disabled workers at any age, disabled widows and widowers aged 50 or over, beneficiaries 18 or older who receive benefits because of disability beginning before age 22; disabled qualified railroad retirement annuitants.)
- Under certain conditions, a person who becomes re-entitled to disability benefits within 5 years after the end of a previous period of entitlement (or 7 years in the case of disabled widow/ers and disabled children);
- Individuals (and their dependants) with end stage renal disease.

When does coverage begin for those Beneficiaries that are approved during the open enrollment period?

- Coverage will begin July 1st

Many residents are funded by Medicaid. What happens if they cannot afford to pay the monthly premiums?

- State Medicaid programs are required to pay Medicare costs for certain elderly and disabled persons with low incomes and limited resources as long as the individual meets the requirements as a "Qualified Medicare Beneficiary" (QMB). There is also a program for individuals who are deemed Specified Low Income Beneficiaries who may not qualify for payment by the State Medicaid Program.

Where do I get an application for enrollment?

- Call your local Social Security office.

What documents will I need?

- Proof of age
- Proof of earnings such as W-2 forms (or tax returns for the past 2 years)
- Social Security Card
- If applying for disability benefits, documents related to the medical program will be required. The Social Security office will tell you what is specifically required.

Comment:

The following Step-by-Step process is to be used as a guide to manage the open enrollment process in a skilled nursing facility.

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Medicare Program

General Enrollment Roster

Facility Name: _____

Pages _____ of _____

Resident Name	Medicare Number	Medicare Part A Y or N	Medicare Part B Y or N	Date Applied and Type (A / B)	Date of Response	Response and Comments
Column 1	*Column 2*	*Column 3*	*Column 4*	*Column 5*	*Column 6*	*Column7*
Mary Medicare	*123-45-6789-A*	*N*	*Y*	*1/10/XX – Part A*	*1/29/XX*	*Part A approved*

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Medicare General Enrollment
Recommended Process

	Action	Responsible Person	Deadline Date
Step 1	Assemble your team to include: Administrator, MDS Coordinator, Business Office Manager, Social Worker, Director of Nursing, Therapy Representative.	Administrator	12/10
Step 2	Complete the general enrollment roster (columns 1-4)for **ALL current residents and any new admissions.** Add new admissions on an ongoing basis.	Business Office Manager	12/10
Step 3	Obtain the Medicare Enrollment form from your local Social Security Office.	Social Service	12/20
Step 4	If resident is determined not to have Medicare, research the resident's financial folder and eligibility status.	Business Office Manager	1/20
Step 5	Discuss with resident or Responsible party the benefits of completing an application for enrollment in Medicare and the financial implications to the resident and/or responsible party.	Social Service	1/30
Step 6	Complete applications for ALL residents without Medicare.	Social Service	2/10
Step 7	Submit the Application to Social Security.	Social Service	2/10
Step 8	File all completed applications in financial order.	Business Office Manager	2/10
Step 9	Follow up with Social Security office following submission of applications.	Social Service	3/10
Step 10	Update roster (column 6 & 7) with responses from Social Security office.	Social Service	3/10
Step 11	**Complete the process for ANY new admissions (without Medicare benefits) admitted between January 1 – March 31**	**MDS Coordinator**	**3/31**

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Medicare Program

Request for Information From Social Security Records

Individual's Name: _____
First M.I. Last

Social Security Number: _____ – – ____

Date of Birth: _____/_____/_____
Month Day Year

Medicare Claim Number: _____

I authorize Social Security to release verification of my Medicare claim number, Medicare eligibility dates, or date of birth to:

_____
Name of Facility Requesting Information

_____ _____
Signature of Individual Date

Please Provide (check appropriate lines)

_____ 1) Verification of eligibility to Medicare

_____ Part A Hospital
_____ Part B Medical

Part A date = _____
Part B date = _____
for SSA use only

_____ 2) Verification of Medicare Claim Number

for SSA use only

_____ 3) Verification of Date of Birth:

for SSA use only

Name of Person Requesting Information: ___
Phone Number: ( ) –

_____
Signature of SSA employee providing information

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Suffixes

Suffixes to Medicare Numbers

Letter Suffix	What Suffix Means
A	Primary Claimant (Wage, Earner, retirement, old age of disability)
B	Aged wife, age 62 or over
B1	Aged husband, age 62 or over
B2	Young wife, with a child in her care
B3	Aged wife, aged 62 or over, second claimant
B5	Young wife, with a child in her care, second claimant
B6	Divorced wife, age 62 or over
BY	Young husband, with a child in his care
C1-C9	Child-includes minor, student or siabled child
D	Aged Widow, age 60 or over
D1	Aged widower, age 60 or over
D2	Aged widow (2nd claimant)
D3	Aged widower (2nd claimant)
D6	Surviving Divorced Wife, aged 60 or over
E	Mother (widow)
E1	Surviving Divorced Mother
E4	Widowed Father
E5	Surviving Divorced Mother
F1	Parent (Father
F2	Parent (Mother)
F3	Stepfather
F4	Stepmother
F5	Adopting Father
F6	Adopting Mother
HA	Disabled claimant (wage earner)
HB	Aged wife of disabled claimant, age 62 or over
M	Uninsured – Premium Health Insurance Benefits (Part A)
M1	Uninsured -Qualified for but refused Health Insurance Benefits (Part A)
T	Uninsured- Entitled to HIB (Part A) under deemed or renal provisions; or Fully insured who have elected entitlement only HIB
TA	Medicare Qualified Government Employment (MQGE)

TB	MQGE aged spouse
W	Disabled Widow
W1	Disabled Widower
W6	Disabled Surviving Divorced Wife
Note: This list is not complete, but captures the most common beneficiary codes. The meaning of the letter suffix does not affect the processing of a Medicare claim. However, one should be aware that there will always be a letter suffix on the HIC number, and the suffix may change. Changes in suffix letter could require a resubmission of a claim.	

Clinical Eligibility Requirements

A beneficiary is eligible for post hospital extended care if the following requirements are met:

- Beneficiary's need for and receipt of skilled care on a daily basis approved by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter these skilled services can only be provided in a SNF.
- Services must be needed for a condition which was treated during the patient's qualifying stay

  OR

  For a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

Technical Eligibility Requirements

Technical eligibility remains per the Medicare Intermediary Manual (MIM-3) and the Skilled Nursing Facility Manual (HIM-12).

- Enrolled in Medicare Part A and has days available to use.
- Three-day qualifying prior hospital stay.
- Thirty-day transfer.

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Part A Eligibility

Eligibility: An individual meets the technical and clinical criteria to access their Medicare benefit.

Technical

- Beneficiary is enrolled to access Medicare Part A benefits.
  - Verify beneficiary's Medicare card
- Beneficiary has had a **qualifying hospital stay**.
  - Was on hospital census for at least three consecutive midnights.
  - Hospital stay was covered by Medicare Part A.
- Beneficiary is admitted to a **Medicare Certified Bed**.
- Beneficiary has **benefit days available** in spell of illness/benefit period.
- Physician must **order, certify and recertify** the need for daily skilled services.
  - Day of admission, within 14 days of date of admission, and subsequently every 30 days up to 100 days
- Beneficiary is admitted to a SNF **within thirty days** after discharge from a hospital or the last covered Medicare day of a SNF stay.
  - Assuming benefit days are available

Clinical

- Beneficiary requires a **daily skilled service** that is a continuation of care for the same illness, injury or related condition for which the patient was admitted to the hospital, or for a condition that arose and/or was treated while an inpatient in the hospital or SNF.
  - Nursing and/or Rehabilitation
- As a **practical matter,** considering economy and efficiency, the daily skilled service can be provided only on an inpatient basis in a SNF.
- Services are **reasonable and necessary** for treatment of the illness or injury.
  - Consistent with the nature and severity of the illness or injury.
  - The medical needs are within accepted standards of medical practice.
  - The services are reasonable in terms of duration and quality.

All of the above conditions must be met for coverage

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Medicare Program

Part B Eligibility

Eligibility: An individual meets the technical and clinical criteria to access their Medicare benefit.

- Beneficiary is enrolled in Medicare Part B benefits.
  - Verify beneficiary's Medicare card.
- Physician must **order, certify and recertify** the services to be rendered every 30 days (therapies require certification every 90 days).
- Services must be **skilled.**
- Services must be **reasonable and necessary.**
- Appropriate documentation in the medical record to support Medicare Part B Coverage.
  - The medical needs are within accepted standards of medical practice.
  - The services are reasonable in terms of duration and quality.

All of the above conditions must be met for coverage

Physician Certification and Recertification

Medicare requires that the physician certify and re-certify the resident's need of skilled care. (See Code of Federal Regulations 42 CFR Ch. IV §424.20). Physician certification and recertification are not new requirements for SNF care under PPS. However, in past years, physician certification and re-certification were not primary areas of review by the intermediaries or MACs. Since the inception of PPS, SNF's are finding that physician certifications and re-certifications are primary areas for evaluation by the intermediaries or MACs.

The physician's certification/recertification is a condition by payment. **This certification is not required to be written on any specific forms, not in a specific location within the chart. The physician may use a Physical Certification and Re-certification form, note the need for skilled care in his/her physician progress notes, etc**., as long as the certification is made within the time frames specified within the Federal Regulations. Federal certification time frames are:

The first certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.

- The first recertification is required no later than the 14th day of post-hospital SNF care.
- Subsequent recertifications are required at least every 30 days after the first certification.

Certification

- Must be signed on admission or as soon thereafter as possible by the physician.
- MUST BE DATED.
- Must state the reason(s) services are required.

Re-certification

- First re-certification must be signed on or before the 14th day by the physician.
- Subsequent recertifications must be signed at intervals which may not exceed 30 days.
- MUST BE DATED.
- Re-certification must contain a reason for the continued stay, an estimate of how long skilled care will be needed and discharge plans.

Signatures

- Certifications and recertifications may be signed by the physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of any emergency and has knowledge of the case; or
- A physician assistant, nurse practitioner or clinical nurse specialist who is working in collaboration with a physician and not employed by the facility.

If the certification or recertification is not timely, then you must obtain a delayed certification from the physician the delay must be explained. The certification form is maintained within the facility records. The Code of Federal Regulation's notes that delayed certifications/re-certifications are acceptable when "there is a legitimate reason for delay". A resident being unaware of his or her entitlement when treatment is rendered is considered a legitimate delay. The statement must explain the reason for the delay. A delayed certification may be included with one or more recertifications on a single signed statement.

Harmony Healthcare INTERNATIONAL

Medicare Program

Physician Certification and Re-Certification Form

Patient _____ Admission Date _____ Health Insurance Claim Number _____

Certification

Of a patient admission. Required at time of admission

I certify that SNF services are required to be given on an inpatient basis because of the above named patient's needs for skilled nursing care on a continuing basis for the condition (s) for which he/she was receiving inpatient hospital services prior to he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

_____ _____

(Physician's Signature) (Time and Date)

Recertification

Of continued SNF inpatient care. On or before the 14th

I certify that continued SNF inpatient care is necessary for the following reason (s):

_____

_____

I estimate that the additional period of SNF inpatient care will be ____ days (or ___weeks.

Plans for post-SNF care are: ___ Home Health Agency ___ Office Care Other (specify)

_____

Date Due_____

Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

_____ _____

(Physician's Signature) (Date)

Recertification

Of continued SNF inpatient care. 30 days from previous certification date.

I certify that continued SNF inpatient care is necessary for the following reason (s):

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be ____ days (or ___weeks.

Plans for post-SNF care are: ___ Home Health Agency ___ Office Care Other (specify)

Date Due_____

Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

_____ _____

(Physician's Signature) (Date)

Recertification

Of continued SNF inpatient care. 30 days from previous certification date.

Date Due_____

I certify that continued SNF inpatient care is necessary for the following reason (s):

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be ____ days (or ___weeks. Plans for post-SNF care are: ___ Home Health Agency ___ Office Care ___ Other (specify)

Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

_____ _____

(Physician's Signature) (Date)

Ambulance Service

I hereby certify that ambulance service was medically necessary for the above named patient.

_____ _____

(Physician's Signature) (Date)

Medicare Program

Physician certification and re-certification form

Patient	Admission date	Health Insurance Claim Number
Sally Sample	*4/15/09*	*123-456-7890*

Certification
of a patient admission.
Required at time of admission.

I certify that SNF services are required to be given on an inpatient basis because of the above named patient's needs for skilled nursing care on a continuing basis for the condition (s) for which he/she was receiving inpatient hospital services prior to he/she was receiving inpatient hospital services prior to his/her transfer to the SNF.

_____ (PHYSICIAN'S SIGNATURE)

4/15/09 2:20 pm (TIME AND DATE)

Recertification
of continued SNF inpatient care. On or before the 14th day.

I certify that continued SNF inpatient care is necessary for the following reason (s):
Daily skilled nursing for multiple wound care.

I estimate that the additional period of SNF inpatient care will be 45 days (or ___weeks.
Plans for post-SNF care are: ___ Home Health Agency ___ Office Care __x__ Other (specify)
Patient to remain in LTC environment.

Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

Date Due *4/22/09*

_____ (PHYSICIAN'S SIGNATURE)

4/28/00 (DATE)

Recertification
of continued SNF inpatient care. 30 days from previous certification date.

I certify that continued SNF inpatient care is necessary for the following reason (s):
_____
_____
_____

I estimate that the additional period of SNF inpatient care will be ____ days (or ___weeks.
Plans for post-SNF care are: ___ Home Health Agency ___ Office Care ___ Other (specify)
Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

Date Due_____

_____ (PHYSICIAN'S SIGNATURE)

_____ (DATE)

RECERTIFICATION
of continued SNF inpatient care. 30 days from previous certification date.

I certify that continued SNF inpatient care is necessary for the following reason (s):
_____
_____
_____

I estimate that the additional period of SNF inpatient care will be ____ days (or ___weeks.
Plans for post-SNF care are: ___ Home Health Agency ___ Office Care ___ Other (specify)
Continued SNF care is for same condition (s) for which patient received inpatient hospital services:

Date Due_____

_____ (PHYSICIAN'S SIGNATURE)

_____ (DATE)

Ambulance Service

I hereby certify that ambulance service was medically necessary for the above named patient.

_____ (PHYSICIAN'S SIGNATURE)

_____ (DATE)

Harmony Healthcare International (HHI)
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Therapy Certification and Establishment of The Treatment Plan

Establishing the plan: The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).

The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan, which is described below, is not the same as certifying the plan, which is described in §§220.1.1 and 220.1.3

Outpatient therapy services shall be furnished under a plan established by:

- A physician/NPP (consultation with the treating physical therapist, occupational therapist, or speech-language pathologist is recommended. Only a physician may establish a plan of care in a CORF;
- The physical therapist who will provide the physical therapy services;
- The occupational therapist who will provide the occupational therapy services; or
- The speech-language pathologist who will provide the speech-language pathology services.

The plan may be entered into the patient's therapy record either by the person who established the plan or by the provider's or supplier's staff when they make a written record of that person's oral orders before treatment is begun.

Treatment under a Plan: The evaluation and treatment may occur and are both billable either on the same day or at subsequent visits. It is appropriate that treatment begins when a plan is established.
Therapy may be initiated by qualified professionals or qualified personnel based on a dictated plan. Treatment may begin before the plan is committed to writing only if the treatment is performed or supervised by the same clinician who establishes the plan. Payment for services provided before a plan is established may be denied.

Two Plans: It is acceptable to treat under two separate plans of care when different physician's/NPP's refer a patient for different conditions. It is also acceptable to combine the plans of care into one plan covering both conditions if one or the other referring physician/NPP is willing to certify the plan for both conditions. The treatment notes continue to require timed code treatment minutes and total treatment time and need not be separated by plan. Progress reports should be combined if it is possible to make clear that the goals for each plan are addressed. Separate progress reports referencing each plan of care may also be written, at the

discretion of the treating clinician, or at the request of the certifying physician/NPP, but shall not be required by contractors.

B. Contents of Plan (See §220.1.3 for certifying the plan.)

The plan of care shall contain, at minimum, the following information as required by regulation (42CFR424.24, 410.61, and 410.105(c) (for CORFs)). (See §220.3 for further documentation requirements):

- Diagnoses;
- Long term treatment goals; and
- Type, amount, duration and frequency of therapy services.

The plan of care shall be consistent with the related evaluation, which may be attached and is considered incorporated into the plan. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

Long term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. When episodes in the setting are short, measurable goals may not be achievable; documentation should state the clinical reasons progress cannot be shown. The functional impairments identified and expressed in the long-term treatment goals must be consistent with those used in the claims-based functional reporting, using nonpayable G-codes and severity modifiers, for services furnished on or after January 1, 2013. (Reference: 42CFR410.61 and 42CFR410.105 (for CORFs)

The amount of treatment refers to the number of times in a day the type of treatment will be provided. Where amount is not specified, one treatment session a day is assumed.

The frequency refers to the number of times in a week the type of treatment is provided. Where frequency is not specified, one treatment is assumed. If a scheduled holiday occurs on a treatment day that is part of the plan, it is appropriate to omit that treatment day unless the clinician who is responsible for writing progress reports determines that a brief, temporary pause in the delivery of therapy services would adversely affect the patient's condition.

The duration is the number of weeks, or the number of treatment sessions, for THIS PLAN of care. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification of a plan, it is desirable, although not required, that the clinician also estimate the duration of the entire episode of care in this setting.

The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients' goals. For example, it may be clinically appropriate, medically necessary, most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals' needs.

Certification of the Plan of Care

Method and Disposition of Certifications

Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. It is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment. Since delayed certification is allowed, the date the certification is signed is important only to determine if it is timely or delayed. The certification must relate to treatment during the interval on the claim. Unless there is reason to believe the plan was not signed appropriately, or it is not timely, no further evidence that the patient was under the care of a physician/NPP and that the patient needed the care is required.

The format of all certifications and re-certifications and the method by which they are obtained is determined by the individual facility and/or practitioner. Acceptable documentation of certification may be, for example, a physician's progress note, a physician/NPP order, or a plan of care that is signed and dated by a physician/NPP, and indicates the physician/NPP is aware that therapy service is or was in progress and the physician/NPP makes no record of disagreement with the plan when there is evidence the plan was sent (e.g., to the office) or is available in the record (e.g., of the institution that employs the physician/NPP) for the physician/NPP to review.

For example, if during the course of treatment under a certified plan of care a physician sends an order for continued treatment for 2 more weeks, contractors shall accept the order as certification of continued treatment for 2 weeks under the same plan of care. If the new certification is for less treatment than previously planned and certified, this new certification takes the place of any previous certification. At the end of the 2 weeks of treatment (which might extend more than 2 calendar weeks from the date the order/certification was signed) another certification would be required if further treatment was documented as medically necessary.

The certification should be retained in the clinical record and available if requested by the contractor.

214. Covered Level of Care – General

Care in a Skilled Nursing Facility is covered if all of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§214.1 – 214.3);

- The patient requires these skilled services on a daily basis (see §214.5);

- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a Skilled Nursing Facility (see §214.6).

If any one of these three factors is not met, a stay in a Skilled Nursing Facility, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care **could not be made** if a patient needs an **intermittent** rather than daily skilled service.

In determining whether the level of care requirements are met, the first consideration should be whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements do not have to be addressed.

In addition, the services must be furnished pursuant to a physician's order and be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Example 1: *Even though the irrigation of a catheter may be a skilled nursing service, daily irrigations may not be "reasonable and necessary" for the treatment of a patient's illness or injury.*

214.1 Skilled Nursing and Skilled Rehabilitation Services

A. Skilled Services – Defined skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Note: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Assume that skilled services provided by a participating SNF are furnished by or under the general supervision of the appropriate skilled nursing or skilled rehabilitation personnel.

B. Principles for Determining Whether a Service is Skilled

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The nature of the service and the skills required for safe and effective delivery of that service are considered in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

Example: Even where a patient's full or partial recovery is not possible, a skilled service still could be needed to **prevent deterioration** or to **maintain current capabilities**. A cancer patient, for instance, whose prognosis is terminal may require skilled services at various stages of his illness in connection with periodic "tapping" to relieve fluid accumulation and nursing assessment and

intervention to alleviate pain or prevent deterioration. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel (see §214.3.A).

- A service that is ordinarily considered non-skilled could be considered skilled service in cases in which, because of special medical complications, skilled nurses or skilled rehabilitation personnel are required to perform or supervise it or to observe patient. In these cases, the complications and special services involved must be documented by physician's orders and nursing or therapy notes.

Example: The existence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, a patient with a preexisting acute skin problem, pre-existing peripheral vascular disease, or a need for special traction of the injured extremity might need skilled nursing or skilled rehabilitation personnel to observe for complications or to adjust traction.

Example: Whirpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition was complicated by circulatory deficiency, areas of desensitization, or open wounds.

- In determining whether services rendered in a Skilled Nursing Facility constitutes covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

Example: An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent and has a Grade 1 decubitus ulcer and is unable to communicate and make her needs known. Even though the specific service provided is unskilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, observe the patient's progress, and to evaluate the need for changes in the treatment plan.

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

Example: A primary need of a nonambulatory patient may be frequent changes in position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service even though such services are obviously necessary.

The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

C. Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

1. Management and Evaluation of a Patient Care Plan. The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. Skilled management would be required where the sum total of unskilled services which are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety.

Example 1: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is

essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and not require skilled nursing personnel.

Example 2: An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled oversight of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

2. **Observation and Assessment of Patient's Condition.** Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized.

Example 1: A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine when the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized.

Example 2: A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin of the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required.

Example 3: A patient has undergone hip surgery and has been transferred to a Skilled Nursing Facility. Skilled observation and monitoring of the patient is necessary for possible adverse reaction to the operative procedure, development of phlebitis, breakdown, or need for the administration of subcutaneous Heparin.

Example 4: A patient has been hospitalized following a heart attack. Following treatment but before mobilization, he is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated and continued until the patient's treatment regimen is essentially stabilized.

Example 5: A frail 85-year-old man was hospitalized for pneumonia. The infection resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to a SNF for monitoring of fluid and nutrient intake and the assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration.

Example 6: A patient/resident left the acute hospital on a high dosage of Coumadin with daily clotting time studies. Coumadin is reimbursable until a maintenance dosage is attained and the patient/resident shows no adverse symptoms. **Do not deny if the dosage is not regulated on a daily basis**. Regulation is an integral part of this patient/resident's coverage. Ongoing observation and assessment, notifying the physician and multiple changes in the plan of care, are also skilled in nature.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was reasonable probability for such a complication or further acute episode "Reasonable probability" means that a potential complication or further acute episode is a likely possibility.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to the physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders precluded by law from participating in Medicare.) Therefore, these cases must carefully be documented.

3. Teaching and Training Activities. Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

D. Questionable Situations. There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

- The primary service needed is oral medication; or
- The patient is capable of independent ambulation, dressing, feeding, and hygiene.

214.2 Direct Skilled Nursing Services to Patients. Some examples of direct skilled nursing services are:

- Intravenous injections;
- Intravenous feedings;
- Nasogastric tube, gastrostomy, and jejunostomy feedings;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheter;
- Application of dressings involving prescription medications and aseptic techniques (see §214.4 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage III or worse, or widespread skin disorder (see §214.4 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress (see §214.4 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early postoperative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

214.3 Direct Skilled Rehabilitation Services to Patients

A. Skilled Physical Therapy

1. General. Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an **active written treatment plan** designed by the physician after any needed consultation with a qualified physical therapist;

- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and **skills of a qualified physical therapist;**

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the **condition** of the patient will **improve materially in a reasonable and generally predictable period of time**, or the services must be necessary for the establishment of a safe and effective maintenance program;

- The services must be considered under accepted standards of medical practice to be **specific and effective treatment** for the patient's condition; and

- The services must **be reasonable and necessary** for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Example 1: An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.

Example 2: A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulatory status, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of

the patient's total condition, the physical therapy services are reasonable and necessary.

If the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results, the physical therapy would not be reasonable and necessary, and thus would not be covered skilled physical therapy services.

Many SNF inpatients do not require skilled physical therapy services but do require services which are routine in nature. Those services can be performed by supportive personnel; e.g., aides or nursing personnel, without the supervision of a physical therapist. Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

2. Application of Guidelines. Some of the more common physical therapy modalities and procedures are:

a. Assessment. The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measures of range of motion, strength, balance, coordination, endurance, and functional ability.

b. Therapeutic Exercises. Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

c. Gait Training. Gait evaluation and training furnished to a patient when the ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy if they reasonably can be expected to improve the patient's ability to walk significantly.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

d. Range of Motion. Only the qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy. Range of motion

exercises constitute skilled physical therapy only if they are part of actual treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost to the degree to be restored).

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care.

e. Maintenance Therapy. The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services (see §214.1.B). The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

Example: A Parkinson's patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine which type of exercises are required for the maintenance of his present level of function. The initial evaluation of the patient's needs, the designing of the maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, and such infrequent reevaluations as may be required, would constitute skilled physical therapy.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last restorative session, the physical therapist will have already designed the maintenance program required and instructed the patient or support personnel in the carrying out of the program.

Skilled Maintenance Therapy for Safety: If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may

be necessary for the safe and effective delivery of such services. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

Example: Where there is an unhealed, unstable fracture, which requires regular exercise to maintain function until the fracture heals, the skills of a therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

f. Ultrasound, Shortwave and Microwave Diathermy Treatments. The modalities must always be performed by or under the supervision of qualified physical therapist and are skilled physical therapy.

g. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths. Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case e.g., where the patient's condition is complicated by circulatory deficiency, areas desensitization, open wounds, fractures or other complications.

B. Speech Pathology – See §230.3.B

C. Occupational Therapy – See §230.3.C

214.4 Nonskilled Supporting or Personal Care Services. The following services are not skilled services unless rendered under circumstances detailed in §214.1.B:

- Administration of routine oral medications, eye drops, and ointments. The fact that a patient cannot be relied upon to take such medications himself or that State law requires all medications to be dispensed by a nurse to institutional patients would not change their service to a skilled service);
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying containers and cleaning them and clamp tubing);
- Changes of dressings for noninfected postoperative or chronic conditions;

- Prophylactic and palliative skin care, including bathing and application creams, or treatment of minor skin problems;
- Routine care of the incontinent patient, including use of diapers and protective sheets;
- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin circulatory condition or needs to have traction adjusted);
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and
- General supervision of exercises which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking) (see §230.3.A.2(d)).

214.5 Daily Skilled Services – Defined. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis", i.e., on essentially a 7-day-a-week basis. However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when he needs and receives those services on at least 5 days a week. Accordingly, if a facility provides physical therapy on only 5 days a week and a patient in the facility requires and receives physical therapy on each of those days, the requirement that skilled rehabilitation services be provided on a daily basis is meet. (If the services are available less than 5 days a week, though, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

Example: A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

Benefit Period (Spell of Illness)

Description

A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient can be paid by the hospital insurance plan. A patient is eligible for 100 days of skilled nursing facility services during a benefit period. As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods he/she may have. The term "benefit period" is synonymous with spell of illness.

Starting a Benefit Period

A benefit period begins the first day on which a patient is furnished inpatient hospital or Skilled Nursing Facility (SNF) services (by a qualified provider) after entitlement to hospital insurance begins. The date of discharge from any inpatient or SNF stay will count as the first day of a new benefit period. A transfer from one hospital to another is not considered a discharge even if the transfer is considered a discharge under the Prospective Payment System (PPS). A leave of absence is not considered a discharge from the hospital. Admission to a qualified SNF or to the SNF level of care in a swing bed hospital *begins a benefit period even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met*.

Ending a Benefit Period

A benefit period ends when a beneficiary has not been an inpatient of a hospital or an inpatient of any SNF for 60 consecutive days, the benefits will be renewed for full and coinsurance days only.

To determine the 60 consecutive day period, begin counting with the day the individual was discharged. A benefit period cannot end while a beneficiary is an inpatient of a SNF where the SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

Benefit Period Examples

Example 1: Ms. Jones enters the SNF on October 20. She is discharged on January 24. She has used 20 full SNF and 74 coinsurance days of her first benefit period. Ms. Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital or SNF stays, she begins a new benefit period. Her Part A coverage is completely renewed.

Example 2: Mr. Greene enters the SNF on December 15. His benefits are exhausted on March 23. His skilled level of care continues until April 10. He is at a non-skilled level of care from April 11 to April 19. On April 20, Mr. Greene's skilled level of care resumes even though benefits are exhausted because Mr. Greene's level of care is now skilled, Mr. Greene is still in his first benefit period. Mr. Greene will not begin a new benefit period until he is out of the hospital (and has not received any skilled care in a SNF for 60 consecutive days).

Example 3: Mr. Smith enters the hospital on March 20. He is discharged from the hospital and admitted to the SNF for skilled level of care services on March 22. Although Mr. Smith was not hospitalized for at least three days, the benefit period for utilization purposes will still be extended as long as Mr. Smith remains at a skilled level of care.

The spell of wellness is communicated to Medicare thought the no pay bill system.

Benefit Period Calculation

When calculating a resident's 100 days of Medicare Part A coverage, always include any days previously used in another skilled nursing facility.

The following days are not included in the attached 100 day calculation table:

- Days a resident was not in a facility – hospital, home, etc.
- Days of discharge from facility.

100 Day Calculation

1. Leap Year Not Included.
2. When calculating, be sure to count days used in another facility. **do not count** Hospital Days

Admit Date	Day 100	Admit Date	Day 100	Admit Date	Day 100	Admit Date	Day 100
01/01	04/10	02/17	05/27	04/05	07/13	05/22	08/29
01/02	04/11	02/18	05/28	04/06	07/14	05/23	08/30
01/03	04/12	02/19	05/29	04/07	07/15	05/24	08/31
01/04	04/13	02/20	05/30	04/08	07/16	05/25	09/01
01/05	04/14	02/21	05/31	04/09	07/17	05/26	09/02
01/06	04/15	02/22	06/01	04/10	07/18	05/27	09/03
01/07	04/16	02/23	06/02	04/11	07/19	05/28	09/04
01/08	04/17	02/24	06/03	04/12	07/20	05/29	09/05
01/09	04/18	02/25	06/04	04/13	07/21	05/30	09/06
01/10	04/19	02/26	06/05	04/14	07/22	05/31	09/07
01/11	04/20	02/27	06/06	04/15	07/23	06/01	09/08
01/12	04/21	02/28	06/07	04/16	07/24	06/02	09/09
01/13	04/22	03/01	06/08	04/17	07/25	06/03	09/10
01/14	04/23	03/02	06/09	04/18	07/26	06/04	09/11
01/15	04/24	03/03	06/10	04/19	07/27	06/05	09/12
01/16	04/25	03/04	06/11	04/20	07/28	06/06	09/13
01/17	04/26	03/05	06/12	04/21	07/29	06/07	09/14
01/18	04/27	03/06	06/13	04/22	07/30	06/08	09/15
01/19	04/28	03/07	06/14	04/23	07/31	06/09	09/16
01/20	04/29	03/08	06/15	04/24	08/01	06/10	09/17
01/21	04/30	03/09	06/16	04/25	08/02	06/11	09/18
01/22	05/01	03/10	06/17	04/26	08/03	06/12	09/19
01/23	05/02	03/11	06/18	04/27	08/04	06/13	09/20
01/24	05/03	03/12	06/19	04/28	08/05	06/14	09/21
01/25	05/04	03/13	06/20	04/29	08/06	06/15	09/22
01/26	05/05	03/14	06/21	04/30	08/07	06/16	09/23
01/27	05/06	03/15	06/22	05/01	08/08	06/17	09/24
01/28	05/07	03/16	06/23	05/02	08/09	06/18	09/25
01/29	05/08	03/17	06/24	05/03	08/10	06/19	09/26
01/30	05/09	03/18	06/25	05/04	08/11	06/20	09/27
01/31	05/10	03/19	06/26	05/05	08/12	06/21	09/28
02/01	05/11	03/20	06/27	05/06	08/13	06/22	09/29
02/02	05/12	03/21	06/28	05/07	08/14	06/23	09/30
02/03	05/13	03/22	08/29	05/08	08/15	06/24	10/01
02/04	05/14	03/23	08/30	05/09	08/16	06/25	10/02
02/05	05/15	03/24	07/01	05/10	08/17	06/26	10/03
02/06	05/16	03/25	07/02	05/11	08/18	06/27	10/04
02/07	05/17	03/26	07/03	05/12	08/19	06/28	10/05
02/08	05/18	03/27	07/04	05/13	08/20	06/29	10/06
02/09	05/19	03/28	07/05	05/14	08/21	06/30	10/07
02/10	05/20	03/29	07/08	05/15	08/22	07/01	10/08
02/11	05/21	03/30	07/07	05/16	08/23	07/02	10/09
02/12	05/22	03/31	07/08	05/17	08/24	07/03	10/10
02/13	05/23	04/01	07/09	05/18	08/25	07/04	10/11
02/14	05/24	04/02	07/10	05/19	08/26	07/05	10/12
02/15	05/25	04/03	07/11	05/20	08/27	07/06	10/13
02/16	05/26	04/04	07/12	05/21	08/28	07/07	10/14

Medicare Program

Harmony Healthcare INTERNATIONAL

100 Day Calculation

1. Leap Year Not Included.
2. When calculating, be sure to count days in used in another facility. **do not count** Hospital Days

Admit Date	Day 100	Admit Date	Day 100	Admit Date	Day 100	Admit Date	Day 100
07/08	10/15	08/21	11/28	10/04	01/11	11/17	02/24
07/09	10/16	08/22	11/29	10/05	01/12	11/18	02/25
07/10	10/17	08/23	11/30	10/06	01/13	11/19	02/26
07/11	10/18	08/24	12/01	10/07	01/14	11/20	02/27
07/12	10/19	08/25	12/02	10/08	01/15	11/21	02/28
07/13	10/20	08/26	12/03	10/09	01/16	11/22	03/01
07/14	10/21	08/27	12/04	10/10	01/17	11/23	03/02
07/15	10/22	08/28	12/05	10/11	01/18	11/24	03/03
07/16	10/23	08/29	12/06	10/12	01/19	11/25	03/04
07/17	10/24	08/30	12/07	10/13	01/20	11/26	03/05
07/18	10/25	08/31	12/08	10/14	01/21	11/27	03/06
07/19	10/26	09/01	12/09	10/15	01/22	11/28	03/07
07/20	10/27	09/02	12/10	10/16	01/23	11/29	03/08
07/21	10/28	09/03	12/11	10/17	01/24	11/30	03/09
07/22	10/29	09/04	12/12	10/18	01/25	12/01	03/10
07/23	10/30	09/05	12/13	10/19	01/26	12/02	03/11
07/24	10/31	09/06	12/14	10/20	01/27	12/03	03/12
07/25	11/01	09/07	12/15	10/21	01/28	12/04	03/13
07/26	11/02	09/08	12/16	10/22	01/29	12/05	03/14
07/27	11/03	09/09	12/17	10/23	01/30	12/06	03/15
07/28	11/04	09/10	12/18	10/24	01/31	12/07	03/16
07/29	11/05	09/11	12/19	10/25	02/01	12/08	03/17
07/30	11/06	09/12	12/20	10/26	02/02	12/09	03/18
07/31	11/07	09/13	12/21	10/27	02/03	12/10	03/19
08/01	11/08	09/14	12/22	10/28	02/04	12/11	03/20
08/02	11/09	09/15	12/23	10/29	02/05	12/12	03/21
08/03	11/10	09/16	12/24	10/30	02/06	12/13	03/22
08/04	11/11	09/17	12/25	10/31	02/07	12/14	03/23
08/05	11/12	09/18	12/26	11/01	02/08	12/15	03/24
08/06	11/13	09/19	12/27	11/02	02/09	12/16	03/25
08/07	11/14	09/20	12/28	11/03	02/10	12/17	03/26
08/08	11/15	09/21	12/29	11/04	02/11	12/18	03/27
08/09	11/16	09/22	12/30	11/05	02/12	12/19	03/28
08/10	11/17	09/23	12/31	11/06	02/13	12/20	03/29
08/11	11/18	09/24	01/01	11/07	02/14	12/21	03/30
08/12	11/19	09/25	01/02	11/08	02/15	12/22	03/31
08/13	11/20	09/26	01/03	11/09	02/16	12/23	04/01
08/14	11/21	09/27	01/04	11/10	02/17	12/24	04/02
08/15	11/22	09/28	01/05	11/11	02/18	12/25	04/03
08/16	11/23	09/29	01/06	11/12	02/19	12/26	04/04
08/17	11/24	09/30	01/07	11/13	02/20	12/27	04/05
08/18	11/25	10/01	01/08	11/14	02/21	12/28	04/06
08/19	11/26	10/02	01/09	11/15	02/22	12/29	04/07
08/20	11/27	10/03	01/10	11/16	02/23	12/30	04/08
						12/31	04/09

Medicare Program

Benefit Period

Resident:_____ RM #_____ Date:_____

Hosp Admit:_____ Hosp Disch:_____

DX:_____

Skilled Services:_____

Orders for Therapy to Eval. and Treat. on Admit Date:_____ Mins. Est. Therapy:_____

SNF Admit:_____ Expected SNF Disch_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
Jan																																
Feb																																
Mar																																
Apr																																
May																																
Jun																																
Jul																																
Aug																																
Sept																																
Oct																																
Nov																																
Dec																																

Legend

A = SNF Admit
E = End Dates (for MDS)
30 = 30 Day Assessment
T = Total Days Used
H = Hosp
5 = 5 Day Assessment
60 = 60 Day Assessment
90 = 90 Day Assessment
D = Discharge
O = PPS Observation Days
14 = 14 Day Assessment

214.6 Services Provided on an Inpatient Basis as a "Practical Matter". In determining whether the daily skilled care needed by an individual can, as a "practical matter", only be provided in a Skilled Nursing Facility on an inpatient basis, the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services are considered.

As a "practical matter", daily skilled services can be provided only in a Skilled Nursing Facility if they are not available on an outpatient basis in the area in which the individual resides and transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting

The availability at home of capable and willing family or the feasibility of obtaining other assistance for the patient should be considered. Even though needed daily skilled service might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

Example: A patient undergoing restorative physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk of further injury from falling, of dehydration or of malnutrition because insufficient supervision or assistance could be arranged for the patient in his home. Under these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

A. The Availability of Alternative Facilities or Services. Alternative facilities or services may be available to a patient if health care providers such as home health agencies are utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

Example: Where the residents of a rural community general utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is

available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage and noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that such care cannot be covered by Medicare is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from independently practicing physical therapist. However, the fact that Medicare reimbursement could not be made for the services because the $500 expense limitation applicable to the services of an independent physical therapist had been exceeded because the patient was not enrolled in Part B, would not be a basis for determining that as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternative services is not a factor to be considered.

B. Whether Available Alternatives are More Economical in the Individual Case. If a generally more economical care alternative is available to provide the needed care, whether the use of the alternative actually would be more economical in the individual case is considered.

Example 1: If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

Example 2: If needed care could be provided in the home, but the patient's residence so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

C. Whether the Patient's Physical Condition Would Permit Him to Utilize an Available More Economical Care Alternative. In determining the practicality of using more economical care alternatives, the patient's medical condition should be considered. If the use of those alternatives would adversely affect the patient's medical condition then as a practical matter the daily skilled services can only be provided by an SNF on an inpatient basis.

If the use of a care alternative involves transportation of the individual on a daily basis whether daily transportation would cause excessive physical hardship is considered. Determinations on

whether a patient's condition would be adversely affected if available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely affected by daily transportation to a care facility, even though he is able to ambulate to some extent.

Example: A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs with safety. The patient lives alone in a second floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are only available in a CORF one mile away from her apartment. However, because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SNF.

The "practical matter" criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring a SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF for the receipt of his or her required skilled care. Very often special arrangements, not feasible on a daily basis, have had to be made to allow the absence from the facility. Where frequent or prolonged periods away from the SNF become possible, however, then questions as to whether the patient's care can, as a practical matter, only be furnished on an inpatient basis in an SNF may be raised. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences. (see §242.3 for counting inpatient days during a leave of absence).

A conservative approach to retain the presumption for waiver of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If a SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not. (see §356.2, Improper SNF Coverage Decisions).

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Medicare Program

Therapeutic Pass
Therapeutic Pass Form

Patient Name: Ima R. Sample Medical Record #: 1234

Unit : I Room: 213 A

Physician: Dr. Flinstone

Physician Order: Date pass: 07/04/2011 Time Out: 11:30 a.m. Time Returned: 6:00 p.m.

Person to accompany patient on pass:

Name: Ulma B. Sample

Relationship to patient: Daughter

Medication	Dose	Route	Times	Special Instructions
Macrodantin	50 mg	p.o.	5:00 pm	Take with meal

Safety issues: Unsteady on feet, needs assist with transfers, uses walker, stand by assist.

Preventative instructions: Ensure clean pathways, watch physical barriers.

Complications to watch for: Nausea related to medication.

Emergency instructions: Call physician at 1-(234) 567-8910.

N. Nurse RN

Nurse's Signature

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Leave Of Absence

The Practical Matter criterion of the CMS Publication 12 cautions that frequent or prolonged periods away from the SNF could raise questions as to whether the patient's care can, as a practical matter, be furnished only in a SNF. Decisions regarding the need for SNF care are based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements for the provision, if any, of this care during any absences. CMS also cautions against notifying patients that leaving the facility will result in denial of coverage.

Note: Standard leave of absence orders should not be obtained for the Medicare Part A patient as this may jeopardize Medicare coverage.

Most patients receiving Medicare Part A coverage are unable to leave the facility due to physical or medical conditions and the risk of complications. However, for those patients requesting to leave the facility for brief periods (four hours or less), it is recommended that a physician order be obtained stating: "patient may go out of the facility for a therapeutic pass with a responsible person for a few hours."

Holidays are the most common days patients and families request a therapeutic pass.

Document in the nursing note that instructions were given to the responsible person regarding:

- Emergency protocol
- Symptoms which may occur
- Diet restrictions and necessary monitoring

Upon return, nursing documents the patient's condition during the leave from the facility (as reported by the responsible person). Documentation should include, but is not limited to:

- Any symptoms experienced
- Problems noted
- Medications given
- Patient's tolerance, etc.

Overnight stays (out of the facility) are not reimbursed by Medicare. Upon admission, all patients and responsible parties should be apprised of the Medicare guidelines, especially during the holiday season. If a family and/or patient insist on an overnight stay, they should understand that they are jeopardizing Medicare Part A coverage, and that a reviewer would question whether the patient's care could only be furnished in a SNF.

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Transfer Rule (30 Days)

The 30-day transfer rule is applied to any resident entering a skilled nursing facility. The 30-day transfer rule states that a patient must be admitted to a certified bed within 30 days of the last Medicare covered day in a hospital or skilled nursing facility. When determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days.

If the resident goes home, or is admitted into an intermediate bed and more than 30 days have passed since discharge, a new 3-day qualifying hospital stay is required before the resident can be considered for skilled coverage.

Medical Appropriateness Admission Rule
(30-Day Exception Rule)

An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a pre-determinable time period. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or non-covered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

General Guidelines and Examples:

1. On rare occasions a patient/resident admitted to a skilled nursing facility from an acute hospital does not require skilled services immediately post-hospital, but may require such services within a predictable time frame, which exceeds 30 days. The delay must be an established pattern of care and is, therefore, medically predictable.

2. The **Medically Predictable Rule** also applies even if the patient/resident is admitted directly from the hospital to the skilled nursing facility for a period of covered care, then non-covered care, and finally resumes skilled care for the medically predictable period.

3. The patient/resident must require daily skilled nursing and/or skilled rehabilitation services.

4. In order for the **Medical Predictability Rule** to be valid, it should be worded as a "Medical Predictable Patient/Resident" on the patient/resident's **Hospital Discharge Summary** and signed by the physician. It can also be established by a signed telephone order the day of admission. **the day after admission is too late.**

5. Most direct admissions to the skilled nursing facility will be reimbursed under Medicare Part A for observation and assessment or rehabilitation services for strengthening to prepare the patient/resident for a more aggressive rehabilitation program.

6. The patient/resident does not need to be in a certified bed during the period of medical predictability, **unless** being covered for Part A services for a daily skilled service.

7. The patient/resident may be discharged home during the Medical Predictability period and then readmitted for Part A coverage.

8. In addition to therapy admission orders, a copy of the original Medical Predictability order must be obtained for the skilled nursing facility records. To facilitate such an admission, close cooperation with the referral source is imperative.

Follow these steps when admitting a patient/resident who meets the criteria for Medical Predictability:

1. Obtain a physician's order for a "Predictable Readmit" at the time of admission to the facility. Remember, if in doubt as to whether the patient/resident will require a Predictable Readmit order, obtain the order at the time of admission.

2. The physician's order must be specific as to the therapy discipline required, the medical necessity for the delay, and a predictable time frame for outcome. An example of Predictable Readmit Order:

   "Predictable readmit for physical therapy for transfer training and gait training in six weeks when patient is no longer non-weight bearing."

3. If medically necessary, the original time frame can be extended by having the physician write a new order designating the new time frame. NOTE: If the original time frame expires without a renewal order, the Predictable Readmit is invalid.

The following case studies illustrate Medical Predictability situations:

1. On January 10, 1992, a patient/resident was admitted to the skilled nursing facility directly from the hospital. He was admitted with a comminuted fracture of the right hip. The physician's order, obtained at time of discharge read PT BID X five days per week for two weeks for strengthening exercises, ROM right LE, bed mobility, and right NWB transfer training. Predictable readmit for physical therapy for gait training in eight weeks due to NWB status. Physical therapy concentrated on NWB transfer training and bed mobility. Patient/resident is medically stable and was discharged from Part A on January 31, 1992. Patient/resident was moved to a non-certified bed.

   On March 30, 1992, he went to his physician for an x-ray. He returned with the following order; "Physical therapy evaluation for gait training BID, five times per week, for four weeks." The patient/resident was readmitted to a certified bed and covered by Medicare Part A, even though it has been more than 30 days from admission.

2. A patient/resident was discharged home from the hospital after a right BK amputation, for wound care with home health services on March 1, 1992. At the time of discharge from the hospital, the following Medical Predictability order was written.

"Admit to skilled nursing facility in eight weeks for physical therapy for prosthetic training after stump was healed." As a practical matter, outpatient rehabilitation is not available for this patient/resident. On May 28, 1992, the stump has healed and the patient/resident is admitted to the skilled nursing facility to begin the rehabilitation program under Part A.

Medical Predictability Effects on Benefit Period

In the infrequent situation where the patient/resident has been discharged from the hospital to his home more than 60 days before he is ready to begin a course of deferred care in a skilled nursing facility, a new spell of illness begins with the day the beneficiary enters the skilled nursing facility thereby generating another 100 days of skilled nursing facility benefits. Another qualifying hospital stay would not be required, providing the care furnished is clearly related to the hospital stay in the previous benefit period and represents care for which the need was predicted at the time of discharge from such hospital stay.

Medical Needs are Not Predictable

When a patient/resident's medical needs and the course of treatment are not predictable at the time of hospital discharge because the exact pattern of care which he will require and the time frame in which it will be required is dependent on the developing nature of his condition, his admission to a skilled nursing facility more than 30 days after discharge from the hospital could not be justified under this exception to the 30-day rule.

Skilled Coverage Overview

Skilled Nursing Facility Coverage

Care in a SNF is covered if the following three conditions are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel;
- The patient requires these skilled services on a daily basis; and,
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three conditions is not met, a stay in a SNF, even though it might include the delivery of some skilled service, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing SNF services to determine whether the level of care requirements are met, first consider whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements do not have to be addressed.

In addition, the services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his/her particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity and be certified and recertified by a physician.

Nursing and/or Rehabilitation Services

Skilled nursing and/or skilled rehabilitation services are those services, furnished based on the orders of a medical professional, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and,
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Determining Whether a Service is Skilled

Principles for determining whether a service is skilled include:

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service.

- Consider the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

- When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.

- A service that is ordinarily considered non-skilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented in the physician's orders and nursing or therapy notes.

- In determining whether services rendered in a SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specified services were unskilled.

- The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel.

Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services.

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Presumptive Coverage Criteria

Definition of the 5-Day Presumption

- When the initial Medicare required assessment (5-day assessment) results in a beneficiary being correctly assigned to one of the upper 52 RUG-IV groups, this effectively creates **a presumption of coverage for the period from admission up to and including the ARD for that assessment.**

- This presumption is valid through the ARD of the 5 day assessment.

Determination of Skilled Care Beyond the 5-Day Presumption

- Continuation of coverage once established by the RUG-IV presumption is dependent upon the subsequent course of the resident's actual condition and care needs as documented in the medical record.

- The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the beneficiary's condition and care needs, thus meeting the skilled care definition. If the services are not medically necessary, a decision of non-coverage should be made.

Five Day Presumption

- Requires placement in Top 52 RUG-IV groups.

- Services must be reasonable and necessary.

- Applies to Medicare 5-day assessment only.

- Extends from admission up to and including the ARD.

Direct Skilled Nursing

- Enteral Feeding-26% daily calorie requirements and at least 501 milliliters fluid per day.
- Suprapubic catheters – This procedure is a major vector for infection that can be fatal if improperly performed. (insertion, sterile irrigation and replacement).
- Daily insulin injections with 2 order changes over last 14 days.
- IV (parental) medications.
- N/G, gastrostomy tubes, jejunostomy tubes.
- Application of dressing with prescription medications and aseptic technique.
- Treatment of pressure ulcer stage III or worse.
- Initial phases of a regimen involving medical gases such as bronchodilators and oxygen therapy.
- Colostomy Care.
- Bowel and Bladder Training.
- Aggregate unskilled services.

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Management of Care Plan

The development, management and evaluation of a patient care plan based on physician orders constitutes skilled services when:

- The beneficiary's physical and mental condition requires skilled level technical or professional personnel to safely plan, monitor and manage care.
- The plan involves a variety of personal care services and the aggregate of those services, in light of the patient's condition, requires the involvement of technical or professional personnel.

Although a properly instructed person could perform these services, the ability to understand the relationship between services and the ultimate effect of one upon the others is essential. In this circumstance the skills of a nurse are required even though the individual services may not be skilled (42 CFR 409.33(ii)).

Reminder: The overall condition must be documented in the medical record to support the finding that recovery and safety can be ensured only if the total care is planned, managed and evaluated by skilled technical or professional personnel.

Example A:

Beneficiary with history diabetes mellitus and angina pectoris is recovering from an open reduction of a fractured femur requiring:

- Skin care per diabetic protocol.
- Appropriate oral medications.
- Diabetic diet.
- Exercise program to preserve muscle tone and body condition.
- Observation for signs and symptoms of complication and or deterioration as a result of restricted activity.

Management and Evaluation of a Care Plan

- Based on a physician's order.
- Requires skilled technical or professional personnel.
- Overall patient condition must be documented in the medical record to support the need.

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Observation and Assessment

"Observation and assessment constitutes skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modifications of treatment or for additional medical procedures until his or her condition is stabilized." (42 CFR 409.33)

Example A:

Beneficiary with diagnosis of CHF may require continuous close observation for:

- Signs and symptoms of decompensation.
- Abnormal fluid balance.
- Medication side effects signaling the need for an adjustment in the medical treatment.

Example B:

Beneficiary with diagnosis of surgical hip replacement may require observation and assessment for:

- Postoperative complications.
- Presence of co-morbid conditions/physical problems.
- Acute psychological symptoms such as depression, anxiety or agitation.
- To ensure safety of resident in the case of suicidal or homicidal behaviors. **The need for these services must be documented by physician's orders or nursing/therapy notes.**

Skilled Observation and Assessment

- Identification and evaluation for treatment plan modifications.
- Requires skills technical or professional.

1.2 - Review of Observation and Assessment and Management and Evaluation in SNFs - (Rev. 3, 11-22-00)

A. General

Intermediaries must use Medical Review guidelines in conjunction with the Medicare SNF coverage guidelines and policy training guidelines. As stated in the policy training guidelines, intermediaries review for coverage. Where coverage is not present, no Medicare payment is to be made.

All SNFs are required by regulation to assess each patient, identify their needs, and develop an individual care plan to meet the needs. (See 42 CFR 483.20.) Many patients in SNFs require some skilled services and skilled nursing oversight to ensure that the patient care plan is carried out.

The purpose of these Medical Review guidelines is to help the intermediary distinguish between patients who require daily skilled observation and assessment or management and evaluation and patients who require periodic skilled services on a less than daily basis and/or a supportive environment and oversight to ensure their general well being. In determining the appropriate extent of review for a particular claim, intermediaries must keep the following in mind:

- Cover a claim once sufficient indicators exist to establish that it meets level of care requirements; and

- Deny a claim only after the reviewer has completed review of all aspects of the claim without finding sufficient indicators to establish coverage.

B. Observation and Assessment Definition

Observation and assessment is reasonable and necessary when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures. It is needed until the patient's treatment regimen is essentially stabilized. The need for skilled observation and assessment is driven also by the inherent complexity of planned services and their impact on the patient's overall condition.

C. Indicators of the Need for Skilled Observation and Assessment

The determination of Medicare coverage includes consideration of many factors. These factors in combination could indicate the potential for a change in the patient's condition resulting in the need for treatment and plan of care modification. Factors intermediaries consider in evaluating the need for skilled observation and assessment include:

- Condition of the patient at discharge from acute facility;
- Consideration of factors that may indicate medical instability, e.g., changes to medications or unstable laboratory values; and
- Multiple medical problems that are likely to interact to create complications or acute episodes.

D. Documentation to Support Coverage

There must be documentation of instability or the probability of a change in the patient's condition. The presence of any one or more of the following is sufficient:

- A nursing **care plan** that describes the patient's condition, specifies problems or potential problems and planned intervention on a **daily** or more **frequent basis**;
- Indication of daily or more frequent monitoring of **vital signs, description of lung or bowel sounds and skin condition, deficiencies in nutritional status and hydration, mental status** and **mobility** related to the instability or probable changes in condition. This information documents that there is ongoing observation and assessment of the patient;
- **Documented changes** in the patient's vital signs, nutritional status, skin condition, etc. that reflect instability. Lack of changes in physical condition does not, in itself, preclude the need for observation and assessment. Documentation must support that there is a reasonable probability for changes in the patient's condition; and
- Repeated **modifications in the treatment plan** as a result of changes in the patient's condition.

Example 1 (Skilled): The patient has unstable diabetes with fluctuating blood glucose levels and resulting symptoms of both hyperglycemia and hypoglycemia occurring intermittently. Assessment of these symptoms is required each shift by an R.N. or L.P.N. The patient's blood glucose level is ordered to be checked via fingerstick and sliding scale insulin given twice a day, as well as, the patient receiving both a.m. and p.m. insulin. Because of the instability of the patient's diabetic condition, observation and assessment of symptoms, food intake, and blood glucose is required by a professional every four to eight hours.

Example 2 (Further Review): The patient has diabetes that is controlled with an oral hyper-glycemic medication such as Diabinese and diet (elimination of concentrated sweets). The patient's blood sugar is well controlled by medication and diet modification, and a fasting blood glucose is done every 3 months for monitoring purposes. The intermediary must deny only if a review of all aspects of the claim fails to reveal sufficient indicators of the need for skilled observation and assessment described above (or any other skilled service) to establish coverage.

Example 3 (Skilled): The patient has Alzheimer's dementia that is progressing at a rapid rate. Behaviors are unstable and inconsistent. This requires continuous monitoring with both behavioral and medication intervention frequently to increase the functional capability of the patient.

Example 4 (Further Review): The patient is newly diagnosed with multi-infarct dementia, secondary to a resolved cerebrovascular accident. However, behaviors related to dementia are stable and consistent, mainly forgetfulness, so that the patient needs a reminder to dress and when to eat. A denial is appropriate only if a review of **all** aspects of the claim fails to reveal sufficient indicators of the need for skilled observation and assessment described above (or any other skilled service) to establish coverage.

E. Management and Evaluation Definition

The development, management, and evaluation of a patient care plan, based on the physician's orders, constitutes skilled nursing services when these services require the involvement of skilled personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. Skilled personnel are required for planning and management of a treatment plan where the patient's overall condition supports a finding that recovery and safety can be assured only if the total care, skilled or not, is planned and managed by the nurse.

F. Indicators of the Need for Skilled Management of Unskilled Services

Factors intermediaries consider in determining the need for skilled management and evaluation include:

- Documented medical symptoms (not just diagnoses) and concerns related to the symptoms which have the potential for serious complications;
- Documented functional deficits, physical or mental or other health risk behaviors which would complicate the care of the medically at risk patient (e.g., bed confined, poor nutrition, dehydration, confusion);
- Presence of a treatment plan that requires daily or more frequent intervention and requires that a skilled professional evaluate the effectiveness of the interventions on a daily basis;
- History of frequent hospitalizations or emergency room visits related to falls, dehydration, and malnutrition;
- Would the condition of the patient deteriorate or recovery be impeded if the beneficiary did not have a skilled nurse managing the care on a daily basis, i.e., what would happen to the patient if there was not daily skilled management of the treatment plan? If daily skilled management is not required, does the patient require other skilled services that together with the need for skilled management result in daily skilled care?

- Are the services required by the patient interrelated? Is a medical professional needed to understand the relationship?

- If a patient did not require skilled management and evaluation prior to an acute episode, but receives it after the acute episode is resolved, is the skilled management and evaluation justified by an actual change in the patient's condition (and not furnished merely because of the occurrence of the acute episode itself)?

- Type, number, and complexity of services, being furnished on a daily basis; and

- Changes in the care plan or physician's orders. Documentation must reflect the patient's condition and medical needs, the treatment regimen and evidence of the potential for serious complication. Documentation that may support coverage include the following:

- A description of medical problems, and related concerns for the patient;

- Multiple entries or other evidence that reflect concern with patient's recovery or risks/potential complications if patient's care is not carefully supervised;

- Evidence that nurses/therapists are assessing or supervising results of care that is given by non-skilled personnel and verifying that the care is furnished; and

- A care plan that clearly shows the complexity of the care required.

Example 1 (Skilled): The following is one example of a patient who needs skilled management of unskilled services:

The patient has a diagnosis of Alzheimer's disease that is in final stages. Documented medical problems include weight loss, dehydration, and frequent symptomatic urinary tract infections. These problems are all related to functional declines that can occur in patients at this stage of Alzheimer's disease. This requires continuous planning of various interventions to maintain adequate food and fluid intake, and evaluation of effectiveness of approaches. Monitoring of urine output and prompt treatment of any infections is also required.

Example 2 (Further Review): In contrast, the following claim contains indicators of the need for further review:

The patient has diagnoses of congestive heart failure, peripheral vascular disease, gout, non-insulin dependent diabetes and is legally blind. Although the combination of these diagnoses suggests a potential risk to the patient, the patient's condition is stable and asymptomatic. The care described consists of assisting the patient from bed to chair several times a day, and assistance with meals and activities of daily living. The physician monitors the general condition of the patient and does a medication review and adjustment every 3 months. A denial is

appropriate only if a review of all aspects of the claim fails to reveal sufficient indicators of the need for skilled management and evaluation described above (or any other skilled service) to establish coverage.

G. Sources of Documentation

- Medical information forms that clearly describe the information needed to make a coverage decision include:
- Hospital discharge summaries and transfer forms;
- Physician orders and progress notes;
- Patient care plans;
- MDS;
- Nursing and rehabilitation therapy notes; and
- Treatment and flow sheets (include nurses' aide) and vital sign records, weight charts and medication records.

H. Other Considerations

The need for skilled observation and assessment or management and evaluation may end when the medical condition is stabilized, the patient recovers from the acute condition, or the treatment plan is well established and risks to the patient are minimized.

In some instances, skilled observation and assessment and management and evaluation overlap in their functions and definitions. However, the reviewer must require specific evidence of the need for skilled management and evaluation.

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Patient Education Services

Patient education services are skilled when and if the services of a technical or professional person is required to teach a patient a self-maintenance program.

Example

Recent amputee needs skilled rehabilitative services provided by technical or professional personnel to provide the necessary gait training and prosthetic care.

Patient Education

- For the teaching of a self-maintenance program
- Requires technical or professional staff

Teaching and Training Activities

Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

Factors Which Impact on Patient's/Family's Learning

- Disease Process
- Discomfort
- Hearing
- Vision
- Educational Level
- Spoken Language
- Environment

- Procedure(s) being taught
- Presentation Methods utilized

Indications That Teaching and Training Activities are Being Carried Out

- Description of procedures being taught within facility.
- Description of patient's/family's response, i.e., self-administration of medications.
- Description of self-care.
- Description of teaching aids, i.e., literature, films.

Evaluation of the Patient's Response to Teaching

- Patient's/Family's response to staff questions re: procedure or medication.
- Return demonstration of skills, i.e., insulin injection.
- Demonstrated retention of material taught; vs. having to remind patient/family of procedures to follow.

Teaching Patients with Cardiovascular System Problems

- Explanation of causes of the disorder – i.e., impaired circulation.
- Symptoms of the specific disorder.
- Inspection of extremities, if circulation impaired.
- Care of extremities, when circulation impaired:
  - Advise positions which would alter circulation
  - Need for warmth
  - Activities which would improve circulation
  - Use of elastic stockings, if applicable
- Reason for and intended effect of therapy.
- Reasons to refrain from constrictive clothing

- Medications that are prescribed

  - Dosage and frequency
  - Desired affect
  - Side effects
  - Administration, how to monitor

Teaching Patients How to Care for a Recent Colostomy and Ileostomy

- Supplies needed – how and where to obtain.
- Care of the skin, as prescribed.
- Care of extremities, when circulation impaired:

  - Cleaning with surgical soap.
  - Application of prescribed item around the ostomy site (Aluminum Paste, Zinc Oxide, Milk of Magnesia).

- Change of the ostomy appliance

  - Emptying of appliance.
  - Cleansing of the ostomy appliance.

- Use of irrigating solutions, if prescribed

  - How to irrigate the colostomy
    - Controlling of odors

- Diet, as prescribed

Teaching a Newly Diagnosed Diabetic to Administer Insulin Injections, to Prepare and Follow a Diabetic Diet and to Observe Foot-Care Precautions

Characteristics of Controlled Diabetes

- Feeling of well being.
- Maintenance of normal body weight on a well-balanced diet.
- Negative urine tests.
- Normal levels of blood sugar and acetone.

Administration of Insulin Injections

- Action of insulin.
- Teaching directed toward providing information about the specific type and strength of insulin that patient is being administered.
- Supplies needed; where and how to obtain.
- Storage of insulin.
- Drawing of prescribed dose.
- Actual injection.
- Rotation of sites.

Diabetic Diet

- Direct toward the specific diet that patient has been prescribed.
- Selection and preparation of food, i.e., fresh vs. canned/frozen; baked vs. fry.
- Maintenance of diet when away from home.
- Preparation of menus, specific to patient's diet.

Foot (and Skin) Care for the Patient with Diabetes

- Predisposition to poor circulation of patient with diabetes.
- Wash feet gently; will decrease possibility of trauma.
- Use soft towel to dry the feet.
- Dry skin between toes.
- May lanolize the feet, but not toes.
- Application of maintaining dryness of feet.

- Recommended footwear – well-fitting, closed shoes.
- Cutting of toenails straight across.
- Cleaning of nails.
- Cutting of nails correctly.
- Inspection of skin for breakdown and/or infection.

Manifestations of Uncontrolled Diabetes: Symptoms and How to Prevent

- Copious urination
- Constant thirst
- Persistent hunger
- Flushed and dry skin
- Weakness
- Fatigue
- Drowsiness
- Impending Insulin Shock: Symptoms and how to prevent
    - Sweating
    - Dizziness
    - Palpitations
    - Shallow breathing
    - Trembling
    - Blurred or double vision
    - Hunger
    - Confusion

Monitoring and Recording of Urine and/or Blood Glucose Levels

- Testing of urine for sugar-acetone – dependent upon method prescribed
- Testing of blood for glucose – dependent upon prescribed method

Teaching Patients How to Perform Self-Catheterization and Self-Administration of Gastrostomy Feedings

Gastrostomy Feedings

- Explanation of procedure and intended effect of therapy.
- Supplies and equipment needed: care of equipment.
- Preparation of formula, as prescribed.
- How and where to obtain formula, supplies and equipment?
- Symptoms which should be reported. (Nausea, diarrhea)

Urinary Catheters

- Explanation of reasons for the specific catheter, i.e., health problem.
- Description of supplies and equipment.
- Explanation and demonstration of procedure, including care when you having indwelling catheter.

    - Fluid intake required, i.e., types of
    - Measurement of output
    - Positioning of draining container
    - Irrigation of the catheter; supplies needed
    - Changing the drainage apparatus
    - Cleaning the urinary catheter externally
    - Taping of the catheter to prevent tension and minimize pulling it out
    - Bladder restraining, if indicated

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Skilled Rehabilitation Services

Included in Chapter 15 of the Medicare Benefit Policy, to be considered reasonable and necessary the following conditions must each be met. (This is a representative list of required conditions and does not fully describe reasonable and necessary services. See the remainder of this section and associated information in section 230.):

The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:

- Medicare manuals (such as this manual and Publications 100-03 and 100-04),
- Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd, and
- Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.

The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.

While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.

There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and

The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

Note: Claims for therapy services denied because they are not considered reasonable and necessary are excluded by §1862(a)(1) of the Act and are thus subject to consideration under the waiver of liability provision in §1879 of the Act.

The concept of rehabilitative therapy includes recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, or decrease in severity, or rationalization for an optimistic outlook to justify continued treatment.

Covered therapy services shall be rehabilitative therapy services unless they meet the criteria for maintenance therapy requiring the skills of a therapist described below. Rehabilitative therapy services are skilled procedures that may include but are not limited to:

- Evaluations; reevaluations
- Establishment of treatment goals specific to the patient's disability or dysfunction and designed to specifically address each problem identified in the evaluation;
- Design of a plan of care addressing the patient's disorder, including establishment of procedures to obtain goals, determining the frequency and intensity of treatment;
- Continued assessment and analysis during implementation of the services at regular intervals;
- Instruction leading to establishment of compensatory skills;
- Selection of devices to replace or augment a function (e.g., for use as an alternative communication system and short-term training on use of the device or system); and
- Patient and family training to augment rehabilitative treatment or establish a maintenance program. Education of staff and family should be ongoing through treatment and instructions may have to be modified intermittently if the patient's status changes.

Skilled Therapy

Rehabilitative therapy occurs when the skills of a therapist, (See definition of therapist in section 220 of this chapter) are necessary to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation. (See also section 220.3 of this chapter for documenting skilled therapy.)

Skilled therapy may be needed, and improvement in a patient's condition may occur, even where a chronic or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition. In the case of a progressive degenerative disease, for example, service may be intermittently necessary to determine the need for assistive equipment and establish a program to maximize function. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require

the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.

Services that can be safely and effectively furnished by non-skilled personnel or by PTAs or OTAs without the supervision of therapists are not rehabilitative therapy services. If at any point in the treatment of an illness it is determined that the treatment is not rehabilitative, or does not legitimately require the services of a qualified professional for management of a maintenance program as described below, the services will no longer be considered reasonable and necessary. Services that are not reasonable or necessary should be excluded from coverage under §1862(a)(1) of the Act.

Potential for Improvement Due to Treatment

If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, therapy would not be covered because it is not considered rehabilitative or reasonable and necessary. Improvement is evidenced by successive objective measurements whenever possible (see objective measurement instruments for evaluation in the §220.3.C of this chapter).

Therapy is not required to effect improvement or restoration of function where a patient suffers a transient and easily reversible loss or reduction of function (e.g., temporary weakness which may follow a brief period of bed rest following abdominal surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are not covered. (See exceptions for maintenance in §220.2D of this manual).

Maintenance Programs

During the last visits for rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function. The specialized skill, knowledge and judgment of a therapist would be required, and services are covered, to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered under ordinary circumstances. The patient may perform such a program independently or with the assistance of unskilled personnel or family members.
Where a maintenance program is not established until after the rehabilitative therapy program has been completed (and the skills of a therapist are not necessary) development of a maintenance program would not be considered reasonable and necessary for the treatment of

the patient's condition. It would be excluded from coverage under §1862(a)(1) of the Act unless the patient's safety was at risk (see below).

Example: A Parkinson patient who has been under a rehabilitative physical therapy program may require the services of a therapist during the last week or two of treatment to determine what type of exercises will contribute the most to maintain the patient's present functional level following cessation of treatment. In such situations, the design of a maintenance program appropriate to the capacity and tolerance of the patient by the qualified therapist, the instruction of the patient or family members in carrying out the program, and such infrequent reevaluations as may be required would constitute covered therapy because of the need for the skills of a qualified professional.

Evaluation and Maintenance Plan without Rehabilitative Treatment. After the initial evaluation of the extent of the disorder, illness, or injury, if the treating qualified professional determines the potential for rehabilitation is insignificant, an appropriate maintenance program may be established prior to discharge. Since the skills of a therapist are required for the development of the maintenance program and training the patient or caregivers, this service is covered.

Example: The skills of a qualified speech-language pathologist may be covered to develop a maintenance program for a patient with multiple sclerosis, for services intended to prevent or minimize deterioration in communication ability caused by the medical condition, when the patient's current medical condition does not yet justify the need for the skilled services of a speech-language pathologist. Evaluation, development of the program and training the family or support personnel would require the skills of a therapist and would be covered. The skills of a therapist are not required and services are not covered to carry out the program.

Skilled Maintenance Therapy for Safety

If the services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of a therapist may be necessary for the safe and effective delivery of such services. When the patient's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

Example. Where there is an unhealed, unstable fracture, which requires regular exercise to maintain function until the fracture heals, the skills of a therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

Documentation Requirements

These types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise. The timelines are minimum requirements for Medicare payment. Document as often as the clinician's judgment dictates but no less than the frequency required in Medicare policy:

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;
- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due. See definitions in section 220 and certification policy in section 220.1.3 of this chapter. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the certification or recertification is due.
- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due. (See definitions in section 220 and descriptions in 220.3 D);
- Treatment notes for each treatment day (may also serve as progress reports when required information is included in the notes);
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

Document Information to Meet Requirements

In documenting records, clinicians must be familiar with the requirements for covered and payable outpatient therapy services as described in the manuals. For example, the records should justify:

The patient is under the care of a physician/NPP;

- Physician/NPP care shall be documented by physician/NPP certification (approval) of the plan of care; and
- Although not required, other evidence of physician/NPP involvement in the patient's care may include, for example: order/referral, conference, team meeting notes, and correspondence.

Services require the skills of a therapist.

- Services must not only be provided by the qualified professional or qualified personnel, but they must require, for example, the expertise, knowledge, clinical judgment, decision making and abilities of a therapist that assistants, qualified personnel, caretakers or the patient cannot provide independently. A clinician may not merely supervise, but must apply the skills of a therapist by actively participating in the treatment of the patient during each progress report period. In addition, a therapist's skills may be documented, for example, by the clinician's descriptions of their skilled treatment, the changes made to the treatment due to a clinician's assessment of the patient's needs on a particular treatment day or changes due to progress the clinician judged sufficient to modify the treatment toward the next more complex or difficult task.
- A therapist's skill may also be required for safety reasons, if an unstable fracture requires the skill of a therapist to do an activity that might otherwise be done independently by the patient at home. Or the skill of a therapist might be required for a patient learning compensatory swallowing techniques to perform cervical auscultation and identify changes in voice and breathing that might signal aspiration. After the patient is judged safe for independent use of these compensatory techniques, the skill of a therapist is not required to feed the patient, or check what was consumed.

Services are of appropriate type, frequency, intensity and duration for the individual needs of the patient.

- Documentation should establish the variables that influence the patient's condition, especially those factors that influence the clinician's decision to provide more services than are typical for the individual's condition.
- Clinicians and contractors shall determine typical services using published professional literature and professional guidelines. The fact that services are typically billed is not necessarily evidence that the services are typically appropriate. Services that exceed those typically billed should be carefully documented to justify their necessity, but are payable if the individual patient benefits from medically necessary services. Also, some services or episodes of treatment should be less than those typically billed, when the individual patient reaches goals sooner than is typical.
- Documentation should establish through objective measurements that the patient is making progress toward goals. Note that regression and plateaus can happen during treatment. It is recommended that the reasons for lack of progress be noted and the justification for continued treatment be documented if treatment continues after regression or plateaus.
- Needs of the Patient. When a service is reasonable and necessary, the patient also needs the services. Contractors determine the patient's needs through knowledge of the individual patient's condition, and any complexities that impact that condition, as described in documentation (usually in the evaluation, re-evaluation, and progress report). Factors that contribute to need vary, but in general they relate to such factors as

the patient's diagnoses, complicating factors, age, severity, time since onset/acuity, self-efficacy/motivation, cognitive ability, prognosis, and/or medical, psychological and social stability. Patients who need therapy generally respond to therapy, so changes in objective and sometimes to subjective measures of improvement also help establish the need for services. The use of scientific evidence, obtained from professional literature, and sequential measurements of the patient's condition during treatment is encouraged to support the potential for continued improvement that may justify the patients need for therapy.

Functional information included on claims as required.

The clinician is required to document in the patient's medical record, using the G-codes and severity modifiers used in functional reporting, the patient's current, projected goal, and discharge status, as reported pursuant to functional reporting requirements for each date of service for which the reporting is required. See section 220.4 below for details on documenting G-code and modifiers.

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Physical Therapy

The documentation must indicate that the severity of the physical, neurological or cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. The special knowledge of a physical therapist is required to decrease or eliminate limitations in functional mobility performance. Physical therapists must often address underlying factors which interfere with functional mobility. These factors could include cognitive, sensory, or perceptual deficits.

Skilled services include, but are not limited to reasonable and necessary:

- Patient evaluations;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professionals;
- Analyzing and modifying functional tasks;
- Determination that the modified task obtains optimum performance through tests and measurements;
- Providing instructions of the task(s) to the patient, family, care-givers; and
- Periodically reevaluating the patient's status with corresponding readjustment of the PT program.

A period of practice may be approved for the patient and/or patient's care-givers to learn the steps of the task, to verify the task's effectiveness in improving function, and to check for safe and consistent performance.

Common Physical Therapy Modalities and Procedures

Common physical therapy modalities and procedures include the following:

Assessment. The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability.

Therapeutic Exercises. Therapeutic exercises that must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

Gait Training. Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy if they reasonably can be expected to improve significantly the patient's ability to walk.

Range of Motion. Only the qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy. Range of motion exercises constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care.

Ultrasound, Short-wave, and Microwave Diathermy Treatments. These modalities must always be performed by or under the supervision of a qualified physical therapist and are skilled physical therapy.

Hot packs, Infrared Treatments, Paraffin Baths and Whirlpool Baths. Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of treatments or baths in a particular case.

The documentation must indicate that the severity of the physical, emotional, perceptual, or cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. In addition, intermediaries consider instructions required by the patient and/or the patient's care-givers. Instructions may be required for activities that most healthy people take for granted. The special knowledge of an occupational therapist is required to decrease or eliminate limitations in functional activity performance. Occupational therapists must often address underlying factors which interfere with specific activities. These factors could be cognitive, sensory, or perceptual deficits.

The occupational therapist modifies the specific activity by using adapted equipment, making changes in the environment, altering procedures for accomplishing the task, and providing specialized assistance to meet the patient's current and potential abilities. Skilled services include, but are not limited to reasonable and necessary:

- Patient evaluations;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professionals;
- Analyzing and modifying functional tasks;
- Determination that the modified task obtains optimum performance through tests and measurements;
- Providing instructions of the task(s) to the patient, family, care-givers; and
- Periodically reevaluating the patient's status with corresponding readjustment of the OT program.

A period of practice may be approved for the patient and/or patient's care-givers to learn the steps of the task, to verify the task's effectiveness in improving function, and to check for safe and consistent performance.

7.3.6 - Reporting on New Episode or Condition - (Rev. 3, 11-22-00)

Occasionally, a patient who is receiving or who has received OT services experiences a new illness. The provider must document the significance of any change to the patient's functional capabilities. This may be through pre and post episodic nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient had completed treatment a

significant change in the patient's functional status must be documented to warrant a new treatment plan.

A. Pain

Intermediaries consider documentation describing the presence or absence of pain and its effect on the patient's functional abilities in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion materially aids correct decisions. Documentation should describe the limitations placed upon the patient's ADL, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

B. Therapeutic Programs

The objective documentation should support the skilled nature of the program, and/or the need for the design and establishment of a maintenance OT program. The goals should be to increase functional abilities in ADL, mobility or patient safety. Documentation should indicate the goals and type of program provided.

Intermediaries may approve claims when the therapeutic program, because of documented medical complications, the condition of the patient, or complexity of the OT employed, must be rendered by, or under, the supervision of an occupational therapist. For example, while functional ADL may be performed safely and effectively by non-skilled personnel, fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled occupational therapist intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or occupational therapist notes. For correct MR decisions, the patient's losses and/or dependencies in ADL, mobility and safety must be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless documentation supports why skilled OT is needed for the patient's medical condition and/or safety.

Intermediaries approve the establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions to supportive personnel and/or family members need to safely and effectively carry it out. They may approve reevaluation when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be justification for readjusting a maintenance program, e.g., loss of previous functional gains.

C. Cardiac Rehabilitation Exercise

OT is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there is also a diagnosed non-cardiac condition requiring it, e.g., a patient who is recuperating from an acute phase of heart disease

may have had a stroke which requires OT. (While the cardiac rehabilitation exercise program may be considered by some a form of OT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.)

D. Transfer Training

The documentation should describe the patient's functional limitations in transfer ability that warrant skilled OT intervention. Documentation includes the special transfer training needed to perform functional daily living skills and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Intermediaries approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the activities of daily living or mobility.

Documentation that supports only repetitious carrying out of the transfer method once established, and monitored for safety and completion does not show covered care.

E. Fabrication of and Training in Use of Orthoses, Prostheses and Adaptive Equipment

Intermediaries approve reasonable and necessary fabrication of orthoses, prostheses, adaptive equipment, and reasonable and necessary skilled training needed in their safe and effective use, if documentation indicates the need for the device and training in its use.

F. OT Forms

Documentation may be submitted on a specific form the intermediary requires or may be copies of the provider's record. However, the form must capture the needed Medical Record information. If the reviewer chooses to require a particular form, show the OMB clearance number. The information submitted must be complete. If it is not, intermediaries may deny the claim and request additional information. The information required to support the bill is that which is required by an occupational therapist to properly treat a patient.

G. Certification and Re-certification

OT services must be certified and re-certified by a physician and must be furnished while the patient is under the care of a physician. OT services must be furnished under a written plan of treatment established by the physician or a qualified occupational therapist. If the plan is established by an occupational therapist, it must be reviewed periodically by the physician.

The plan of treatment must be established (reduced to writing by either professional or the provider when it makes a written record of oral orders) before treatment is begun. When

outpatient OT services are continued under the same plan of treatment for a period of time, the physician must certify at least at 30-day intervals that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for review of the plans. A re-certification must be signed by the physician, who reviewed the plan of treatment. Any changes to the treatment plan established by the occupational therapist must be in writing and signed by the therapist or by the attending physician. The physician may change a plan of treatment established by the occupational therapist. However, the occupational therapist may not alter a plan of treatment established by a physician.

7.4.1 - OT Availability - (Rev. 3, 11-22-00)

Two or more disciplines may provide therapy services to the same patient. There may also be occasions where these services are duplicated. In many instances, the description of the services appears duplicated, but the documentation proves that they are not. Some examples where there is **not** a duplication include:

A. Transfers

PT instructs the patient in transfers to achieve the level of safety with the techniques. OT utilizes transfers as they relate to the performance of daily living skills (e.g., transfer from wheelchair to bathtub).

B. Pulmonary

PT instructs the patient in an adapted breathing technique. OT carries the breathing retraining into activities of daily living.

C. Hip Fractures/Arthroplasties

PT instructs the patient in hip precautions and gait training. OT reinforces the training with precautions for activities of daily living, e.g., lower extremity dressing, toileting, and bathing.

D. CVA

PT utilizes upper extremity neurodevelopmental (NDT) techniques to assist the patient in positioning the upper extremities on a walker and in gait training. OT utilizes NDT techniques to increase the functional use of the upper extremity for dressing, bathing, grooming, etc.

Speech Pathology Services and Conditions

Speech-language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Speech-language pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met:

- The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
- The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist; and
- There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.

Diagnostic and Evaluation Services

The speech-language pathologist employs a variety of formal and informal language assessment tests to ascertain the type, casual factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition that previously contraindicated speech pathology.

Dysphagia-Medical Workup

The medical workup ensures that providers select patients for this type of therapy only after a proper medical diagnostic evaluation by a physician. The medical workup is used to determine a primary diagnosis, form the basis of estimates of progress and to establish whether the difficulty involves the oral, pharyngeal, or esophageal phase of swallowing. This may involve collaboration with therapists or speech-language pathologists.

Dysphagia – Oral, Pharyngeal or Esophageal (Upper One Third) Phase of Swallowing

Documentation should include the patient's level of alertness, motivation, cognition, and deglutition and include at least one of the following conditions:

- History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia. Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgly voice quality after swallowing liquids or delayed or slow swallow reflex;

- Presence of oral motor disorders such as drooling, oral food retention, leakage of food or liquids placed into the mouth;

- Impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties;

- Coordination and/or, sensation loss, (postural difficulties) or other neuromotor disturbances;

- Post-surgical reaction affecting ability to adequately use oropharyngeal structures used in swallowing;

- Significant weight loss directly related to non-oral nutritional intake (g-tube feeding) and reaction to textures and consistencies; and,

- Existence of other conditions such as presence of tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, and cricopharyngeal dysfunction.

Esophageal dysphagia is regarded as difficulty in passing food from the esophagus to the stomach.

Dysphagia – Esophageal (Lower Two Thirds) Phase of Swallowing

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow have not generally been shown to be amenable to swallowing therapy techniques. An exception might be made when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated and could constitute reasonable and necessary care.

Dysphagia – Assessment Criteria

Document professional assessments indicating history, current eating status, and clinical observations.

A videofluoroscopic assessment (modified barium swallow) should be conducted and interpreted by a radiologist (often with assistance and input from the physician and/or individual disciplines).

The assessment and final analysis and interpretation should document a definitive diagnosis; identification of the swallowing phase(s) affected, and recommend the treatment plan.

Dysphagia – Care Planning

Describe goals and type of care planned specifically addressing each problem identified in the assessment. The documentation must indicate a reasonable expectation that the patient will make material improvement within a reasonable period of time.

Dysphagia – Safety

The documentation must indicate appropriate treatment goals to improve a patient's swallowing function, as well as indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Improving the patient's safety and quality of life by reduction or elimination of alternative nutritional support systems and advancement of dietary level, with improved nutritional intake should be the primary emphasis and treatment goal. The documentation must be consistent with these goals and indicate the reasonableness and need for skilled intervention.

Dysphagia – Professional Qualifications

Swallowing rehabilitation is a highly specialized service. Providers must ensure that professionals rendering care have the necessary specialized training and experience to properly treat the dysphagia.

6 – Medical Review of Part B Intermediary Outpatient Speech-Language Pathology (SLP) Bills - (Rev. 3, 11-22-00)

Intermediaries use the following guidelines for review of SLP services. They base the review of SLP on effective focused review criteria. They implement the HCFA edits only if data supports their effectiveness in focusing review. These criteria do not apply to SLP services provided under a home health plan of care. The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits.

Intermediaries do not deny a bill solely on the basis that it exceeds the criteria in the edits. The edits are **only** for selecting bills to review or for paying bills without MR if they meet

Level I criteria. Intermediaries must not provide automatic coverage up to these criteria. They neither guarantee minimum nor set maximum coverage limits.

6.1 - Level I Review - (Rev. 3, 11-22-00)

SLP edits have been developed for a number of diagnoses which were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with these diagnoses will require skilled SLP. The edits do not specify every diagnosis which may require SLP, and therefore, the fact that a given diagnosis does not appear in the edits does not create a presumption that SLP services are not necessary, or are inappropriate. Intermediaries do not approve or deny claims at Level I for medical necessity. They pay claims that pass the edits in Exhibit I and any additional edits approved by the RO without being subjected to Level II MR.

For patients receiving SLP services only (V57.3, Speech therapy) during an encounter/visit, the appropriate V code for the service is sequenced first, and, if documented, the diagnosis or problem for which the services are performed is sequenced second. The intermediary standard system must program the system to read the diagnosis or problem sequenced second to determine if it meets the Level I SLP edits.

Example: SLP services V57.3, for a patient with aphasia 784.3. The V code will be sequenced first, followed by the code for aphasia (V57.3, 784.3). Intermediaries edit for aphasia not the V code. They use this same procedure for V57.89, other specified rehabilitation procedure, and V57.9, unspecified rehabilitation procedure.

Providers should complete the following documentation to ensure payment upon review from the intermediary or MAC.

Facility and Patient Identification:	Facility name, patient name, provider number, HICN, age
Diagnosis:	The primary diagnosis for which SLP services were rendered must be listed by ICD-9-CM code first; other Dx(s) applicable to the patient or that influence care must follow.
Duration:	The expected length of treatment time.
Number of Visits:	The total number of visits completed since SLP services were initiated by the billing provider for the diagnosis being treated. Include the last visit in the billing period in the total visits to date. **Do not obtain only the visits for this month's billing period.** (Value code 52).

Date Treatment Started (Occurrence Code 45):	The date SLP services were initiated by the billing provider for the speech, language and related disorder.
Billing Period:	When SLP services began and ended in the billing period (from/through dates).

6.2 - Level II Review - (Rev. 3, 11-22-00)

If a bill meets the intermediary's focused MR criteria, they refer it to the Level II MR health professional staff. If possible, they have a speech-language pathologists review SLP bills. Once the bill is selected for focused MR, they review the data in conjunction with medical information submitted by the provider.

A. Payable SLP Services

Intermediaries pay SLP services only if they meet applicable Medicare coverage requirements. Each bill for SLP services that is subjected to Level II MR must be supported with adequate medical documentation to make a determination. (See MIM §§3101 and 3148.)

6.3 - MR Documentation - (Rev. 3, 11-22-00)

When a claim is referred to Level II MR, intermediaries use the following pertinent data elements in addition to those used for Level I review:

Medical History:	Intermediaries obtain only the medical history which is pertinent to, or influences the SLP treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring SLP, and any pertinent prior SLP treatment.
Speech, Language, and Related Disorder:	The diagnosis or diagnoses established by the speech-language pathologist. Examples are spoken language production disorder (expressive aphasia), dysarthria, and dysphagia.
Date of Onset (Occurrence Code 11):	The date of onset or exacerbation of the speech, language and related disorder diagnosis for which services were rendered by the billing provider.
Physician Referral and	Self-explanatory

Date Received by the Billing Provider:	
Initial Assessment and Date:	The procedure used by the speech-language pathologist to diagnose speech, language, and related disorders, and the date the initial assessment is completed by the billing provider.
Plan of Treatment and Date Established:	Self-explanatory
Date of Last Certification:	Intermediaries obtain the date on that the plan of treatment was last certified by the physician.
Progress Notes:	Intermediaries obtain updated patient status reports concerning the patient's current functional communication abilities/limitation.

6.3.1 - Medical History - (Rev. 3, 11-22-00)

If a history of previous SLP treatment is not available, the provider may furnish a general summary regarding the patient's past relevant medical history recorded during the initial assessment with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior treatment for the current condition, progress made, and treatment by the referring physician must be provided when available. The level of function prior to the current exacerbation or onset should be described.

The patient's medical history includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.
The history of treatments from a previous provider is necessary for patients who have transferred to a new provider for additional treatment. For chronic conditions, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled care.

6.3.2 - Assessment - (Rev. 3, 11-22-00)

Intermediaries approve the initial assessment when it is reasonable and necessary for the speech-language pathologist to determine if there is an expectation that either restorative services or establishment of a maintenance program will be appropriate for the patient's condition.

Reassessments are covered if the patient exhibits a demonstrable change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated SLP services. Periodic routine reevaluations (e.g., monthly, bimonthly) for a patient undergoing a

SLP program are part of the treatment session and are not covered as separate evaluations. An initial assessment or reassessment that is determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals. The initial assessment must include objective baseline diagnostic testing (standardized or non-standardized), interpretation of test results, and clinical findings. If baseline testing cannot be accomplished for any reason, note this in the initial assessment or progress notes, along with the reason(s). Include a statement of the patient's expected rehabilitation potential.

6.3.3 - Plan of Treatment - (Rev. 3, 11-22-00)

The plan of treatment must contain the following:

- Type and nature of care to be provided;
- Functional goals and estimated rehabilitation potential;
- Treatment objectives;
- Frequency of visits; and
- Estimated duration of treatment.

A. Functional Goals

Functional goals must be written by the speech-language pathologist to reflect the level of communicative independence the patient is **expected** to achieve outside of the therapeutic environment. The functional goals reflect the final level the patient is expected to achieve, are realistic, and have a positive effect on the quality of the patient's everyday functions. Intermediaries assume that certain factors may change or influence the final level of achievement. If this occurs, the speech-language pathologist must document the factors which led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status;
- Communicate personal self-care needs;
- Engage in social communicative interaction with immediate family or friends; or
- Carry out communicative interactions in the community.

Note: The term "communication" includes speech, language, as well as voice skills.

A functional goal may reflect a small, but meaningful change that enables the patient to function more independently in a reasonable amount of time. For some patients, it may be the ability to give a consistent "yes" and "no" response; for others, it may be the ability to demonstrate a

competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phases, and still others may regain conversational language skills.

B. Treatment Objectives

Treatment objectives are specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

C. Frequency of Visits

Frequency of visits is an estimate of how often the treatments are to be rendered (e.g., 3x week).

Length of visits are typically 30, 45, or 60 minutes. Sometimes patients are seen for shorter periods several times a day (e.g., three 10 minute sessions, or a total of 30 minutes). Rarely, except during an assessment, are sessions longer than 60 minutes. If so, the provider must justify them, by noting, for example, that the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average, special staff/family training is required. Post-operative intensive treatment is sometimes required (e.g., tracheoesophageal puncture) or post-onset of disorder (due to intensive family involvement).

D. Estimated Duration of Treatment

Estimated duration of treatment refers to the total estimated time over which the services are to be rendered, and may be expressed in days, weeks, or months.

6.3.4 - Progress Reports - (Rev. 3, 11-22-00)

Intermediaries obtain progress reports or treatment summary for the billing period including:

- The initial functional communication level of the patient at this provider setting;
- The present functional level of the patient and progress (or lack of progress) specific for this reporting period;
- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, intermediaries approve the services up to the time that no further significant

practical improvement can be expected. Progress reports must document a continued expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated. Intermediaries must not interpret the term "significant" so stringently that they may deny a claim because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall functional ability will occur. However, the speech-language pathologist and/or physician should document such lack of progress and explain the need for continued intervention.

Documentation includes a short narrative progress report and objective information in a clear, concise manner. This provides the reviewer with the status on progress in meeting the plan of treatment, along with any changes in the goals or the treatment plan. Medical reviewers request that new plans be forwarded with the original so that they can review the entire plan. However, the reviewer must have access to an overall treatment plan with final goals and enough objective information with each claim to determine progress toward meeting the goals.

Consistent reporting is important. For example, if the provider reports that the patient can produce an "m" 25 percent of the time, then reports 40, 60, 90 percent success, the intermediary may believe that treatment might be ending. However, if they have the final goal and the objectives, they can see the progress toward that goal and the steps needed to reach it. The speech-language pathologist might state that the final goal is "the ability to converse in a limited environment."

One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors." Short-term goals may include the patient's ability to initiate easier phonemes before other, more difficult, phonemes. Therefore, the speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might work on a group of phonemes having a "feature" in common before working on another group. For example, working on all bilabials (since the patient can easily see the movement), might be desirable prior to sounds that are produced more intraorally.

The speech-language pathologist may choose how to demonstrate progress. However, the method chosen, as well as the measures used, generally remain the same for the duration of treatment. The provider must interpret reports of test scores, or comparable measures and their

relationship to functional goals in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to document progress is changed, the reasons must be documented, including how the new method relates to the previous method. If the speech-language pathologist reports a sub-test score for one month, then a score of a different sub-test the next month without demonstrating the sub-test's interrelationship, you are not able to judge the progress. The intermediary should return these claims for an explanation/interpretation. They may refer the claims to Level III MR if needed.

6.3.5 -Level of Complexity of Treatment - (Rev. 3, 11-22-00)

Intermediaries must base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

6.3.6 - Reporting on New Episode or Condition - (Rev. 3, 11-22-00)

Occasionally, a patient who is receiving, or has previously received SLP services, experiences a secondary or complicating new illness. The provider documents the significance of any change to the communication capabilities. This may be by pre-and post-episodic objective documentation, through nursing notes or by physician reports. If the patient is receiving treatment, it might have to be lengthened because of his change in condition. If the patient has completed treatment, a significant change in the communication status must be documented to warrant a new treatment plan.

6.3.7 - Certification and Re-certification - (Rev. 3, 11-22-00)

SLP services must be certified and re-certified by a physician and furnished while under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified speech-language pathologist providing such services. If the plan is established by a speech-language pathologist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When outpatient SLP services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Intermediaries obtain the re-certification when reviewing the plan of treatment since the same interval of at least 30 days is required for the review of the plans. Re-certification must be signed by the physician who reviewed the plan of treatment. Any changes established by the speech-language pathologist must be in writing and signed by the speech-language pathologist or by the

attending physician. The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

6.4 - Qualified Speech-Language Pathologist - (Rev. 3, 11-22-00)

The following information is provided to familiarize the intermediary staff with Medicare requirements for qualifications of speech-language pathologists and specific acronyms commonly used. A qualified speech-language pathologist meets the following criteria:

- A person who is licensed, if applicable, by the State in which he/she is practicing; and
- Is eligible for a certificate of clinical competence in SLP granted by the American Speech Language Hearing Association; or
- Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

A qualified speech-language pathologist normally indicates certification status by utilizing CCC-SLP or CFY-SLP. A CCC-SLP is a Certificate of Clinical Competence in SLP and a CFY-SLP is a Clinical Fellowship Year in Speech-Language Pathology.

6.5 - Skilled and Unskilled Procedures - (Rev. 3, 11-22-00)

Certain services are skilled or non-skilled by definition. However, for coverage, the services must be reasonable and necessary based on the MR of the documentation submitted. The following are examples of specific types of skilled and nonskilled SLP procedures.

A. Skilled Procedures. Skilled procedures include:

- Diagnostic and assessment services to ascertain the type, causal factor(s) and severity of speech and language disorders. Reassessment is needed if the patient exhibits a change in functional speech or motivation, clearing of confusion, or remission of some other medical condition which previously contraindicated SLP or audiology services.
- Design of a treatment program relevant to the patient's disorder(s). Continued assessment of progress during the implementation of the treatment program, including documentation and professional analysis of the patient's status at regular intervals.
- Establishment of compensatory skills (e.g., air-injection techniques, word finding strategies).

- Establishment of a hierarchy of speech-language tasks and cueing that directs a patient toward communication goals.

- Analysis related to actual progress toward goals.

- Patient and family training to augment restorative treatment or to establish a maintenance program.

B. Unskilled Procedures. The following are considered unskilled procedures:

- Non-diagnostic/non-therapeutic routine, repetitive and reinforced procedures (e.g., the practicing of word drills without skilled feedback).

- Procedures which are repetitive and/or that reinforce previously learned material which the patient or family is instructed to repeat.

- Procedures which may be effectively carried out with the patient by any nonprofessional (e.g., family member, restorative nursing aide) after instruction and training is completed.

- Provision of practice for use of augmentative or alternative assessment communication systems.

Note: It is only after the patient has established a high level of consistency of performance in a task with the speech-language pathologist that unskilled techniques can be implemented.

6.5.1 - Statements Supporting and Not Supporting Coverage - (Rev. 3, 11-22-00)

This is documentation which is objective or subjective and demonstrates whether there is progress toward a stated functional goal.

A. Statements Supporting Coverage

Typically, these statements have an objective component which is compared to previous reports, and which demonstrate progress toward a stated functional goal.

Examples: "Mr. Smith achieved 75 on the Word Subtest on the Johnson Test of Aphasia compared with last month's score of 50 on the same Subtest."

"Mr. Jones achieved a combined score of 352 on the A, B, C, D, and E subtests this month compared with an overall score of 250 for these same subtests last month."

"Mrs. Jones achieved the next steps in the treatment plan outlined last month (see attached sheet). If she continues at this rate, she should complete treatment within the next 2 months."

"Mrs. Jones achieved 75% (7.5 out of 10 or 75 out of 100) on word naming which compares to last month's score of 50% (5.0 out of 10 or 50 out of 100)."

Note: Percentages should be based on real number count. **Interpretation of scores must be presented in progress notes or summary information.** The narrative should also contain reference to objective scoring, comparison of previous scores, or treatment plan with present status compared to previous status. This information may be embedded in narrative or attached, however, the reviewer should have access to this information and **stated functional goals.**

B. Statements That Do Not Support Coverage

Typically, statements that do not support coverage are subjective, and do not demonstrate progress toward a stated functional goal, or a comparison to previous test scores.

Examples: "Ms. Jones is very concerned about going home. She has begun smoking again which is causing family as well as physical problems."

"Speech somewhat slurred today."

"Mr. Smith more consistent in responses."

"Mr. Jones has shown significant improvement in his ability to make himself understood."

"Patient is now able to inject air 80% of the time." (No comparison to previous report.)

"Mrs. Smith achieved 75% accuracy on word naming task. (No comparison to previous report)."

"Auditory comprehension improved from moderately impaired to mildly impaired." (By itself, the statement does not offer sufficient objective information.)

C. Resumption of Treatment

There are conditions and circumstances that justify resuming treatment after it has been delayed. Intermediaries obtain verification (when needed for coverage decisions). Examples include:

- Patient becomes more alert, attentive, cooperative;

- Patient shows rehabilitation potential;
- Medical complications cleared;
- Environmental change improves motivation or communicative capabilities;
- Progressive nature of disorder warrants further treatment; and
- Drug or other medical treatment is reduced or ended.

6.5.2 - MR Considerations - (Rev. 3, 11-22-00)

A. Disorders Typically Not Covered for the Geriatric Patient

- Stuttering (except neurogenic stuttering caused by brain damage);
- Fluency Disorder;
- Cluttering;
- Disprosody;
- Disfluency;
- Myofunctional Disorders;
- Tongue Thrust; and
- Behavioral/Psychological Speech Delay.

B. Maintenance Program

Intermediaries approve claims only when the specialized knowledge and judgment of a qualified speech-language pathologist is required to design and establish a maintenance program. By the time the patient's restorative program has been completed, the maintenance program has already been designed, with instructions to the patient, supportive personnel, or family. They do not approve a separate charge for establishing the maintenance program immediately after the restorative program has been completed.

Intermediaries obtain documentation that justifies a provider reestablishing a maintenance program, e.g., loss in previous functional abilities occurs, intervening medical conditions develop, difficulty in communicating with care-givers arises.

The initial assessment should be documented with standardized testing (if possible) to establish base-line data. This is critical if a claim is submitted for care at a future date. Documentation should show that the maintenance program is designed by the speech-language pathologist appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician.

The maintenance program is established when documentation indicates it has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The documentation must give reasonable assurances that this has occurred. After that point, the services are not reasonable and necessary.

C. Group Treatment

Generally, group therapy treatment and attendance at social or support groups, such as stroke clubs or lost cord clubs, are not payable. Intermediaries ensure that the "reasonable and necessary" requirements are met.

D. Total Laryngectomy

Total laryngectomy is surgical removal of the larynx. Documentation may involve pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about alternative communication methods, and to provide an immediate means of communication. Documentation includes assessment and any treatment necessary to establish a means of communication using esophageal speech, an artificial larynx (electronic or pneumatic device), a tracheoesophageal puncture prosthesis, and/or other alternate communication methods.

E. Partial Laryngectomy

A partial laryngectomy is the surgical removal of part of the larynx. Documentation includes the voice problems that require assessment and treatment. Documentation may involve pre-op/post-op sessions as part of the assessment, and to inform the patient, the family, and staff about voice problems. Documentation for rehabilitation includes the assessment and type of treatment required for the voice disorders, as well as base-line objective data and progress notes.

F. Total Glossectomy

A total glossectomy is the surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication and/or

to establish an effective maintenance program. Documentation includes assessment and type of treatment for the articulation disorders. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

G. Partial Glossectomy

A partial glossectomy is the surgical removal of part of the tongue. Documentation should indicate the articulation problems that require assessment and treatment. Documentation may include pre-op/post-op sessions as part of the assessment to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery. Documentation includes the assessment and type of treatment for the articulation disorders including base-line objective data and progress notes. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

H. Congenital Disorders

Documentation for congenital disorders must always substantiate need, e.g., no previous treatment; the patient's communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected SLP communication. Intermediaries approve claims for maintenance or short-term treatment only if objective documentation supports that need.

I. Alzheimer's Disease (chronic brain syndrome, organic brain syndrome)

Objective documentation must indicate the patient's condition, alertness and mental awareness. Documentation must justify that services are needed to establish a reasonable and necessary maintenance program. Review these claims carefully for medical necessity.

J. Chronic Conditions

Intermediaries approve claims for patients with chronic conditions such as MS, ALS, Parkinson's Disease or Myasthenia Gravis if they document a need for reasonable and necessary short-term care or a need to establish a maintenance program. However, clear documentation must be present concerning any prior care or maintenance program designed for the same condition. They approve claims for reasonable and necessary short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, but only when the documentation supports the need to increase function, or to establish a maintenance program.

6.5.3 - FMR Evaluation - (Rev. 3, 11-22-00)

The HCFA edits will aid in identifying SLP claims for FMR. Intermediaries perform regular evaluations of provider claims which pass or fail the edits. Intermediaries must change the

focused review selection based on the results of the evaluation. For example, a provider billing at an aberrant rate consistently, just below the parameters is to be subjected to focused review.

Intermediaries must be on the alert for any of the following trends or characteristics in developing focused MR:

- Edits with high charges per aggregate bill charges;
- Providers billing a higher than average utilization of specific diagnostic codes that fall just below the edit parameters; or
- Specific principal DX codes, such as those with longer visits and duration, those representing the most frequent denials in pre-pay MR, special codes, and/or certain edit groups such as 1, 3, 5 and 8 in one quarter, and others in the next quarter.

6.5.4 - SLP Terms - (Rev. 3, 11-22-00)

A. Agnosia

Agnosia is the inability to attach meaning to sensory information although the physiologic receptor mechanism is intact.

B. Agrammatism

Agrammatism is the impairment of the ability to produce words in their correct sequence; difficulty with grammar and syntax.

C. Agraphia

Agraphia is a disorder of writing. It may result from a central nervous system lesion or from lack of muscular coordination.

D. Anomia

Anomia is loss of the ability to identify or to recall and recognize names of persons, places or things.

E. Aphasia

Aphasia is a communication disorder caused by brain damage and characterized by complete or partial impairment of language comprehension, formulation, and use. It excludes disorders associated with primary sensory deficits, general mental deterioration, or psychiatric disorders. Partial impairment is often referred to as dysphasia.

F. Aphonia

Aphonia is loss of voice.

G. Apraxia

Apraxia is:

- Disruption in the ability to transmit a motor response along a specific modality; involves disruption of voluntary or purposeful programming of muscular movements while involuntary movements remain intact; characterized by difficulty in articulation of speech, formulation of letters in writing, or in movements of gesture and pantomime.

- In speech, a nonlinguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movements (respiratory, laryngeal, and oral) for the volitional production of phonemes.

H. Dysarthria

Dysarthria is the term for a collection of motor speech disorders due to impairment originating in the central or peripheral nervous system. Respiration, articulation, phonation, resonation, and/or prosody may be affected; volitional and automatic actions, such as chewing and swallowing, and movements of the jaw and tongue may also be deviant. It excludes apraxia and functional or central language disorders.

I. Dysphagia

Dysphagia is difficulty in swallowing. It may include inflammation, compression, paralysis, weakness, or hypertonicity of the esophagus.

J. Generalization

Generalization is:

- In conditioning, the eliciting of a conditioned response by stimuli similar to a particular conditioned stimulus.

- Transfer of learning from one environment to a similar environment; the more similar the environments or situations, the greater transfer takes place.

K. Hard Glottal Attack

A hard glottal attack is forceful approximation of the vocal folds during the initiation of phonation.

L. Intonation

Intonation is the linguistic system within a language which is concerned with pitch, stress, and juncture of the spoken language; a unit with specific communicative import, such as interrogation, exclamation, and assertion.

M. Lexicon

Lexicon is total accumulation of linguistic signs, words or morphemes, or both, in a given language; the list of all the words in a language.

N. Morphology

Morphology is a component of grammar concerned with the formation of words, the smallest meaningful unit in a language, as a bridge between phonology and syntax.

O. Obturator

Obturator is (l) Any structure which occludes an opening. (2) Prosthetic appliance, similar to a dental plate, that forms an artificial palate to cover a cleft palate, designed so that the musculature of the palate and pharynx are able to contract around it.

P. Paraphasia

Paraphasia is any error of commission modifying a specific word (sound and morpheme substitution) or of word substitution in the spoken or written production of a speaker or writer.

Q. Perseveration

Perseveration is the tendency to continue an activity, motor or mental, once started, and to be unable to modify or stop even though it is acknowledged to have become inappropriate.

R. Phoneme

Phoneme is the shortest arbitrary unit of sound in a given language that can be recognized as being distinct from other sounds in the language.

S. Phonological

Phonological is a component of grammar determining the meaningful combination of sounds.

T. Pitch

Pitch is acuteness or gravity of a tone, dependent upon the frequency of the vibrations producing it and their intensity and overtone structure. The greater the number of vibrations per unit of time, the higher the pitch and the more acute the tone.

U. Pragmatics

Pragmatics is the functional use of language in context. It includes such factors as intention in communication; sensorimotor actions preceding, accompanying, and following the utterance; knowledge shared in the communicative dyad; and the elements in the environment surrounding the message.

V. Prosody

Prosody is:

- Physical attributes of speech that signal linguistic qualities such as stress and intonation. It includes the fundamental frequency intensity of the voice, and the duration of the individual speech sounds.

- A melody of speech determined primarily by modifications of pitch, quality, strength, and duration; perceived primarily as stress and intonational patterns.

W. Psychoacoustics

Psychoacoustics is the combined disciplines of psychology and acoustics concerned with the study of man's response to sound.

X. Semantic

Semantic is a component of grammar concerned with word meanings and meaningful sentences.

Y. Syntactic

Syntactic is a component of grammar concerned with grammatically well formed structures.

6.5.5 - Acronyms and Abbreviations - (Rev. 3, 11-22-00)

ADL - Activities of Daily Living.
ALPS - Aphasia Language Performance Scales.
ASHA - American-Speech-Language-Hearing Association.
ASL - American Sign Language.
CVC - Consonant-vowel-consonant.
CPS - Cycles per second. Former unit of measurement for the number of successive compressions and rarefactions of a sound wave within one second of time, now replaced with Hertz (Hz).
Dx - Diagnostic therapy.
MLU - Mean Length of Utterance - Average length of oral expressions as measured by a representative sampling of oral language. It is usually obtained by counting the number of morphemes per utterance and dividing by the number of utterances.
VOT - Voice Onset Time - (1) Time between the release of the stop consonant and the beginning of voicing in the vowel. (2) Time required to initiate sound at the vocal folds.

6.5.6 - SLP Tests - (Rev. 3, 11-22-00)

These tests include but are not limited to:

A. Widely Used Adult Language Tests

- Ammons Full Range Picture Vocabulary Test;
- Aphasia Clinical Battery I;
- Aphasia Language Performance Scales (ALPS);
- Appraisal of Language Disturbances (ALD);
- Boston Diagnostic Aphasia Examination (BDAE);
- Communicative Abilities in Daily Living (CADL);
- Examining for Aphasia;
- Functional Communication Profile;
- International Test for Aphasia;
- Language Modalities Test for Aphasia;
- Language Proficiency Test (LPT);
- Minnesota Test for Differential Diagnosis of Aphasia;
- Porch Index of Communicative Abilities (PICA);
- Revised Token Test;
- Sklar Aphasia Scale;
- Token Test for Receptive Disturbances in Aphasia;
- Hodson Phonological Process Analysis;
- Clinical Evaluation of Language Functions (CELF);
- Western Aphasia Battery.

B. Widely Used Adult Articulation Tests

- Apraxia Battery for Adults (ABA);
- Assessment of Intelligibility of Dysarthric Speech;
- Compton-Hutton Phonological Assessment;
- Frenchay Dysarthria Test;
- The Fisher-Logemann Test of Articulation Competence;
- Iowa Pressure Articulation Test;
- Templin Darley Test of Articulation.

C. Speech and Language Diagnostic Tests

Speech and language diagnostic tests are an initial assessment (including diagnostic testing, if clinically possible) must be performed **prior** to the commencement of treatment. If the reviewer needs assistance in understanding tests used, consult the speech language pathologist consultant or the American Speech, Language, Hearing Association.

10 - Special Instructions for MR of Dysphagia Claims - (Rev. 3, 11-22-00)

Intermediaries must follow the procedures described below for medical review of dysphagia claims for SLP, OT, and PT services.

A. Medical Work-up

Documentation by the physician must establish a preliminary diagnosis and form the basis of estimates of progress. Patients must be selected for therapy after a proper medical diagnostic evaluation by a physician. The medical work-ups must document whether the difficulty involves the oral, pharyngeal, or esophageal phase of swallowing. This may involve collaboration with therapists or speech-language pathologists.

B. Dysphagia Criteria - Oral, Pharyngeal, or Esophageal (upper one third) Phase of Swallowing

Documentation must indicate the patient's level of alertness, motivation, cognition, and deglutition. In addition, at least one of the following conditions must be present:

- History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia;

- Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgling voice quality after swallowing liquids or delayed or slow swallow reflex;

- Presence of oral motor disorders such as drooling, oral food retention, leakage of food or liquids placed into the mouth;

- Impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties;

- In-coordination, sensation loss, (postural difficulties) or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the buccal cavity and/or bite, chew, suck, shape and squeeze the food bolus into the upper esophagus while protecting the airway;

- Post-surgical reaction affecting ability to adequately use oropharyngeal structures used in swallowing;

- Significant weight loss directly related to non-oral nutritional intake (g-tube feeding) and reaction to textures and consistencies; or

- Existence of other conditions such as presence of tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis, and cricopharyngeal dysfunction.

C. Esophageal (lower two thirds) Phase of Swallow

Esophageal dysphagia (lower two thirds of the esophagus) is difficulty in passing food from the esophagus to the stomach. If peristalsis is inefficient, patients may complain of food getting stuck or of having more difficulty swallowing solids than liquids. Sometimes patients experience esophageal reflux or regurgitation if they lie down too soon after meals.

Inefficient functioning of the esophagus during the esophageal phase of swallowing is a common problem in the geriatric patient. Swallowing disorders occurring only in the lower two thirds of the esophageal stage of the swallow have not generally been shown to be amenable to swallowing therapy techniques and may not be approved. An exception might be when discomfort from reflux results in food refusal. A therapeutic feeding program in conjunction with medical management may be indicated and constitute reasonable and necessary care. A reasonable and necessary assessment of function, prior to a conclusion that difficulties exist in the lower two thirds of the esophageal phase, may be approved, even when the assessment determines that skilled intervention is not appropriate.

D. Assessment

Medical work-up and professional assessments must document history, current eating status, and clinical observations such as:

- Presence of a feeding tube;
- Paralysis;
- Coughing or choking;
- Oral motor structure and function;
- Oral sensitivity;
- Muscle tone;
- Cognition;
- Positioning;
- Laryngeal function;
- Oropharyngeal reflexes; and
- Swallowing function.

This information is used to determine necessity for further medical testing, e.g., videofluoroscopy, upper GI series, endoscopy. If videofluroscopic assessment is conducted (modified barium swallow), documentation must establish that the exact diagnosis of the swallowing disorder cannot be substantiated through oral exam and there is a question as to whether aspiration is occurring. The videofluoroscopy assessment is conducted and interpreted by a radiologist with assistance and input from the physician and/or individual disciplines. The assessment and final analysis and interpretation should include a definitive diagnosis, identification of the swallowing phase(s) affected, and a recommended treatment plan. An analysis by an individual discipline may be submitted as a separate line item charge.

E. Care Planning

Documentation must delineate goals and type of care planned which specifically addresses each problem identified in the assessment, such as:

- Patient care-giver training in feeding and swallowing techniques;
- Proper head and body positioning;
- Amount of intake per swallow;
- Appropriate diet;
- Means of facilitating the swallow;
- Feeding techniques and need for self help eating/feeding devices;
- Food consistencies (texture and size);
- Facilitation of more normal tone or oral facilitation techniques;
- Oromotor motor and neuromuscular facilitation exercises to improve or motor control;
- Training in laryngeal and vocal cord adduction exercises;
- Compensatory swallowing techniques; and

- Oral sensitivity training.

As with all rehabilitation services, there must be a reasonable expectation that the patient will make material improvement within a reasonable period of time.

F. Professional Services

Services are sometimes performed by speech-language pathologists, occupational therapists and physical therapists in concert with other health professionals. Services are often performed as a team with each member performing unique roles which do not duplicate services of others. Services may include, but are not limited to, the following example.

Example: One professional assisting with positioning, adaptive self help devices, inhibiting abnormal oromotor and/or postural reflexes while another professional is addressing specific exercises to improve oromotor control, determining appropriate food consistency form, assisting the patient in difficulty with muscular movements necessary to close the buccal cavity or shape food in the mouth in preparation for swallowing. Another professional might be addressing a different role, such as increasing muscle strength, sitting balance and head control.

Intermediaries medically review in accordance with general principles for coverage in MIM §§3101ff. and documentation in PIM Chapter 6 §§5ff., §§6ff., and 7ff.

G. Chronic Progressive Diseases

Patients with progressive disorders, such as Parkinson's disease, Huntington's disease, Wilson's disease, multiple sclerosis, or Alzheimer's disease and related dementias, do not typically show improvement in swallowing function, but will often be helped through short-term assistance/instruction in positioning, diet, feeding modifications, and in the use of self help devices. Intermediaries medically review documentation in support of short-term assistance/teaching and establishment of a safe and effective maintenance dysphagia program.

Chronic diseases such as cerebral palsy, status post-head trauma or stroke (old) may require monitoring of swallowing function with short-term intervention for safety and/or swallowing effectiveness. Documentation should relate to either loss of function, or potential for change. As with other conditions/disorders, the reasonableness and necessity of services must be documented.

Documentation should include:

- Changes in condition or functional status;
- History and outcome of previous treatment for the same condition; and
- Other information which justifies the start of care.

H. Nasogastric Tube or Gastrostomy Tube

The presence of a nasogastric or gastrostomy tube does not preclude need for treatment. Removal of a nasogastric or gastrostomy tube may be an appropriate treatment goal.

I. Safety

Although the documentation must indicate appropriate treatment goals to improve a patient's swallowing function, it must also indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Improving the patient's safety and quality of life by reduction or elimination of alternative nutritional support systems and advancement of dietary level, with improved nutritional intake should be the primary emphasis and goal of treatment. The documentation must be consistent with these goals and indicate the reasonableness and need for skilled intervention.

J. Skilled Level of Care

Documentation of ongoing dysphagia treatment should support the need for skilled services such as observation, treatment, and diet modification. Documentation which is reflective of routine, repetitive observation or cuing may not qualify as skilled rehabilitation.
For example, repeated visits in which the care-giver appears only to be observing the patient eating a meal, reporting on the amount of food consumed, providing verbal reminders (e.g., slow down or cough) in the absence of other skilled assistance or observation suggests a non-skilled or maintenance level of care. Maintenance programs are covered for a brief period and are usually included during the final visits of the professional.

K. Professional Qualifications

Swallowing rehabilitation is a highly specialized service. Intermediaries should assume that the professionals rendering care have the necessary specialized training and experience. They refer any suspected patterns of poor quality to the RO.

L. Consultation

Intermediaries are encouraged to seek consultation/advice from the American Speech-Language-Hearing Association, American Occupational Therapy Association, and American Physical Therapy Association as these claims often require MR by therapy or speech-language pathology consultants.

Definition

Respiratory therapy is defined as services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Respiratory Therapy Services

Respiratory therapy services include but are not limited to:

- The application of techniques for support of oxygenation and ventilation in the acutely ill patient;
- The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and such equipment as resuscitators and ventilators;
- Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning;
- Diagnostic tests for evaluation by a physician, e.g., pulmonary function tests, spirometry, and blood gas analyses;
- Pulmonary rehabilitation techniques;
- Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services; and,
- Such services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel.

To Qualify for Reimbursement

To qualify for reimbursement under Medicare, such therapy:

- Must qualify as a covered service; and,
- Must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

Qualifications as a Covered Service

Section 4432(b)(5)(D) of the Balanced Budget Act (BBA) of 1997 amended Section 1861(h)(7) of the Social Security Act to cover the full range of services that SNFs generally provide, either directly or under arrangements with any qualified outside source. Therefore, services of respiratory therapists are covered under Part A when provided by a nurse on the staff of the SNF or under arrangements made directly between the SNF and any qualified respiratory therapist, regardless of whether the therapist is employed by the SNF's transfer agreement hospital.

Although some diagnostic testing is considered respiratory therapy, coverage of such tests is governed by the guidelines relating to the coverage of diagnostic tests.

Criteria for Determining if Respiratory Therapy is Reasonable and Necessary

To be considered reasonable and necessary for the diagnosis or treatment of an individual's illness or injury, respiratory therapy services furnished to a beneficiary must be:

Consistent with the Nature and Severity of the Individual's Symptoms and Diagnosis – A patient's primary or secondary diagnosis alone may justify the need for respiratory therapy. However, there may be cases in which the primary or secondary diagnosis alone does not justify the need for respiratory therapy, but the medical evidence indicates a combination of diagnoses which may justify therapy.

Reasonable in Terms of Modality, Amount, Frequency and Duration of the Treatment – Although respiratory therapy services may be reasonable and necessary based on the nature and severity of the patient's condition, they must also be reasonable and necessary with respect to modality, amount, frequency, and duration.

Generally Accepted by the Professional Community as Being Safe and Effective Treatment for the Purpose Used – In the absence of evidence to the contrary, it may be presumed that respiratory therapy is an accepted treatment and may be covered under Medicare.

While there are many conditions for which respiratory therapy may be indicated, for Medicare purposes, coverage of respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for such services.

Examples of the Guidelines

Setting Up Environment and Instructing Patients in Its Use – When appropriate, setting up of respiratory equipment, instructing and monitoring patient progress in the use of equipment or on postural drainage, and breathing exercises by a respiratory therapist or technician are considered reasonable and necessary services even though the direct patient supervision of such therapy may be the responsibility of the nursing service.

Oxygen Therapy – Oxygen therapy is administered utilizing many devices ranging from the simple nasal cannula to progressively complex techniques providing controlled oxygen concentrations. Such devices are usually applied, maintained, and monitored by respiratory therapists and technicians.

The goal of oxygen therapy is to maintain adequate tissue and cell oxygenation while trying to minimize the danger of oxygen toxicity. Periodic measurement of the oxygen saturation at rest and/or during exercise aids in determining the appropriate amount of oxygen to be administered, and is necessary until the patient has achieved a stable status.

The physician's order must state the oxygen device and/or the specific flow rate or concentration of oxygen desired. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy.

Monitoring Services – The term monitoring means periodic checking of the equipment in actual use for the purpose of ascertaining that it is functioning properly; monitoring the patient's condition to ensure they are receiving the proper mixtures of medical gases, mists and aerosols; periodic checking of the acute and chronically ill patients; and checking the patient's progress. Checking solely to determine if a patient is using oxygen and the amount of oxygen used is not considered the type of monitoring that requires specialized skills or training, and therefore, is not a covered respiratory therapy service.

Medicare Part A Beneficiary

Nursing Documentation

Documentation must focus upon the conditions for which the patient is receiving skilled coverage. These conditions may have prompted the initial hospitalization, but also include the conditions that arose during their recovery in the SNF. Skilled services must be identified as rendered on a daily basis to support Medicare Part A coverage. Supportive nursing notes contain details regarding skilled treatments, observations and assessments for exacerbations of conditions, and teaching and training provided. Components of daily nursing notes include: System assessments, ADL support provided, and any pertinent data that supports a high likelihood of change in condition. Documenting the patient's attendance and response to therapy upon return to the unit supports a team approach toward ensuring medical safety and promoting recovery.

The American Nurses Association standards of nursing practice require that documentation be based on the nursing process, ongoing and accessible to all members of the healthcare team. For professional, helpful, and accurate documentation based on the requirements of your state's Nursing Practice Act, your notes should be:

- Objective, not critical or subjective.
- Clear, concise, and comprehensive.
- Accurate, truthful and honest; documentation should not appear self-serving, especially if an incident or injury occurs.
- Reflective of observations, not of unfounded conclusions.
- Reflective of a resident's response to care and actions taken to rectify unsatisfactory responses.
- A complete record of nursing care provided, including assessments, identification of health issues, a plan of care, implementation, and evaluation.
- Permanent, retrievable, confidential, resident-focused, and outcome based.
- Completed using forms, methods and systems that are consistent with these standards, facility policies, and also state laws.

Documentation to support coverage must identify the instability or probability of a change in the patient's condition. The presence of one or more of the following is sufficient:

- A nursing care plan that describes the patient's condition, specifies problems or potential problems and planned intervention on a daily basis or more frequent basis;

- Indication of daily or more frequent monitoring of vital signs, description of lung or bowel sounds and skin conditions, deficiencies in nutritional status and hydration, mental status and mobility related to the instability or probable changes in condition. This information documents that there is ongoing observation and assessment of the patient;

- Documented changes in the patient's vital signs, nutritional status, skin condition, etc. that reflect "instability". Lack of changes in physical condition does not, in itself, preclude the need for observation and assessment. Documentation must support that there is a **reasonable probability for changes in the patient's condition**; and

- **Repeated modifications in the treatment plan** as a result of changes in the patient's condition.

Admission Note

The following information should be included in all admission notes:

- Time and date of admission.

- Mode of Transportation, assist level with transfers.

- Location prior to admission.

- Age, primary diagnosis, other pertinent medical history.

- Prior level of functioning and if possible, discharge diagnoses.

- List any skilled needs which have been identified.

Example Admission Nurses Note

- Patient was admitted on 9/21/06 at 5:30 p.m. from Hospital with left TKA, via ambulance requiring 2 people assist with transfer from the stretcher. Medical history includes IDDM, HTN, and CAD. He lives with his wife and he ambulated with a cane, and he plans to return home. Patient will require daily skilled nursing assessments for complications related to knee replacements and multiple medical complications. Daily observation and assessment of vital signs, monitoring for pain and response to medication, daily assessment of wound, drainage and treatment, effects of immobility, pulmonary assessment, observation for signs and symptoms of infection, embolism and thrombophlebitis.

- 12/1/06 2pm: This 89 year old female is admitted to a Medicare certified bed via ambulance stretcher from General Hospital with 2 attendants. Patient transferred to bed and positioned with assist of 3. Patient was hospitalized after a fall sustaining a contusion of the hip and further found to have suffered an acute MI. X-rays are negative for fracture. Cardiac medications have been initiated and BP's low during hospital stay.

Additionally, hospital course includes the development of pneumonia, exacerbation of COPD and UTI treated with IV antibiotics, IV fluids, IV steroids and respiratory treatments. Past history of COPD, HTN and compression fractures of LS spine. Patient is admitted for daily skilled nursing for observation and assessment of cardiopulmonary status, monitoring for recurrence of infection and pain management. Patient to receive skilled PT and OT services to assist in return to PLOF, independent with self care and mobility with discharge plan for return to home alone. Patient is alert and oriented x4 and motivated to return home. See nursing admission assessment for additional details.

- (Date/Time) 80 year old female admitted to RMNH Medicare A bed, RM 101B via CC Ambulance from Falmouth Hospital for daily skilled services. She was admitted to FH on date for CHF and mental status changes. Medical Hx includes: CVA 9/99 with R sided weakness, HTN & CHF. Prior to admit to FH, resident was home alone living independently with family nearby. Resident will require daily skilled nursing observation and assessment of her cardiopulmonary status to eval for danger of recurrence of CHF and related complications. Also include: Skin, VSS, Cardio/Pulmonary assessment, cognition, etc.

The initial nursing admission note should identify the mode of transportation into the facility. Nursing needs to identify that the patient arrives via stretcher/ambulance, private auto or chair car. Admission notes need to further identify how the patient transferred from the stretcher and how the removal of stretcher linens and positioning in bed occurred upon the patient's arrival. The patient that is transferred from the stretcher and positioned in the bed may yield the extensive assist of two coding for the 5-day MDS, assuming that 3 occurrences of extensive assistance have been provided in the last 7 days.

Patient was admitted via stretcher and received extensive assist of three to move from the stretcher to the bed. Patient received extensive assist of two to position in the bed.

Daily Note

Supportive skilled documentation includes the following terms or phrases:

- Skilled neurological assessment resulted in…
- Observation and assessment for potential complications related to …
- The patient requires daily skilled management and evaluation of care plan.
- The patient is at high risk for falls secondary to…
- The patients' medication was adjusted to… on going skilled assessment of medication regime will be needed to promote recovery and ensure medical safety.
- The patient continues to require daily skilled nursing as her treatment regiment is not essentially stabilized and there is potential for recurrence of …
- The patient continues to require daily skilled rehab for…

Additional guidelines for daily skilled observation and assessments of common conditions include:

- **Neurological**: resident's level of consciousness and response to verbal and/or painful stimuli, pupil size, reaction, movement/weakness, seizure, activity.
- **Respiratory:** Shortness of breath, dyspnea, cyanosis, lung sounds – rales, rhonchi, wheezing; productive cough, thick, copious sputum; respiration, depth, and rate; blood gases.
- **Cardiac:** Pulse rate, rhythm; peripheral edema; chest pain; lung sounds; adverse reactions and/or adjustments to medication; rapid weight gain; cyanosis.
- **Gastrointestinal:** Nausea, vomiting; diarrhea; sudden weight loss; gastric pain.
- **Circulatory:** Pedal pulse; color, warmth of extremity; capillary refill; edema; pain/numbness/tingling.
- **Surgical:** Incision site – signs and symptoms of infection, approximation.
- **Genitourinary:** Urinary tract infection – burning, frequency, hematuria, pain and fever: Urine culture and sensitivity.

The daily skilled narrative nursing note shows the critical thinking, judgment decision making by skilled nurses. It further supports why daily skilled coverage is appropriate. A complete record contains an accurate and functional representation of the individual. It must contain data regarding the status of the individual, plans of care and provides evidence of the effects of the care provided.

Example Daily Nurses Note

- Daily skilled nursing observation and assessment of cardiopulmonary status reveals BP of 98/58, AP 66 and irregular, 02 sat 92% on oxygen @2l/m, RR 26 with dyspnea upon exertion and productive cough. Rhonchi present in bilateral lung fields. Respiratory treatment via nebulizer tolerated well without significant change in AP rate. Patient encouraged and instructed in coughing and deep breathing exercises expectorating large amounts of yellow sputum following nebulizer. MD notified of BP and parameters ordered for cardiac medications. Patient is continent and voiding clear yellow odorless urine without complaints of dysuria. Temperature 99 degrees, fluids are encouraged and

taken well. Patient was medicated for complaints of left hip pain (6/10) prior to rehab with response to (2/10) following medication. Patient requires extensive assist of 2 to position in bed, transfer to wheelchair and bedside commode due to hip pain and weakness. Patient attended PT and OT with noted fatigue upon return however, remains motivated to return to PLOF and home. Alert and oriented x4.

Additional examples include:

- Patient is at high risk for exacerbation of (condition). Daily skilled nursing services are required to assess and observe for signs and symptoms of exacerbation of (condition). Assessment reveals: (objective data)

- Due to the complexity of the patients' medical status, daily skilled nursing oversight and management of care plan is required to ensure medical safety and promote recovery. (identify active medical/psychological conditions)

- Patients' medical status is unstable and warrants daily skilled nursing observation and assessment for potential changes to treatment regimen until status has essentially stabilized. (identify unstable conditions with objective data)

Documentation should identify response to treatment, change in condition and changes in treatment. Good practice indicates that for functional and behavioral objectives, the clinical record should document change toward achieving care plan goals. Medicare documentation must provide an accurate, timely and complete picture of the skilled nursing or therapy needs of the resident. Documentation must justify the clinical reasons and medical necessity for Medicare part A coverage, the skilled services being delivered, and the on-going need for coverage.

Weekly Note

A weekly Medicare note by the Medicare nurse may be indicated to support skills for patients needing additional documentation. These notes would summarize outcomes of skilled observation and assessment. In conjunction with nursing education, this note can serve as a model for daily notes. Medicare notes should have the specific areas highlighted by underlining the skilled areas.

Conflicts in ADL coding found throughout the medical record (nursing assistant flowsheets) can be resolved by providing clarification in a weekly Medicare note.

This note is an exceptionally important note to define the reasons for skilled care. The care component worksheets can be of assist, however, it is imperative that the following are addressed:

- Onset date
- Reasons for skilling
- Rehab frequency, duration, and working discharge date
- Progress toward set goals
- Level of assist with bed mobility, eating, transfers, toileting
- Staff/Family Training
- Last covered day and projected discharge date and place

Example Weekly Nurses Note

- Patient discussed at weekly beneficiary review meeting. Potential for medical complications related to (L) CVA. Plan of care is being monitored to promote recovery and ensure medical safety. Anticoagulation therapy in process.

1. Vital Signs _____
2. Presence or absence of active abdominal, joint pain or other pain.
3. Presence or absence of active signs of bleeding (hematuria, petechiae, bruising, bloody stools, nose bleeds) at least Q day.
4. Presence or absence of signs of hemorrhage under the skin (oral mucosa and/or conjunctiva at least Q day).
5. Color-cyanosis or pallor.
6. Patient/resident/caregiver training RE: S/S of anticoagulant complications.
7. Results of Pro-Times or PTs.
8. Any communication with the physician and reason.
9. Level of care with ADL's include bed mobility, eating, transfers and toileting.
10. Working discharge date with discharge setting

Nursing Note Documentation Cue Sheet

Nursing documentation must focus upon the conditions for which the patient is receiving skilled coverage. These conditions may have prompted the initial hospitalization, but also include the conditions that arose during their recovery in the SNF.

The Fiscal Intermediaries (FI) use the medical review guidelines found in the Program Integrity Manual (PIM) in conjunction with the Medicare SNF coverage guidelines and policy training guidelines to make coverage decisions.

All SNF's are required by regulation to assess each patient, identify their needs, and develop an individual plan of care to meet the needs (42 CFR 483.20.) Many patients in SNF's will require some skilled services and skilled nursing oversight to ensure that the plan of care is carried out. The documentation must "distinguish between patients who require **daily** skilled observation and assessment or management and evaluation and patients that require **periodic** skilled services on a less than daily basis and/or a supportive environment and oversight to ensure their general well being" per the PIM.

Documentation to support coverage must identify the instability or probability of a change in the patient's condition. The following Nursing Note Documentation Cue Sheet provides a guide for nursing skills to cue nursing documentation for admission note contents. Varying with each diagnosis the admission note should contain detailed information on observations and assessments performed during the admission evaluation of the patient.

Identification of specific skilled assessment and observation are identified on the cue sheet. For example, new insulin dependence vs. diabetic management or medication changes. Patients admitted for psychiatric stay would also benefit from listing specific medication changes that require skilled observation and assessment due to the risk of medical complication. For example, new antipsychotic use with risk of fall, weight loss and lethargy vs. medication monitoring.

Nursing Note Documentation Cue
Admission nurses note should include:

Admission Note Contents	Admission Note Contents (cont.)
• Time and date admitted • Room number • Mode of transportation • Location prior to admission • States patient admitted for daily skilled services to a certified Medicare bed • Age, primary diagnosis, other pertinent medical Hx	• Prior to hospital level of functioning and if possible, discharge destination • List of all nursing assessments which related to the primary diagnosis and related secondary diagnoses • List of any other skilled needs which have been identified

Example of Dx: and key observation/assessment points, which should be reflected in nurses note:

Neurological	Respiratory
• Level of consciousness – responds to verbal and/or painful stimuli • Pupil size, reaction • Movement/weakness • Seizure, activity	• Shortness of breath • Dyspnea, cyanosis • Lung sounds – rales, rhonchi, wheezing • Productive cough, thick, copious sputum • Respiration, depth, and rate • Blood gases

Cardiac	Gastrointestinal
• Pulse rate, rhythm • Peripheral edema • Chest pain • Lung sounds • Medication – adverse reactions and/or adjustments • Rapid weight gain • Cyanosis	• Nausea, vomiting • Diarrhea • Sudden weight loss • Gastric pain

Circulatory	Surgical
• Pedal pulse • Color, warmth of extremity • Capillary refill • Edema • Pain/numbness/tingling	• Incision Site – signs and symptoms of infection, approximation

Daily Medicare Nursing Note (Grid Summary)

Skilled nursing services must be identified as rendered on a daily basis to support Medicare Part A coverage.

Supportive nursing notes contain details regarding skilled treatments, observations and assessments for exacerbations of conditions, and teaching and training provided. Components of daily nursing notes include: System assessments, ADL support provided, and any pertinent data that supports a high likelihood of change in condition. Documenting the patient's attendance and response to therapy upon return to the unit supports a team approach toward ensuring medical safety and promoting recovery.

Fine tuned skilled nursing documentation includes key Medicare terminology to offer further support of ongoing skilled coverage. Patient's admitted to the SNF for skilled rehabilitation services are initially hospitalized for a medical condition. It is the medical condition or complications and co-morbidities that contribute to the decline in function thus requiring skilled therapy services AND skilled nursing interventions on a daily basis.

Documentation should identify response to treatment, change in condition and changes in treatment. Good practice indicates that for functional and behavioral objectives, the clinical record should document change toward achieving care plan goals.

Skilled intervention may consist of observing, assessing, educating, training, and managing the overall care of the beneficiary. Recording this intervention assists in painting an accurate portrait for clinical and financial purposes.

Medicare documentation must provide an accurate, timely and complete picture of the skilled nursing or therapy needs of the resident. Documentation must justify the clinical reasons and medical necessity for Medicare Part A coverage, the skilled services being delivered, and the on-going need for coverage.

The Daily Medicare Nursing Note provides an outline of required and supportive data to document on each day/shift during a Medicare Part A stay in the SNF. Space is provided on the back of each sheet for narrative notes regarding situational occurrences.

Daily Medicare Nursing Note

Date: _____

Vital Signs:	DAY	EVE	NOC
Temperature			
Pulse			
Respiration			
Blood Pressure			

Pain Reports:			
Yes/No Scale 1-10			

Pulmonary:			
Lung Sounds			
Oxygen Sat			

Behavior:			
(withdrawn, anxious, sad, refuses care)			

Initials:			

FUNCTIONAL STATUS	DAY		EVE		NOC	
	Self	Support	Self	Support	Self	Support
Bed Mobility: ➢ How patient goes to-and-from lying position, turns on side, positions self; and scoots up in bed.						
Transfer: ➢ How patient moves from bed to chair – wheelchair.						
Eating: ➢ Supplement, snack, tube feeding.						
Toilet Use: ➢ Transfers on/off commode or bed pan; hygiene. ➢ Continent ➢ Incontinent						
Initials:						

*Daily Narrative Note: (Over)

Score Legend for Functional Status	
ADL Self-Performance	**ADL Support**
0-Independent	0-No setup or help
1-Supervision	1-Set help only
2-Limited Assist	2-1 person physical assist
3-Extensive Assist	3-2 person physical assist
4-Total Dependence	8-Activity did not occur
8-Activity did not occur	

Initials	Signatures

Patient Name: _____ Room #: _____ Case #: _____

Daily Medicare Nursing Note (Continued)

Date:	Daily Nurses Note:	Nurses Name:

Hospital to SNF/NF Nurse Telephone Report

When a patient is admitted the pre-admission data from the hospital is vital information to continuum of care. In the case that hospital data is not forwarded the facility can obtain hospital events via the SNF nurse to hospital nurse report. While copies of the supporting documentation are most desired it may be challenging to obtain at times.

It is crucial to know the dates of procedures and services provided while hospitalized. This information is vital to accurately code the MDS, reflect the medical complexity of the beneficiary, guide skilled assessments and ensures optimal reimbursement.
Patients admitted to skilled nursing facilities from acute hospitals are often most vulnerable in the first days following the transfer. In the first few hours and days, outcomes may hinge upon the quality of information provided in the transfer information.

Recent studies per the AMDA (American Medical Directors Association) have identified problems in current processes for inter-institutional patient transfers. Accompanying documentation is at times inaccurate or incomplete. Consequences of inadequate documentation range from unnecessary repetition of costly tests to serious adverse drug interactions, to falls, and worse. Valuable pre-admission data includes:

- Medication Administration Records for IV medication and IV fluid administration
- Treatment records
- Detailed skin assessments
- Emergency Room details
- Transfusion dates
- Progress notes (MD, Nursing and Therapy)
- History and Physical
- Discharge Summary
- Nursing Graphic flowsheets (temperatures, vital signs and Intake and Output records)

When the patient is admitted or returns to the facility without information noted above instruct nursing to review all transfer information and contact the hospital discharging nurse for details as indicated. This is an opportunity for the nurse receiving the patient to obtain data such as IV medications, fluids, oxygen, and ADL support. Record the findings of this interview in the medical record and include the name of the hospital staff member. Not only from a financial perspective is this information important but clinically it will direct skilled observations.

The following form provides an outline of services and levels of care to question during the SNF nurse to hospital nurse interview. The SNF nurse should request the hospital send copies of supporting data discussed during the call.

Hospital To SNF/NF Nurse Telephone Report

Patient Name:		Today's Date:	
Hospital:		Time Anticipated:	
Report taken by:		Report given by:	

Extensive Services

Last Date of IV medication:	
Last Date of IV fluids:	
Suctioning:	
Tracheostomy Care:	
Ventilator Support:	

ADL's:	Patient Performance	Support Provided
Bed Mobility:		
Transfers:		
Eating:		
Toileting:		

Skin Issues:	DC Plan:		Vaccinations:
	Medications:		
Surgical Wounds:			Oxygen/Respiratory Issues:
Pain Issues/Management:			Specific Treatment Concerns:
			Other:

Request hospital to send copies of:

- IV flowsheets and MAR's (IV medications)
- I&O sheets (IV fluids)
- ADL Documentation
- Respiratory flowsheets (trach, ventilator or suctioning support)

Medicare Team Meeting

The Medicare meeting will afford the team a brief review of all the Medicare Part A, Part B and Managed care beneficiaries. Utilization of a team meeting form will keep the group focused during meetings on changes in functional status, interruptions in the number of eligible days, discharge planning and skilled needs.

Discussion of the following areas should also be recorded on the Medicare Team Meeting Form:

1. Name/Payer source.
2. Date of Admission.
3. Admission diagnosis and complex medical conditions.
4. Last covered day.
5. ARD for each assessment period (5, 14, 30, 60. 90. OMRA).
6. RUG scores attained from each assessment.
7. Dates MD certification signed and filed in the medical record.
8. Day of stay.
9. Next targeted ARD.
10. Daily skilled coverage therapy.
11. Daily skilled coverage nursing.
12. Nursing issues.
13. Therapy minutes and target levels.
14. Extensive services dates.
15. MD visits/order changes.
16. ADL's.
17. Anticipated length of coverage.
18. Discharge plan.
19. End 30 day window.
20. Discharge date.

Harmony Healthcare INTERNATIONAL

Nursing Documentation
Medicare Manual

Medicare Team Meeting

Resident Name:_____ Unit/Room: _____ Payor:_____

	5 day	14 day	30 day	60 day	90 day	OMRA
ARD						
RUG						
Cert	Admit	14	44	74		

Date of Admission	
Last Covered Day	
End 30 Day Window	
Discharge Date	

Skilled Admission and Interim Diagnosis (include dates added):	

Skilled Needs	Date:	Date:	Date:	Date:
Medicare Days Exhausted				
Initials				

Notes (D/C planning, needs): Projected D/C Date _____

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Interview for MDS

The interview is a critical component of the assessment process as defined by the Centers for Medicare and Medicaid Services. The *RAI User's Manual* instructs to use interview *equally* with record review and physical assessment and observations in making coding decisions. The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, interacting with the resident and direct care staff validates information in the resident's record.

The following Interview for MDS form provides a guide for questioning staff on support provided and behaviors displayed by patients, which were observed by staff members. The sections directly impacted by the interview include sections: B, C, D, E, G.

Sample Interview for MDS

Patient Name: _____ ARD: _____

	11-7 Shift	7-3 Shift	3-11 Shift
Section B: Short-Term Memory (recall after 5 minutes) **Daily Decision Making** • Independent/appropriate			
• Difficulty in new situations			
• Decisions were poor			
• Never/rarely made decisions • *(choosing clothing, asks for help when necessary, i.e. – acknowledges need to use walker and uses it faithfully)*			
Section C: Making Self Understood • Understood			
• Usually Understood			
• Sometimes Understood			
• Rarely or Never Understood			
Section E: Demonstrated in last 30 days *(occurred:* • *1-3 days of last 7 days* • *4-6 days of last 7 days but not daily* • *occurred daily* • *did not occur last 7 days)*			
• Negative statements			
• Repetitive statements			
• Repetitive verbalizations – calling out persistent anger, annoyed)			
• Self depreciation (*I'am nothing/no use*)			
• Expresses unrealistic fears			
• Recurrent statements that something terrible is about to happen			
• Repetitive health complaints			
• Repetitive non-health related complaints or concerns			

Sample Interview for MDS (continued)

	11-7 Shift	7-3 Shift	3-11 Shift
Section E: Demonstrated in last 30 days (continued): • Unpleasant mood in morning			
• Insomnia/change in usual sleep pattern			
• Sad, pained, worried, facial expression			
• Crying tearfulness			
• Repetitive physical movements *(pacing, hand wringing, restlessness, fidgeting or picking)*			
• Withdrawal from activities of interest			
• Reduced social interaction			
Behaviors: • Verbally abusive			
• Physically abusive			
• Socially inappropriate			
• Disruptive behaviors			
• Resistive to care			
Section G: Bed Mobility **How does patient move to and from lying position. Describe:** • How do you help?			
• How many people to help go from lying to sitting?			
How does patient turn side-to-side? • How do you help?			
• How many people help?			
• Do you use draw sheet or bed pad? Describe.			
Does patient need to be lifted up while in bed? • How many help?			
• Do you use pillows to maintain position in bed? Elevate legs? Describe:			

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	11-7 Shift	7-3 Shift	3-11 Shift
Section G: Bed Mobility (continued):			
Is patient on turning schedule? • How often?			
• How many people to position?			
Transfer: • How does the patient get from bed to chair or chair to bed? Describe:			
Does patient need "boost" to get up from chair? • Describe:			
Do you use gait belt to support weight with transfer? • Describe:			
• How many people to transfer? Describe:			
• Mechanically lift? How many?			
• Lifted manually? How many?			
Eating: • When meal or fluids/snack served to patient, how is it delivered or set up?			
• Can patient feed self?			
• Does patient need any help with intake? Describe:			
• Have you fed this patient food or fluids in the past 7 days? Describe:			
Toilet Use: • Is this patient continent?			
• How does patient get on/off toilet? Describe:			
• How do you help?			
• How many people to transfer?			
• How does the patient cleanse or wipe self after using toilet?			
• Manage depends?			

Sample Interview for MDS (continued)

	11-7 Shift	7-3 Shift	3-11 Shift
Section G: Bed Mobility (continued):			
• Manage clothing don/doff			
• Does the patient use bed pan or urinal?			
• How do you help?			
• Does patient have ostomy or catheter?			
• How is it emptied? Cleansed? Describe.			
• Is patient incontinent?			
• How does changes cleansing get done? Describe: How often?			
• Does patient use commode?			
• How many to transfer?			
• How does this occur?			
Skin: • Any red areas? Describe:			
• Open areas? Describe:			
• Open areas of feet?			

Interviewed:	
Interviewed by:	
Date:	

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Activities of Daily Living

Scoring ADL Performance

ADL's comprise approximately 30% of the rate of reimbursement associated with the RUG score/rate. Accuracy in ADL documentation is critical for care planning and reimbursement.

The resident's performance may vary from day to day, shift to shift, or within shifts. ADL coding is also intended to be an interdisciplinary team process. The physical assistance provided to the patient while in therapy is to be reflected in the ADL coding in Section G of the MDS. An individualized plan of care can be successfully developed only when the resident's self-performance is accurately assessed and the amount and type of support provided to the resident by others is properly evaluated.

There will be patients that are very high functioning during the day and evening shifts. The night shift documentation is extremely valuable as quite often the patient may be exhausted or with discomfort from strenuous rehabilitation programs and require a degree of assistance during this time only. Capture all resources that are utilized to care for each patient.

Common misconception includes coding based upon who is doing more of the activity, which is incorrect. The key determination in the extensive and limited assist levels is weight-bearing support or total dependence in a portion of a sub-task.

ADL Self Performance

Code the resident's performance over the entire shift, not including set-up.

Independent: No staff intervention.

Supervised: Verbal cues or visual oversight.

Limited Assist: Hands on assist that includes contact guard or guided maneuvering.

Contact guard, guided maneuvering, or non-weight bearing support (3 episodes in the past 7 days).

Extensive Assist: Hands on assist that includes **any** weight bearing support **or** dependence in a portion of the sub-task.

Weight bearing support (3 episodes in the past 7 days), full staff participation during some but not all of the observation period, or dependence in a portion of the sub-task.

Total Dependence: Full staff performance or in other words, the patient did not participate whatsoever in performing the task.

ADL Support Provided

No support
Set up help only
One person physical assist
Two or more provided physical assist
Activity itself did not occur during the entire shift

Note that weight-bearing support does not indicate that the patient has a weight-bearing restriction. Weight-bearing support reflects that staff bore the weight of the patient and is the difference between lifting an extremity during the task of dressing versus guiding the limb into the sleeve of a shirt. There is not a percentage of weight supported factored into this coding. Also note that the 3 episodes or occurrences may occur during one shift alone.

The RAI Manual encourages that the assessor to "engage direct care staff, from all shifts, which have cared for the resident over the past 7 days in discussions regarding the resident's ADL functional performance. Remind the staff that the focus is on the last seven days only. Ask probing questions, beginning with the general and proceeding to the more specific." It is with these discussions that inconsistencies can be identified and corrected. It is highly recommended that the assessor schedules time to sit with the nursing assistants while they are documenting. This will allow for review and discussion of the coding increasing the understanding of its value from a clinical standpoint.

The coding of ADL's is intended to be a measurement of actual self-performance and actual staff support. Do not code for what the resident is identified as capable of doing, code for what actually occurred. Variations in function are an expected occurrence as patients demonstrate changes day-to-day and shift-to-shift due to a variety of medical and psychological reasons.

The coding of more assistance provided from one nursing assistant to another is not a reflection of a staff member's inability to perform their job effectively. On the contrary, residents that require assist in moving towards the top of the bed benefit from the 2 person lift to preserve skin integrity and prevent injury to both resident and staff members.

Nursing staff is encouraged to code the flow sheets to reflect the most support provided over the entire 8 hour shift. A patient that is capable of increased participation yet receives greater assist warrants a more in-depth assessment as to the causes of such variances. Accurate ADL coding will assist in identifying and resolving these issues. A number of factors impact ADL status:

Fatigue
Weakness
Acute illnesses
Exacerbation of chronic illnesses
Cognitive deficits
Medication effects
Behaviors such as resistance with care or agitation
Pain
Lack of motivation
Falls

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Nursing Documentation
Medicare Manual

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Activities of Daily Living

Patient Name:	
Month:	
Year:	

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bed Mobility	N																															
	D																															
	E																															
Transfers	N																															
	D																															
	E																															
Eating	N																															
	D																															
	E																															
Toilet Use	N																															
	D																															
	E																															
Walk in Room	N																															
	D																															
	E																															
Walk in Corridor	N																															
	D																															
	E																															
Initials	N																															
Initials	D																															
Initials	E																															

Code:

Independent	I	Resident needs no assistance of any kind to complete activity.
Supervision	S	Resident needs verbal cues, encouragement or oversight to complete activity.
Limited Assist	L	Resident needs physical cues, non-weight bearing guidance to complete activity.
Extensive Assist	E	Resident needs weight bearing assistance to complete any part of the activity.
Total Dependence	T	Resident needs complete care and is not able to complete any part of the activity.

0	No Assistance
1	Assist of one person
2	Assist of two people

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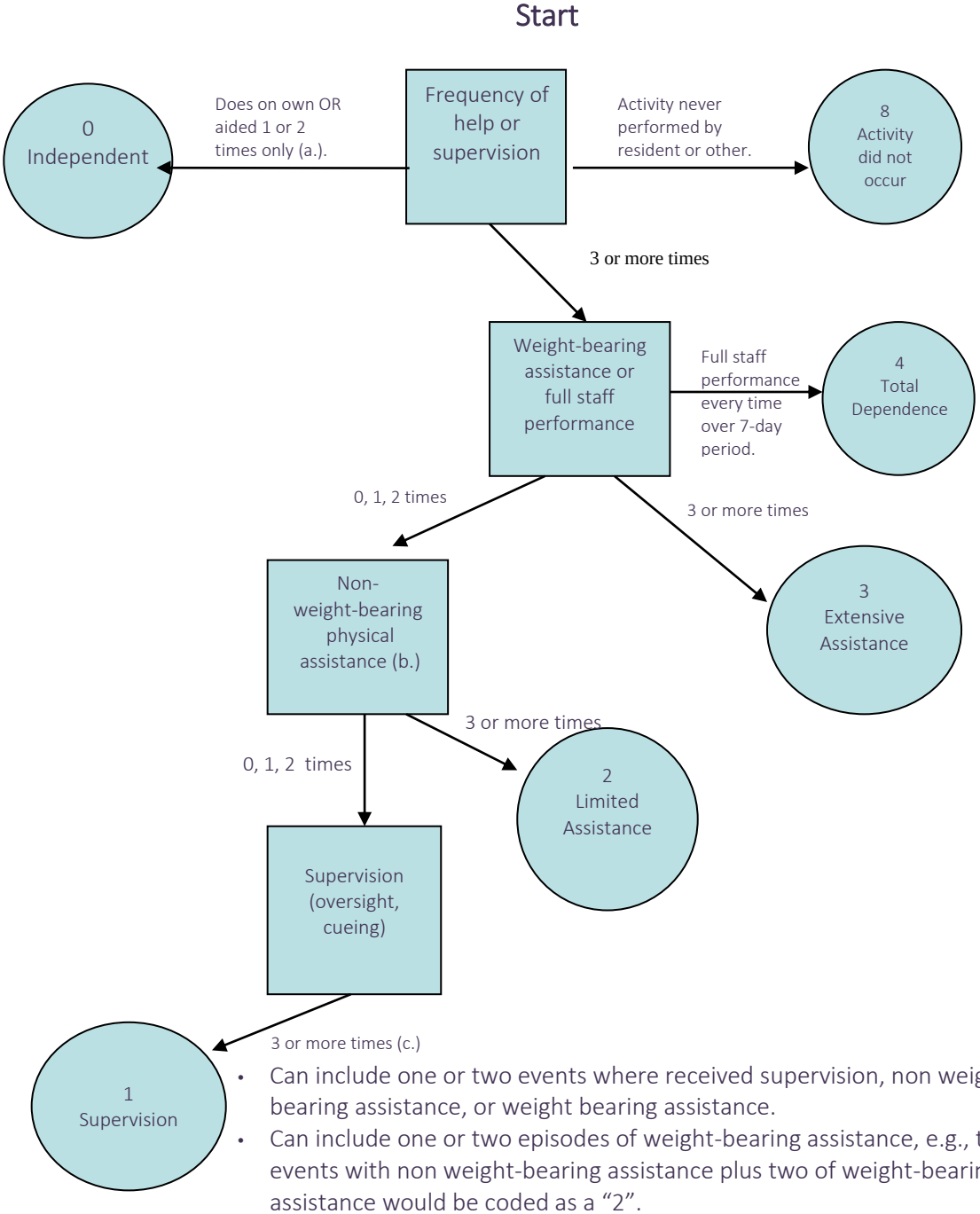
Scoring ADL Self-Performance



- Can include one or two events where received supervision, non weight-bearing assistance, or weight bearing assistance.
- Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a “2”.
- Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a “1”.

Respiratory Therapy

Respiratory Therapy by definition includes coughing and deep breathing exercises, Incentive Spirometry, the assessment of lung sounds as well as the delivery of nebulizer therapy. The patient admitted with an active pulmonary issue is appropriate to receive these skilled assessments on a daily basis. Clinically, patients with active or high risk factors for exacerbation in conditions including COPD, CHF, ARDS, aspiration precautions or pulmonary infections including pneumonia warrant a 5-minute assessment of lung sounds q shift to assess the status of these conditions. The delivery of nebulizer therapy and instruction and Incentive Spirometry qualify the patient for the Special Care RUG. To qualify for the Special Care RUG, Respiratory Therapy must be delivered 7 days with at least 15 minutes per day within the look back period. Documentation of the time spent with the patient while delivering this service is mandated. Implement the following in order to accurately capture these services:

- Initiate competency based instruction and sign off via the staff educator to all licensed nurses, or
- Arrange in-service with the RRT, provided through the oxygen vendor, to provide a facility wide in-service to licensed personnel.
- Maintain documentation of training and competencies in the personnel record.

Follow State Practice Acts and ensure that staff have proven competency in this area to qualify as a "trained nurse". Nurses are not required to have special certifications or advanced training to perform Respiratory Therapy. The RAI Users Manual defines a "trained nurse" as having received training on the administration of respiratory treatments and procedures that may have been provided at the facility, during previous work experience or as part of an academic program.

The facility may use a specialized flowsheet (attached) or record the time spent with the patient on the MAR or TAR as identified below:

- MAR Examples:

DuoNeb 1 unit dose via handheld nebulizer q.i.d.
Record total minutes spent with patient delivering Respiratory Therapy

		3/2/06	3/3/06
DuoNeb 1 unit dose via handheld nebulizer q.i.d.	8 am	JS	SF
	12 pm	JS	SF
	4 pm	RO	KM
	8 pm	RO	KM
Record total minutes spent with patient delivering Respiratory Therapy	8 am	15	20
	12 pm	20	15
	4 pm	15	20
	8 pm	22	15

- TAR Example:

		3/2/06	3/3/06
Skilled Pulmonary Assessment: lung sounds, SaO2, cough and deep breathing exercises BID	7-3 (10 am)	JS	SF
Document findings in narrative notes	3-11 (4 pm)	RO	KM
Record total minutes spent with patient with Skilled pulmonary assessment	10 am	15	20
	4 pm	20	15

Case Examples:

- Patient with dysphagia due to advancing Parkinson's disease has recently been treated for aspiration pneumonia that has now resolved. Patient remains at high risk for recurrent aspiration and remains on a mechanically altered diet with thickened liquids. This patient will benefit from the auscultation of lung sounds and coughing and deep breathing exercises. Implementing medically necessary Respiratory Therapy services and tracking yields SSB for this patient versus the lower 18 RUG otherwise qualified for.

- Patient with unstable end stage pulmonary disease receives nebulizer therapy 4x/day. The patient will remain for long-term care. This patient qualifies for ongoing skilled coverage for daily observation and assessment of pulmonary status until medical status has stabilized. Initiating Respiratory Therapy services and tracking of nebulizer therapy and auscultation of lung sounds, pursed lip breathing instruction and recovery breathing techniques yields SSB versus the non-skilled Medicaid rate.

Respiratory Therapy Services

Assessment and Documentation

The RAI Version 2.0 Manual Page 3-185 defines Respiratory Therapy as:

> Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. **Count only the time that the qualified professional spends with the resident. A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act.**

Respiratory Assessment

Symptom Analysis: When assessing a patient's problem, remember these areas to help the patient describe the problem.

P: Provocative/Palliative
What causes it? What makes it better? What makes it worse?

Q: Quality/Quantity
How does it feel, look, or sound, and how much of it is there?

R: Region/Radiation
Where is it? Does it spread?

S: Severity Scale
Does it interfere with ADL? How does it rate on a severity scale of 1 to 10?

T: Timing
When did it begin? How often does it occur? Is it sudden or gradual? How long does an episode of the symptom last?

Elements of Examination:

- Assessment of Respiratory Effort (i.e., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (i.e., dullness, flatness, hyperresonance)
- Palpation of chest (i.e., tactile fremitus)
- **Auscultation of lungs** (i.e., breath sounds, adventitious sounds, rubs)

Normal Breath Sounds

Sound	Characteristics	Location
Bronchial	Loud, harsh, high pitched	Heard over trachea, bronchi (between clavicles and midsternum), and over main bronchus.
Bronchovesicular	Blowing sounds, moderate intensity and pitch	Heard over large airways, on either side of sternum, and between the scapulae.
Vesicular	Soft breezy quality, low pitched	Heard over the peripheral lung area, heard best at base of lungs.

Adventitious Lung Sounds

Sound	Characteristics	Lung Problem
Crackles	Popping, crackling, bubbling, moist sounds on inspiration	Pneumonia, Pulmonary Edema, Pulmonary Fibrosis
Rhonchi	Rumbling sound on expiration	Pneumonia, Emphysema, Bronchitis, Bronchiectasis
Wheezes	High-pitched musical sound during both inspiration and expiration (louder)	Emphysema, Asthma, Foreign bodies
Pleural Friction Rub	Dry, grating sound on both inspiration and expiration	Pleurisy, Pneumonia, Pleural infarct

Documentation to Support Respiratory Therapy and Assessment

The format for collecting assessment information is facility dependent, meaning whatever format the facility chooses, but must include these necessary elements:

1. Time and Date of service delivered
2. Name of treatment delivered (i.e., Albuterol nebulizer, Atrovent nebulizer, DuoNeb)
3. Breath sounds before and after administration of medication.
4. Respiratory rate before and after administration of medication.
5. Oxygen saturation before and after administration of medication, if ordered.
6. Amount of Oxygen delivered before and again after nebulizer (i.e., 2L NC continuously).
7. Minutes spent with patient, **this includes:**
   - **Minutes it takes to perform assessments before, during and after treatment, as well as the time it takes to prepare the medication and equipment as well as educate the patient to participate in medication delivery.**

Respiratory Definitions

ABG	Arterial puncture for the purpose of assessing oxygenation, ventilation and acid-base status. Includes evaluation, interpretation and communication to other care providers
Team Meeting	Bi-weekly interdisciplinary meetings to discuss patient problems/progression with other team members
Shift Assessment	Physical exam of the patients with review of the chart, physician orders, Kardex and progress notes
Initial Assessment	Comprehensive history and physical assessment of a newly admitted patient (respiratory addendum, problem and goal identification, initial outcome measure)
FVL	Bedside spirometry that measures static lung volumes and flows
BiPAP/CPAP S/U	Initial application of non-invasive positive pressure. Includes mask fit, patient education, pressure check and alarm status
BiPAP/CPAP checks	Systematic evaluations of non-invasive positive pressure. Includes mask fit, patient education, pressure check, alarm status and skin breakdown
Bronchoscope Assist	Monitoring oxygenation/ventilation while providing bedside assistance to physician performing the procedure
FIO2	Fraction of Inspired oxygen: The fraction of inspired oxygen delivered to the patient by the ventilator
ECG	Electrocardiogram
Flutter Valve	Airway adjunct used to help secretion clearance
PEP Therapy	Airway adjunct used to help secretion clearance and treat atelectasis
Home O2 set-up	Qualify and initiate home oxygen for a patient being discharged
IPPB	Positive pressure to augment lung expansion and delivery aerosolized medications
IPV	Positive pressure to augment lung expansion, deliver aerosolized medications and internal percussion
MDI TX	Aerosolized respiratory medication via Metered Dosed Inhaler
MDI TX (TRACH)	Aerosolized respiratory medication via Metered Dosed Inhaler via TRACH
Respiratory Parameters	The measurements of lung volumes/NIF/RBI of a patient breathing spontaneously

Respiratory Definitions (continued)

Aerosol TX	Aerosolized respiratory medication via small volume nebulizer
Aerosol TX (Vent)	Aerosolized respiratory medication via small volume nebulizer delivered to a patient receiving mechanical ventilation
Tank rounds	Maintain/monitoring oxygen tank inventory
Initial PMV	Initial monitoring of a patient's first PMV trial
T-Piece Trial	Monitoring/Documentation the *first three trials* of a patient being removed from mechanical ventilation and breathing spontaneously
TRACH Care	Maintaining a clean TRACH site with sterile water and peroxide. The inter cannula is replaced q shift
Ultrasonic TX	Bland aerosol administration with saline or sterile water for sputum induction/hydration
Circuit Change	Providing clean ventilator tubing for a patient on mechanical ventilation
Ventilator	Evaluation and documentation of the patient response to mechanical ventilation
Ventilator Transport	Transportation of a mechanically ventilated patient for a diagnostic/therapeutic procedure
Suction	Invasive procedure to remove accumulated secretions from the trachea that can't be removed by the patient's spontaneous cough
CPO	Continuous monitoring of the SaO2, done at the bedside with a pulse oximeter
PaO2	Partial pressure of arterial oxygen: measurement reflecting the body's ability to pick up oxygen from the lungs
Oxygen Saturation	Ratio of actual hemoglobin oxygen content to potential maximum oxygen content carrying capacity of the hemoglobin
SIMV	Synchronized Intermittent Mandatory Ventilation: Mechanical ventilation in which the ventilator delivers a set number of specific-volume breaths; the patient may breathe spontaneously between the SIMV breaths at volumes that differ from those on the machine.
PEEP	Positive end expiratory pressure: Increase functional residual capacity (area not used) by stabilizing open alveoli to prevent collapse.
Saturation Study	Continuous monitoring of the SAO2 (with a printed report) done at the bedside with a pulse oximeter for a specific time interval
TRACH Change	Assisting the physician in changing, downsizing a trached patient
CPT: Chest physiotherapy	Bronchial hygiene that consists of postural drainage, positioning and percussion

Nursing Documentation
Respiratory Flow Sheet

Name:	Room #:	Physician:	Mo./Yr.:

Orders:

1. HHN
2. Lung Sounds Q
3. O2 SATS
4. O2 @ VIA R/A
5. Other

Date	Time	Treatment #	Before Treatment				After Treatment				Minutes Spent w/ Patient	Comments	Initial
			L/S	O2 @	R R	O2 SAT	L/S	O2 @	R R	O2 SAT			

Key: D = Diminished C = Crackles W = Wheezes O = Other

Signature	Initials	Signature	Initials	Signature	Initials	Signature	Initials

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Policy and Procedure – Nebulizer Therapy

Equipment

Air compressor, connection tubing, nebulizer, medication and saline solution.

Procedure

Nursing Action	Rationale
Preparatory Phase	
1. Monitor the heart rate before and after the treatment for patients using bronchodilator drugs.	1. Brochodilators may cause tachycardia, palpitations, dizziness, nausea, or nervousness.
Performance Phase	
1. Explain the procedure to the patient. This therapy depends on patient effort.	1. Proper explanation of the procedure helps to ensure the patient's cooperation and effectiveness of the treatment.
2. Place the patient in a comfortable sitting or a semi-Fowler's position.	2. Diaphragmatic excursion and lung compliance are greater in this position. This ensures maximal distribution and deposition of aerosolized particles to basilar areas of the lungs.
3. Add the prescribed amount of medication and saline to the nebulizer. Connect the tubing to the compressor and set the flow at 6 to 8 L/min.	3. A fine mist from the device should be visible.
4. Instruct the patient to exhale.	
5. Tell the patient to take in a deep breath from the mouthpiece, hold breath briefly then exhale.	5. This encourages optimal dispersion of the medication.
6. Nose clips are sometimes used if the patient has difficulty breathing only through the mouth.	
7. Observe expansion of chest to ascertain that patient is taking deep breaths.	7. This will ensure that medication is deposited below the level of the oropharynx.
8. Instruct the patient to breathe slowly and deeply until all the medication is nebulized.	8. Medication will usually be nebulized within 15 minutes at a flow of 6 to 8 L/min.
9. On completion of the treatment, encourage the patient to cough after several deep breaths.	9. The medication may dilate airways, facilitating expectation of secretions.
Follow-up Phase	
1. Record medication used and description of secretions.	
2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed every 24 hours.	
3. Each patient has own breathing circuit (nebulizer, tubing, and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs.	

Source: The Lippincott Manual of Nursing Practice – Seventh Edition.

Core Components

The following documentation worksheets are tools to assist in properly articulating the reason for skilled care. These sheets are organized by diagnosis and are only **guides**. They are **not part** of the medical record and should be placed in a separate binder at the nurse's station.

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Nursing Documentation
Medicare Manual

Core Components
Acquired Immunodeficiency Syndrome (AIDS) (1 of 2)

Daily Nursing Skills: High risk for infection related to immunosuppression (low T4 lymphocyte count or low T4 toT8 ratio). High risk for ineffective individual coping related to life threatening illness, potential loss of role, decisions regarding treatment or poor prognosis for long term survival. High risk for hypoxemia related to ventilation-perfusion imbalance, pneumonia, and weakness. High risk for sensory-perceptual alteration related to neurologic involvement. High risk for social isolation, impaired physical mobility related to fatigue, weakness, hypoxemia, depression, altered sleep patterns, medication adverse affects, and orthostatic hypotension. High risk for nutritional deficit, fluid, volume deficit altered oral mucus membrane related to opportunistic infections.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor CBC.
3. Assess for potential sites of infection daily particularly pulmonary infections.
4. Assess for neurologic infection: stiff neck, headache, visual or motor abnormalities, memory impairment, altered LOC. Record daily mental and neuro assessments.
5. Assess for signs of hypoxemia: tachycardia, restlessness, tachypnea, irritability, pallor, cyanosis. Monitor oxygenation and potential need for use of oxygen.
6. Assess for distal symmetrical sensorimotor neuropathy (common peripheral nerve complication in AIDS): involuntary movements, paresthesias, numbness, pain, weakness and atrophy of the extremities.
7. Document provision of nutritional assessments, and oral cavity assessments for signs of thrush lesions or bleeding.
8. Assess for pharyngitis, stomatitis, esophagitis: inflammation, ulceration, leukoplakia, pain, dysphagia or voice changes.
9. Assess daily for skin integrity. Ensure prompt treatment of pressure ulcers (immunosuppression makes effective treatment difficult).
10. Teach the patient and family about infection prevention measures.
11. Assess nutritional status daily.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.

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Core Components
Acquired Immunodeficiency Syndrome (AIDS) (2 of 2)

14. Teaching and training activities: discuss S&S that may indicate AIDS complications, review waste disposal, educate regarding spread of infection, early reporting of new symptoms, effects of immunosuppression, CBC recommendations, legal resources, community resources, disease and implications.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Aggregate of Unskilled Services

Daily Nursing Skills: Management and evaluation of overall Plan of Care to promote recovery and medical safety. Observation and evaluation of medical condition given the likelihood of change to assess for the need for modification or initiation of additional interventions with the patient's treatment regimen is essentially stabilized.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Monitor and assess vital signs.
2. Administration of oral meds. Monitor for therapeutic or non-therapeutic effects.
3. General maintenance of colostomy and/or ileostomy following initial period.
4. Routine service to maintain satisfactory functioning of indwelling Foley catheter.
5. Changing of dressings, non-infected wounds. Assess for signs of delayed healing or infection secondary to immobility or decreased mobility secondary to medical status.
6. Prophylactic skin care.
7. Routine care of incontinent resident.
8. General maintenance area of a plaster cast.
9. Routine care of braces and splints.
10. Heat as a palliative measure.
11. Routine application of medical gases after initial and regulatory phase. Assess response to medical gases and need to titrate.
12. Assist with ADLs.
13. Turning of positioning
14. S/S of complications:
    A. Type: _____
    B. Observations: _____

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Nursing Documentation
Medicare Manual

Core Components
Amputation

Daily Nursing Skills: Assess and evaluate for signs of complications including increased stump pain, hematoma, infection, suture/staple integrity and stump necrosis. Assess circulation of affected limb, wound care and observations, pain management, psychological manifestations of loss of limb. Signs of effective grieving of loss. Stump care, compression dressings to reduce edema and shape stump to accept prosthesis. Patient education regarding skin hygiene to prevent irritation and/or infection. Monitor nutritional intake and needs to promote healing. Educate need for dietary compliance. Pain management and safety measures post amputation. Monitoring and assessment of associated conditions that precipitated need for amputation (i.e., diabetic, PVD, injury).

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Wound site, treatment and frequency, change in wound status, size (width, color, depth) stage, color, odor, drainage, signs of healing, bleeding, hematoma formation.
3. Assessment for edema.
4. Assessment of CSM, both extremities.
5. Assessment of positioning, both extremities, signs of development of contractures.
6. Presence of callous formation on stump.
7. Signs of development of foot drop, unaffected extremity.
8. Assessment for pain: Site, description of intensity, duration, phantom pain, method of treatment, response, assessment for change or modification of medication or treatment of pain.
9. Presence and effect of use of stump shrinker, user of prosthetic device – type, skin condition.
10. Mobility: balance, assistance required, use of equipment, progress with ambulation and transfers and positioning.
11. Psychosocial adjustment.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities. Patient education and caregiver training.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Anemia

Daily Nursing Skills: To assess and evaluate cardiovascular system, signs and symptoms of blood loss, response to transfusions and signs of reaction to transfusion. Scheduling of activities to promote rest and optimize use of limited energy levels. Monitor patient for signs of excessive fatigue or shortness of breath with activities. Patient's area risk for infection, hemorrhage, increased fatigue and impaired skin integrity. Patient education in medical management and signs of complications.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs Q _____.
2. BP & Pulse Q shift.
3. Nutritional intake (vitamin therapy).
4. Edema: LE's/tingling (describe, degree).
5. Sore mouth.
6. Fatigue, pallor.
7. Dizziness/Faintness/Vertigo.
8. Headaches/Tinnitus.
9. Dyspnea (SOB).
10. Palpitations.
11. Pale mucous membranes, nail beds and conjunctiva.
12. Intake and output.
13. Lab work.

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Nursing Documentation
Medicare Manual

Core Components
Anticoagulation Therapy: Subcutaneous Heparin/New to Coumadin Therapy

Daily Nursing Skills: Patient is at high risk or injury related to anticoagulation therapy. Risk for abnormal bleeding secondary to prolonged clotting times. Daily skilled assessment for signs of bleeding, lab work and evaluation of results, skilled monitoring with changes in dosage. Patient instruction in signs and symptoms to report to caregiver. Follow-up care. Instruction in proper administration of injections.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Presence or absence of active abdominal, joint pain or other pain.
3. Presence or absence of active signs of bleeding, (hematuria, petechiae, bruising, bloody stools, nose bleeds) at least Q day.
4. Presence or absence of signs of hemorrhage under the skin (oral mucosa and/or conjunctiva at least Q day).
5. Color-cyanosis or pallor.
6. Patient/resident/caregiver training.
   RE: S/S of anticoagulant complications, potential interactions.
7. Results of Pro-Times or PTs.
8. Any communication with the physician and reason.
9. Safety education (avoid razors, use soft bristle toothbrush). Potential interactions with over the counter medications. Instruction to consult healthcare provider with any changes in medication regimen. Observation of urine, stool, skin and sputum for signs of bleeding.

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Core Components

Atrial Fibrillation (New Onset) (1 of 2)

Daily Nursing Skills: Atrial fibrillation is the most common form of irregular heartbeat. Irregular heartbeats are caused by abnormal **electrical activity of the heart**. There is a high risk for impaired blood flow to the heart muscle and to the rest of the body. Atrial fibrillation may be caused by an underlying heart disease, such as: Problems with the heart valves, Impaired blood flow to heart muscle (ischemia), weakened heart muscle (cardiomyopathy), and damage to the heart from long-standing, untreated high blood pressure (hypertensive heart disease). Infection processes, endocrine, and pulmonary disease may cause atrial fibrillation. **Anticoagulant medications** may be needed to prevent blood clots and lessen the risk of stroke. Patient is at high risk for abnormal bleeding with anticoagulant therapy. Other medications can control the heart rate with increased risk for adverse drug effects. **Heart failure** may develop if the heart rate cannot be controlled. Atrial fibrillation often causes shortness of breath, dizziness, confusion, or lightheadedness, especially during physical activity. For this reason people with atrial fibrillation may have a decreased activity tolerance with complications related to decreased mobility. There is a high risk for **stroke** caused by atrial fibrillation.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Full Vital Signs: Assessment of findings including Apical Pulse rate and rhythm.
2. Signs and symptoms of shortness of breath, dizziness, confusion, activity intolerance, and signs of decreases oxygen saturation levels.
3. Skilled assessment of lung sounds, edema, chest pain, and signs of pulmonary, cardiac and neurological changes.
4. Cardiac medications with parameters. Documentation of doses held secondary to AP, BP not within established parameters. Signs of adverse effects of medications, laboratory findings.
5. Anticoagulation therapy: Effects, signs of unusual bleeding, abnormal lab results, and changes in dosage.
6. Underlying processes such as infection, endocrine, pulmonary conditions with current treatments and response.
7. Activity tolerance, signs of postural hypotension, increased HR or shortness of breath with physical exertion.
8. Communication with physician and outcome, consults such as cardiology, endocrine, and pulmonary.
9. Rehabilitation services and progress.

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Core Components
Atrial Fibrillation (New Onset) (2 of 2)

10. Teaching and training: Self-monitoring of pulse rate and proper administration of medications. Signs and symptoms to report to health care provider.
11. Discharge planning.

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Core Components
Cardiovascular Disease

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Complete vital signs.
2. Pain (location).
3. Presence or absence of SOB, dyspnea cough, orthopnea, ascites.
4. Factors that precipitate or relieve SOB, dyspnea and pain, (i.e., exercise, positioning).
5. Edema 1+ - 4+.
6. Activity tolerance.
7. Weight.
8. Strength and regulatory of pulse.
9. Diaphoresis.
10. Neck vein distention.
11. I & O.
12. Response to medication.
13. Color (skin, nails, lips).
14. Diet (sodium restricted).
15. Oxygen (rate, how often).
16. Significant changes in blood pressure.

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Nursing Documentation
Medicare Manual

Core Components
Cast Care and Observation

Daily Nursing Skills: Fracture healing starts with the bleeding, tenderness, and swelling. Assess and evaluate pain levels, skin integrity, pulses, posture, positioning in and out of bed, edema, color, odor of the affected limb and safety with mobility.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Edema
   - CMTS
3. Muscular Skeletal Condition:
   - Location of case
   - Therapeutic positioning
4. Skin Condition:
   - Appearance of skin under cast
   - Hygiene of area surrounding cast
5. Transfer:
   - Mobility restrictions
   - Amount of assist needed
6. Locomotion:
   - Mobility restrictions
   - Amount of assist needed
7. Personal Hygiene:
   - Amount of assist needed
8. Toilet Use:
   - Amount of assist needed
9. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
10. Mood:
    - Mood pattern

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Nursing Documentation
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Core Components
Cellulitis

Daily Nursing Skills: Cellulitis is an infection that spreads from the skin to underlying tissue. Cellulitis is caused by bacteria that invade an area of broken skin. The most common types of bacteria are streptococcus and staphylococcus. Cellulitis also can be caused by other types of bacteria, which may affect people with **impaired immune systems** Infection may occur at areas where the skin has been broken, by trauma or infection. Cellulitis can cause tenderness, pain, swelling, and redness at the site of the infection, and fever and chills throughout the body. In adults, infection usually occurs on the legs, face, or arms, but can occur on other areas. Cellulitis can spread infection through the body quickly. There is a high risk for bacteremia (presence of bacteria in the blood) or **sepsis** (infection in the blood). Other high risk complications, such as **thrombophlebitis** or rarely **gangrene** can develop, especially in older adults. Treatment for cellulitis includes antibiotics, taken either orally or intravenously, and local skin care.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Full vital signs and assessment of findings.
2. Detailed assessment of affected skin areas.
3. Presence of drainage, blisters, erythema, signs of necrosis, increased pain, warmth or tenderness.
4. Antibiotic therapy administered: I.V., I.M., or oral route.
5. Edema and pain management
6. Response to treatments.
7. Current rehabilitation services and progress.
8. Communication with physician and outcome, including changes in medication, treatments, and overall Plan of Care.
9. Discharge teaching regarding medication, activity, treatments, and signs of complication to report to healthcare provider.
10. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Cerebral Vascular Accident (CVA) (1 of 2)

Daily Nursing Skills: High risk for further cerebral injury related to interrupted blood flow (embolus, thrombus, or hemorrhage), and complications from impaired physical mobility related to motor cortex or motor pathways. High risk for sensory-perceptual alteration and complications related to cerebral injury. High risk for impaired communication due to cerebral injury.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess neurologic status (LOC, orientation, grips, leg strength, papillary response).
3. **For Occlusive:** Administer anticoagulants as ordered. Monitor prothrombin time and partial thromboplastin time. Check current results before each dose. Observe for S&S's of bleeding. Monitor for S&S's of gastric irritation.
4. Administer medications as ordered for blood pressure, assess for signs of decreased cerebral perfusion.
5. **For Hemorrhagic:** Administer medications for blood pressure, report any signs of neurologic deterioration. Observe for hypotension, bradycardia, or signs of thrombus formation. Monitor for optimal fluid status, observe fluid restrictions. Monitor osmotic diuretics, maintain accurate I&O.
6. Maintain functional alignment, describe needs for bed mobility, and positioning.
7. Provide ROM, document collaboration with PT.
8. Document rehab nursing (encouragement for the patient to perform as much as possible during ADL and transfers); amount of assistance required with ADLs, safety awareness.
9. Record application of anti-embolism stockings, assess for signs of thromboembolic complications, and record any discussion with MD.
10. Record daily skin assessment, presence of edema.
11. Maintain adequate elimination.
12. Record bladder or bowel program, and patient's response, or alteration of program and reason.
13. Assess daily for adaption to visual and/or sensual impairment, balance problems and effect.
14. Assess communication regime for appropriateness, document collaboration with ST.
15. Observe patient's compliance with therapy techniques, document progress with therapy.

Core Components
Cerebral Vascular Accident (CVA) (2 of 2)

16. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
17. Assessment for therapeutic response to medication or discontinuance of medication.

18. Teaching and training activities: Disease process and implications, medications, dose schedule, adverse effects, need for follow up lab tests, signs of cerebral impairment, signs of infection, signs of thromboembolic or other complications, activity and positioning recommendations and mobility aids, food and fluid intake recommendations, bowel and bladder control program, risk factors, safety measures and skin care.
19. Describe current rehabilitation services and progress.
20. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Chronic Obstructive Pulmonary Disease (COPD) (1 of 2)

Daily Nursing Skills: High risk for respiratory failure related to ventilation-perfusion imbalance, ineffective breathing pattern related to emotional stimulation, fatigue or blunting of respiratory drive, nutritional deficit and activity intolerance related to SOB and adverse effects of medications, inactivity-resultant risk for loss of function exercise related hypoxemia, fatigue from sleep disturbance secondary to bronchodilator's stimulant effect, SOB, anxiety, depression. High risk for S&S indicating impending exacerbation. High risk of infection related to stasis of secretions, reduced activity and decreased motility in lungs.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess for need for (or response to) use of oxygen. Titration of oxygen in response to pulse oximetry readings.
3. Administer pharmacologic agents (bronchodilator, antibiotics, corticosteroids, and expectorants).
4. Monitor therapeutic levels of medications as ordered.
5. Perform bronchial hygiene measures as ordered.
6. Pulmonary assessment.
7. Report effectiveness of pulmonary treatment.
8. Maintain adequate fluid intake, monitor I&O.
9. Monitor for signs of infection or further deterioration in respiratory status.
10. Reduce or eliminate environmental irritants.
11. Monitor the patient's reduction of work of breathing, to lessen depletion of oxygen reserves.
12. Monitor nutritional intake and weight.
13. Monitor the use of breathing techniques during ADL.
14. Monitor response to increased activity and recovery breathing after activity.
15. Consult with MD to adjust medications for sleep to optimize bronchodilation and minimize stimulant effects. Monitor the patient's use of bronchial hygiene before sleep, as needed during nocturnal dyspnea.
16. Monitor periods of sleeplessness, including the degree of shortness of breath, pulse rate and rhythm, respiratory rate and breathing sounds.
17. Assess use of relaxation techniques.
18. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).

Core Components
Chronic Obstructive Pulmonary Disease (COPD) (2 of 2)

19. Assessment for therapeutic response to medication or discontinuance of medication.
20. Teaching and training activities: S&S's if impending exacerbation, avoid over medication, practical energy conservation and breathing techniques, S&S's infection. Medication purpose, dose, schedule, adverse effects requiring medical attention. Bronchial hygiene measures. Prevention dehydration, cleaning of respiratory equipment, dietary restrictions, weight monitoring, exercise prescriptions.
21. Describe current rehabilitation services and progress.
22. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Colostomy (1 of 2)

Daily Nursing Skills: High risk for stomal necrosis, complications related to the surgical procedure, bowel wall edema, retraction of stoma related to mucocutaneous separation, peristomial skin breakdown related to fecal contamination. Patient instruction in colostomy care. Troubleshooting potential complications and proper fit of appliances. Instruction in avoidance of foods that are not well tolerated. Signs if impaired coping with changes in body image. Instruction in management of control of odors, prevention of leakage to promote increased acceptance and dignity with change in body image.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess stoma color and document.
3. Document any signs or symptoms of necrosis.
4. Assess viability of proximal bowel.
5. Assess for signs of abdominal distention.
6. Assess and document the integrity of the mucocutaneous suture line at each dressing/pouch change.
7. Document the nutritional support measures for the patient at risk for nutritional deficiency.
8. Document any need for alteration of pouch position for prevention of fecal contamination.
9. Document effectiveness of pouch system and contour to abdominal wall, and reason effectiveness of any changes to system.
10. Document the efficiency of the pouch in proper seal, and protection of skin from stool and tape.
11. Assess for signs of burning, leakage or itching.
12. Assess patient's candidacy for bowel function regulation by irrigation.
13. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
14. Assessment of therapeutic response to medication or discontinuance of medication.

15. Teaching and training activities odor control measures, measures to control flatus, how to conceal pouch under clothing, discuss normal emotional response to colostomy, include helpful coping strategies refer to United Ostomy Association, or local community support group, colostomy impact on bowel function, normal stoma characteristics and function, pouch care, skin care.
16. Describe current rehabilitation services and progress.
17. Discharge planning.

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Core Components
Compression Fractures (1 of 2)

Daily Nursing Skills: Fracture may be displaced or non-displaced. Patient is at high risk related to displaced fragments that may place pressure upon spinal nerves or injure the spinal cord itself. Such pressure will result in partial or complete dysfunction of the body parts innervated from the level of injury. Patient is at high risk for neurological complications related to potential spinal cord involvement. Manifestations may include: numbness and tingling of extremities, temporary or permanent dysfunction, and changes in bowel and bladder function. Nursing interventions are geared towards maintaining stability of the fracture, preventing neurocirculatory problems, and promoting comfort; both physical and psychological. Patient may be at further risk of circulatory complications, GI complications and skin integrity compromise related to decreased physical mobility.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor color, sensation, and movement of extremities.
3. Assess for signs of circulation complications such as thrombophlebitis or DVT with increased edema, pain, redness or positive Homan sign.
4. Positioning measures and tolerance to position changes.
5. Pain assessment including intensity, duration, frequency, factors that increase pain, factors that alleviate complaints of pain. Pharmacological and non-pharmacological measures and response.
   Document any changes in pain management regimen and patient's response.
6. Changes in bowel and bladder function, including new onset incontinence, signs of urinary retention, and constipation. Address interventions to maintain function and relief of complications.
7. Daily skin assessment and signs of development of pressure related areas. Document preventative measures in place and effects.
8. Address signs of impaired coping with pain and physical limitations related to decreased mobility, increased dependence upon others, and pain effects.
9. Assess for decreasing intensity and frequency of pain to evaluate ability to increase physical activity as compression fractures may be treated with bed rest until the pain subsides.
10. ROM exercises to non-affected extremities.
11. Document any discussion with physician include reason for interaction and outcome.

Core Components
Compression Fractures (2 of 2)

12. Patient may be at increased risk for dehydration and weight loss secondary to decreased desire to consume adequate amounts with decreased physical activity and pain. Maintain accurate intake and output monitoring until quantities are proven to be of sufficient amounts.
13. Document tolerance to increased activity level as progressed.
14. Describe current rehabilitation services and progress.
15. Discharge planning.

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Nursing Documentation
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Core Components
Congestive Heart Failure (1 of 2)

Daily Nursing Skills: High risk for decreased cardiac output related to cardiac contractility, altered heart rhythm, fluid volume overload, increased afterload, cardiogenic shock, pulmonary edema, AMI, arrhythmias, thrombolytic complications, liver failure, decreased renal perfusion, increased salt and water retention, renal failure. At risk for activity intolerance due to decreased cardiac output, nocturnal dyspnea. High risk for recurrence of CHF (anticipate prolonged period of observation and assessment because there is a high risk for non-compliance with medical regimen, chronicity and complexity: low sodium diet, with increased appetite, need for changes in lifestyle, including medication, activity).

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Heart rate, rhythm, heart sounds, blood pressure, pulse pressure.
3. Presence or absence of peripheral pulses, compare to baseline assessments.
4. Observe response to medication, both therapeutic, v.s. ranges, side effects.
5. Inotropic agents (digitalis derivatives) monitor for anorexia, pulse below 60, above 100, irregular pulse, nausea, vomiting, visual disturbances. Record all contact with MD.
6. Diuretics – monitor for hypovolemia, hypokalemia, fluid and electrolyte imbalances.
7. Monitor and record all S&S's of hypoxemia, confusion, restlessness, dyspnea, arrhythmias, tachycardia, and cyanosis.
8. Monitor for the need of oxygen, presence of nocturnal dyspnea (record any precipitating activity, vital signs effects of oxygen use).
9. Observe positioning, Semi or high Fowler's and patient response in breathing.
10. Monitor and record accurate daily I&O, weights and report abnormal.
11. Monitor activity closely, group activities and therapeutic interventions to conserve energy. Assess patient's response to increased activity.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assess pulmonary status for crackles, decreased breath sounds, changes in breath sounds.
14. Assess for dependent edema, increasing dyspnea.
15. Assess for signs of dehydration and confusion.
16. Assess for signs of thrombophlebitis or pulmonary embolism.

Core Components
Congestive Heart Failure (2 of 2)

17. Assessment for therapeutic response to medication or discontinuance of medication.
18. Teaching and training activities for energy conservation and work simplification strategies.
19. Describe current rehabilitation and progress.
20. Discharge planning: Medication teaching, follow-up care, signs to report to caregivers, dietary instruction, instruction to report increased fatigue, dyspnea and weight gain.

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Nursing Documentation
Medicare Manual

Core Components
Coronary Artery Disease/Coronary Artery Bypass Graft (CABG) (1 of 2)

Daily Nursing Skills: CABG is performed for significant narrowing and blockages of the coronary arteries due to coronary artery disease. CABG surgery creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart muscles. Potential postoperative complications may include heart attacks, arrhythmias, electrolyte imbalance, bleeding, infection, lung complications, stroke and renal complications. The daily skills of the nurse are required to observe, assess, teach, train and provide the overall management of care plan to ensure medical safety and promote recovery.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Frequent monitoring of vital signs as ordered, blood pressure, temperature, apical pulse describing any dysrhythmias, and respiratory rate and effort.
2. Monitoring of abnormal fluid balances by assessing respiratory status including oxygen saturation dyspnea, adventitious breath sounds and presence of edema.
3. Assess response to coughing and deep breathing exercises or use of Incentive Spirometry
4. Assess for signs of hypoxemia: tachycardia, restlessness, tachypnea, irritability, pallor and cyanosis.
5. Monitor oxygenation and potential need for use of supplemental oxygen.
6. Record assessments of SA02 with titration or weaning of nasal oxygen.
7. Assessment of daily weights with monitoring for peripheral edema with a description of amount of fluid if present or absence of edema.
8. Monitoring of peripheral pulses in all extremities.
9. Description of surgical wounds including staple/suture integrity, drain sites, color of wound bed if visible, wound edges, amount, color and odor of any exudate or drainage.
10. Assess for potential sites of infection daily including urinary post Foley catheter.
11. Assess for neurologic changes such as headache, visual or motor abnormalities, memory impairment, altered LOC.
12. Monitoring of pain with a clear description of interventions offered and their effect.
13. Monitoring of new drug regimens for desired effect and any adverse effects.
14. Assessment for symptoms of dehydration including skin turgor, color and clarity of urine output and condition of mucus membranes.
15. Assess laboratory results including: CBC, electrolytes, drug levels and coagulation studies, review of laboratory studies for abnormal values (**review** is skilled, even for negative results).

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Core Components
Coronary Artery Disease/Coronary Artery Bypass Graft (CABG) (2 of 2)

16. Assess nutritional status daily.
17. Teaching and training activities: discuss signs and symptoms that may indicate cardiovascular complications, review medication schedule, educate in cardiac and sternal precautions, early reporting of signs of infection, effects of cardiac medications, anticoagulation therapy if applicable, community resources, disease and implications.
18. Describe current rehabilitation services and progress.
19. Discharge planning including community resources and physician follow up.

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Core Components
Decubitus Ulcers

Daily Nursing Skills: Assess and evaluate decubitus ulcer response to treatment, signs and symptoms of infection. Local infection of wound, osteomyelitis, signs of sepsis. Control and management of pain, drainage and odors of decubitus ulcer. Skilled ulcer care, assessment for possible modification to treatment to promote healing. Nutritional intake and supports to promote healing.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs, presence of fever.
2. Location on body. Description of wound bed.
3. Odor present.
4. Drainage with color and amount.
5. Communications to physicians with reason and outcome.
6. Complaint of pain. Location, severity and effectiveness of medication and positioning.
7. Nutritional intake, supplements to promote healing.

Weekly

1. Location.
2. Stage.
3. Size (width, length, depth).
4. Odor.
5. Discharge, color and amount, redness, erythema surrounding wound.
6. Description of tissue, signs of granulation or necrosis.
7. Frequency and type of treatments being rendered.
8. Healing progress of decubitus.
9. Use of special equipment: Water mattress, gel pad, air fluidized therapy bed.
10. If not progressing, document call to physician for review and new treatment orders, any consults and results.

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Core Components
Deep Vein Thrombosis (DVT)

Daily Nursing Skills: DVT is an acute, potentially life-threatening condition that necessitates hospitalization. The current standard of care for treatment is with anticoagulation therapy with Heparin followed by long-term oral anticoagulation therapy. The most common factors that lead to development of DVT are venous stasis, vessel wall injury, and hypercoagulability of the blood. Stasis can occur with incompetent valves or inactive muscles. Familial deficiencies of anticlotting factors contribute to hypercoagulation states. Risk factors for development of DVT include, age, prior history of DVT, coagulation abnormalities, and major abdominal /pelvic surgeries and orthopedic procedures of the lower extremities. Other risk factors include obesity, limb trauma, heart disease, advanced neoplasms, post thrombotic syndrome, and Estrogen and oral contraceptive use.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Presence of ankle edema
3. Color of affected limb, sensation and movement.
4. Assessment of pulses of extremities.
5. Calf circumference measurements and assessment of findings.
6. Increased resistance or pain on voluntary dorsiflexion of the foot.
7. Skilled assessment for signs of rapid swelling of the entire limb.
8. Engorged collateral veins of the thigh.
9. Increased skin temperature.
10. Skilled assessment of lung sounds and observation for complaints of sudden onset chest pain, dyspnea, or rapid breathing that may indicate pulmonary emboli.
11. Administration of anticoagulants oral, I.V. or subcutaneous. Skilled observation and assessment for signs of unusual bleeding or potential interactions.
12. Review of laboratory data including PT, I.N.R., and partial prothrombin time.
13. Activity level per physician orders and tolerance.
14. Use of antiembolism stockings or compression wraps.
15. Any referrals or consultations and outcomes
16. Physician visits, order changes, and outcomes
17. Current rehabilitation services and progress
18. Patient education and caregiver training/teaching regarding aftercare, including medication action and precautions, when and how to contact physician with signs of complication or reoccurrence, activity level and future DVT prevention.
19. Discharge planning.

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Core Components
Dehydration (1 of 2)

Daily Nursing Skills: Dehydration occurs when the body loses too much fluid. It also occurs with decreased intake of fluids or loss of large amounts of fluids through diarrhea, vomiting, sweating, or strenuous **exercise**. The body's cells absorb fluid from the blood and other body tissues. By the time the patient become **severely dehydrated**, there is no longer enough fluid in the body to get blood to the organs, and the patient may begin to go into **shock**, which is a life-threatening condition. Medications such as antihypertensives, cathartics, and diuretics increase the risk for dehydration. Skilled nursing assessment for the early signs of dehydration is critical with conditions and diseases that cause high fever, vomiting, or diarrhea. The **early symptoms of dehydration** include: dry mouth, sticky saliva, and reduced urine output with dark yellow urine and change in mentation. Symptoms of **moderate dehydration** include: Extreme thirst. Dry appearance inside the mouth and the eyes don't tear, Decreased urination, or half the normal number of urinations in 24 hours (usually 3 or fewer urinations). Urine is dark amber or brown. Lightheadedness; relieved by lying down. **Severe dehydration** is life threatening. Symptoms that require emergency care (even if only one of them is present) include: Altered behavior, such as severe anxiety, confusion, or not being able to stay awake. Faintness that is not relieved by lying down or lightheadedness that continues after standing for 2 minutes. Changes in pulse rate and rhythm that is weak or rapid. Skin that is cold and clammy or hot and dry. Decreased or absence of urination. Change in level of or loss of consciousness. There is a high risk for kidney failure and circulatory collapse related to dehydration.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs with skilled assessment of findings.
2. Intake and Output monitoring with skilled assessment of findings. Urine color, concentration, and quality.
3. Skilled assessment of barriers to adequate intake and modifications made to treatment plan with outcomes.
4. Skilled assessment of conditions impacting risk for dehydration. Presence of fever, diarrhea, vomiting and interventions to reduce episodes. i.e., fever reduction, antiemetics, and antidiarrheals with outcomes.
5. Current treatment of dehydration: I.V. hydration, fluid challenges, medication modifications, and response.
6. Laboratory results **(review is skilled, even with negative results.)**

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Dehydration (2 of 2)

7. Skilled assessment of mental status, skin turgor, mucous membranes, postural changes in vital signs.
8. Skilled assessment of skin integrity with preventative measures and outcomes.
9. Physician interventions and outcomes.
10. Current rehabilitation services and progress
11. Discharge teaching for self-monitoring, medication effects, signs and symptoms to report to health care providers.
12. Discharge planning.

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Nursing Documentation
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Core Components
Enteral Feeding: NG/Gastrostomy/ Jejunostomy/PEG Tube (1 of 2)

Daily Nursing Skills: Patient is at high risk for aspiration related to placement of feeding tube, positioning and other related diagnosis prompting feeding tube placement. Daily skilled nursing for frequent and periodic checking for tube placement and monitoring of gastric residuals to prevent aspiration. Monitor effectiveness of the feeding and assess the patient's tolerance to the tube and the feeding. Special mouth care is essential to maintain a healthy oral mucosa. Daily assessment of feeding tube site to prevent irritation or complication of infection. Assessment of weights, vital signs, pain, diarrhea and tolerance of any oral intake.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs.
2. Type of tube (NGT, G-Tube, J-Tube).
3. I&O.
4. Replacement of tube, reason.
5. Lung sounds.
6. Signs of electrolyte imbalance, review of abnormal lab results.
7. Complications:
   a. Nausea/vomiting.
   b. Cough/SOB/rales/diarrhea.
   c. Placement and patency of feeding tube.

   Aspiration precautions, positioning, signs of increased residual.
8. Patient teaching on care and management of feeding tube if indicated.

Weekly

1. Skin integrity/problems.
2. Weight change (weigh q week).
3. Type of tube.
4. Amount/type of feeding.
5. Method of administration (gravity, pump or bolus).
6. Signs/symptoms of intolerance.
7. Patient/resident's mental state – pulling out tube/compliance to oral restrictions.
8. Body image concern.

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Nursing Documentation
Medicare Manual

Core Components
Enteral Feeding: NG/Gastrostomy/ Jejunostomy/PEG Tube (2 of 2)

If patient/resident is taking oral food/fluids, document daily.

1. Specific amounts nutrition/hydration.
   a. Food in percentage.
   b. Fluid in number of CCs.
2. Auscultate lungs after each feeding with findings.
3. Amount of assistance required.
4. Participating at optimal level.
5. Motivated to succeed.

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Nursing Documentation
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Core Components
Fluid and Electrolyte Imbalance (1 of 2)

Daily Nursing Skills: Elderly persons are particularly vulnerable to fluid and electrolyte disorders. The elder experiences less total body water as a result of less lean body mass and more fat. The decline in the function of vital regulatory organs and a higher incidence of chronic illnesses also increase risk factors. The elder experiences a diminished ability to reestablish homeostasis when an imbalance has occurred. Elderly persons readily become dehydrated when they experience physiologic stressors from fluid restrictions, fever, diarrhea, infections and diuretic therapy. Fluid imbalance may go unnoticed by the patient as a result of a blunted thirst sensation, swallowing difficulties, misinterpretation of the need for fluids, self-imposed restrictions secondary to fears of incontinence or frequent need to urinate. Fluid loss and electrolyte imbalance is exhibited by the elder is a variety of ways. Symptoms may include changes in behaviors, confusion, apathy, headache, thirst, dry mucous membranes, anorexia, nausea, vomiting, dry and decreased skin turgor, changes in pulse and respiration rate and rhythm, muscle weakness, diarrhea, constipation, abdominal distention and abdominal cramps. With excessive fluid loss hemoconcentration occurs, and the hematocrit, hemoglobin, BUN, and electrolyte levels are increased.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Assessment of vital signs including pulse rate changes, dysrhythmias, and postural hypotension.
2. Intake and Output monitoring and skilled evaluation of findings.
3. Assessment and observation of skin turgor and mucous membranes.
4. Skilled administration of I.V. hydration with observation and documentation of tolerance to fluid replacement, signs of fluid overload with I.V. therapy. Skilled assessment of I.V. site and potential complications of infiltration or inflammatory reaction.
5. Skilled administration of fluids and nutrition via the feeding tube. Free water flushes per physician orders. Assess for signs of intolerance with increased residuals. Replacement of fluids obtained with residual checks to prevent further electrolyte imbalance.
6. Skilled observation and assessment of conditions that further place patient at risk for fluid loss and electrolyte imbalance including fever, diarrhea, excessive wound drainage, increases in respiratory rate, persistent nausea and vomiting. Document interventions to reduce episodes and conditions.
7. Treatment for vomiting and diarrhea. Antiemetics and antidiarrheals administered with assessment of response.
8. Skilled assessment of mental status changes including, confusion, apathy and listlessness.

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Core Components
Fluid and Electrolyte Imbalance (2 of 2)

9. Skilled assessment of respiratory status including breath sounds increased respiratory rate and effort. Document interventions used to reduce increased respiratory effort and distress.
10. Skilled assessment of abdomen including bowel sounds, tenderness, pain, and cramping.
11. Document interventions to relieve symptoms and improve fluid intake.
12. Review of laboratory results **(review without negative results are still skilled)**.
13. Document physician interventions, changes in physician orders and outcome. Discontinuance or changes in diuretic therapy and/or electrolyte replacement.
14. Describe current rehabilitation efforts and progress.
15. Discharge teaching, planning and caregiver education.

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Nursing Documentation
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Core Components
Fractured Hip (1 of 2)

Daily Nursing Skills: High risk for post-operative complications related to the initial trauma injury, surgical intervention or immobility, inadequate fluid replacement, blood loss, neurovascular compromise, impaired oxygenation of tissue, compartment syndrome, pulmonary embolism, fat embolism, thrombophlebitis, aseptic necrosis of the femoral head, non-union of the affected portions, osteomyelitis, pneumonia, arthritic deformities, pressure ulcers secondary to reduced physical mobility and exacerbation of preexisting conditions secondary to surgical intervention.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Assess vital signs: Tachycardia, hypotension, distal pulses.
2. Monitor continually for signs of pain. Record pharmacologic and non-pharmacologic pain strategies, and patient's response.
3. Assess neurovascular status note: Weakened or absent pulses, mottling, cyanosis, paresthesia, loss of sensation, significant increase in edema.
4. Observe for signs of compartment syndrome: Excessive pain exacerbated by stretching, sensory deficits, paralysis, tense or hard swelling, decreasing distal pulses.
5. Document/Prevent signs of complications related to immobility: Encourage ROM exercises, apply and describe use of anti-embolism stockings as prescribed.
6. Record coughing and deep breathing compliance, and daily respiratory assessment for pulmonary complications.
7. Document fluid intake and output, and when indicated the urging of forcing fluids.
8. Assess the adequacy of frequent positioning in both pain management and proper body alignment to prevent skin breakdown. Record proper alignment usually avoid adduction, external rotation, and acute hip flexion.
9. Record and assess skin condition daily for signs of complication due to immobility and self-positioning.
10. Observe incision for adequate healing and signs of infection.
11. Observe for any sudden sharp pain, shortening or rotation of the affected limb, or persistent muscle spasm.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities.

15. Describe current rehabilitation services and progress.
16. Discharge planning.

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Nursing Documentation
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Core Components
Gastrointestinal Bleeding (1 of 2)

Gastrointestinal Bleeding Overview: The many causes of gastrointestinal (GI) bleeding are classified into upper or lower, depending on their location in the GI tract.

Upper gastrointestinal bleeding: Upper GI bleeding originates in the first part of the GI tract—the esophagus, stomach, or duodenum (first part of the intestine). Bleeding can come from ingestion of caustic poisons or stomach cancer. Most often, upper GI bleeding is caused by one of the following: Peptic ulcers, Gastritis, Esophageal varices and Mallory-Weiss tears.

Lower gastrointestinal bleeding: Lower GI bleeding originates in the portions of the GI tract farther down the digestive system—the segment of the small intestine farther from the stomach, large intestine, rectum, and anus. Diverticular disease, angiodysplasia, polyps, hemorrhoids, and anal fissures most commonly cause the bleeding. Blood in the stool can result from cancers, inflammatory bowel disease, and infectious diarrhea.

Daily Nursing Skills: Assess and evaluate for vomiting of blood, bloody bowel movements, or black, tarry stools. Blood may look like "coffee grounds." Assess for signs and symptoms associated with blood loss including the following: fatigue, weakness, shortness of breath, abdominal pain, pale appearance, vomiting of blood usually originates from an upper GI source. Bright red or maroon stool can be from either a lower GI source or from brisk bleeding at an upper GI source. Long-term GI bleeding may go unnoticed or may cause fatigue, anemia, black stools, or a positive test for microscopic blood.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2. Statements made directly by the patient (if possible) quoted. For instance: "I have been having some cramping in my belly but it feels more like gas."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more lethargic today, unable to participate in her therapy and she became very pale and c/o nausea when she attempted to stand."

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Core Components
Gastrointestinal Bleeding (2 of 2)

4. Intake and Output Monitoring. Extremely important to monitor for dehydration secondary to treatments associated with GI bleeding.
5. Assessment of Gastrointestinal System, including:
   a. Presence or absence of bowel sounds (active, inactive) and in which quadrants.

      a. Observe stool sample for presence of blood and test stool for presence of occult blood (guaiac), if ordered.
      b. Complaints of nausea/vomiting, cough, lethargy, fatigue, poor appetite.
      c. Assessment of hydration status including skin turgor, mucous membranes, characteristics of urine output, and toleration of current diet.
      d. Medications that impact diagnosis. For instance: Prilosec to reduce stomach acidity, as well as if medications are being held related to bleeding like Coumadin.
      e. Lab values.
      f. IV Fluid or blood product administration. (Where, when, medication or fluid delivery with administration.)
6. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

Example shift note:

Mrs. Smith continues to receive ongoing skilled observation and assessment for the ongoing signs/symptoms of GI bleeding. Physical therapist reported that during therapy that "Mrs. Smith seemed somewhat more lethargic today, unable to participate in her therapy and she became very pale and c/o nausea when she attempted to stand." She required assist of 2 to transfer from wheelchair to bed and then to reposition while in bed. When she returned to her room, her VS were gathered. BP= 90/62 (baseline 136/84) and her VR= 116 (baseline 84). She refused her regular diet that had been advanced yesterday but tolerated her clear fluids. No bowel movements since yesterday and bowel sounds are present and very active. She denies nausea, cramping, abdominal pain or lightheadedness at this time. A fingerstick BG was assessed to rule out hypoglycemia. BG = 88. Dr. Noitall was informed of findings and a stat Hgb/Hct was ordered. Awaiting lab to draw blood. Will report lab results directly to MD and continue to monitor patient closely for presence of ongoing GI bleeding complications.

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Core Components
Hemiplegia, Hemiparesis, Paraplegia, Quadriplegia (1 of 2)

Definition: Paraplegia is paralysis in both legs, below the waist. It is usually caused by a spinal cord injury or illness. **Quadriplegia** is paralysis below the neck and is also usually the result of a spinal cord injury. In strokes, the paralysis is on one side of the body and is called **hemiparesis** when there is complete paralysis of the affected side. **Hemiplegia** is defined as partial paralysis or weakness on one side of the body and is the term most commonly used in stroke survivors. It is often used instead of hemiplegia even when there is complete paralysis.

Daily Nursing Skills: Patient is at high risk for sensory-perceptual alterations and complications related to impairment of physical mobility from cortex and motor pathway injury. Assess and evaluate for signs and symptoms of Depression, Skin Integrity alterations, muscle atrophy with eventual contractures, immobility, weight loss, neurogenic bladder, infections. This is not an exhaustive list of risk factors. It becomes vital for the nursing team to closely monitor and report any deterioration in condition before they become acute.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and PRN. Be sure to include mental status and postural changes with VS.
2. Assess neurologic status (LOC, orientation, grips, leg strength, papillary responses).
3. Administer medications as ordered especially anti-hypertensive, anti-spasmodic, pain meds and anti-coagulants. Monitor and document effectiveness of medications. Report any side effects immediately.
4. Monitor Intake and Output in detail.
5. Maintain functional alignment; describe needs for bed mobility and positioning.
6. Provide ROM, document collaboration with PT.
7. Document rehab nursing; amount of assistance required with ADLs, safety awareness, and level of participation.
8. Record daily skin assessments. Include presence of edema and the presence of skin breakdown. Stage pressure ulcers using NPUAP guidelines. Remember, MDS completion requires reverse-staging.
9. Maintain adequate elimination.
10. Record bladder or bowel program, and patient's response, or alteration of program and reason.

Core Components
Hemiplegia, Hemiparesis, Paraplegia, Quadriplegia (2 of 2)

11. Assess daily for adaptation to visual and/or sensual impairment, balance problems and effect.
12. Observe patient's compliance with therapy techniques, document progress with therapy.
13. Describe current rehab services and progress.

14. Teaching and training activities: Disease process and implications, mediations, dose schedule, adverse effects, need for follow up lab tests, signs of cerebral impairment, signs of infection, activity and positioning recommendations and mobility aids, food and fluid intake recommendations, bowel and bladder control program, skin care and safety measures.
15. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

** As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

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Nursing Documentation
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Core Components
Hypertension

Daily Nursing Skills: To assess and evaluate full vital signs, complaints of headaches, especially pulsating behind the eyes that occur early in the morning, visual disturbances, nausea and vomiting. Uncontrolled high blood pressure may damage the delicate lining of the blood vessels, which may promote the formation of plaque leading to artherosclerosis. Blood flow through the blood vessels may be reduced. Decreased blood flow, over time to certain organs can cause damage leading to heart disease, heart attack, renal failure, peripheral vascular disease, retinopathy and stroke. Nursing to monitor effectiveness of antihypertensive regimen, titration of medication and parameters to hold medications. Assess for and report signs of adverse responses to medications including unstable vital signs, abnormal lab values, changes in mental status, changes in gait and fall risk.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Blood pressure with each dose of hypertensive medication.
3. Weekly weight.
4. Blurred vision or vertigo.
5. Confusion.
6. Irritability.
7. Sleepiness (side effect of medication).
8. If severe hypertension, lying and standing BP's or BP's before and after activity.
9. Comment on balance when ambulating.
10. Diet restrictions.
11. Headache.
12. Describe current rehabilitation services and progress.
13. Discharge teaching to patient and caregivers: Medications use, action and schedule, dietary compliance, activity level and signs and symptoms to report to healthcare providers.
14. Discharge planning.

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Nursing Documentation
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Core Components
Insulin-Dependent Diabetes Mellitus (IDDM)

Daily Nursing Skills: High risk for hyperglcemia related to inadequate endogenous insulin, prevent or minimize complications while establishing treatment regimen to control altered glucose metabolism, hypovolemia, hyperglycemia, sensory-perceptual alteration, complications of decreased tissue perfusion, cerebral dehydration, hypoxemia, acidosis. Diabetic foot care and inspection as diabetes can damage nerves and reduce blood flow to the feet. Complications may lead to amputation.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor for signs of dehydration, maintain I&O.
3. Monitor fingerstick and blood glucose levels.
4. Monitor urine ketone levels.
5. Observe for signs of hypoglycemia.
6. Observe for signs of ketoacidosis.
7. Monitor level of activity and rest daily.
8. Monitor for signs and symptoms of infection.
9. Assess daily for vascular complications of DM.
10. Observe skin and foot condition daily, record any changes.
11. Assess for signs of urinary tract infection or renal impairment.
12. Assess circulatory status of extremities.
13. Observe for changes in vision.
14. Review of laboratory studies for abnormal (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.
16. Observe for dietary compliance.
17. Teaching and training activities: Diet, exercise, administration of insulin, hypoglycemia, hyperglycemic S&S's, susceptibility to infection and avoidance methods, foot and skin care, circulatory, vision, care. Importance of prompt treatment for any above symptoms.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Insulin-Dependent Diabetes Resident Unable to Administer Own Insulin

Daily Nursing Skills: High risk for hyperglycemia related to inadequate endogenous insulin, prevent or minimize complications while establishing treatment regimen to control altered glucose metabolism, hypovolemia, hyperglycemia, sensory-perceptual alteration, complications of decreased tissue perfusion, cerebral dehydration, hypoxemia, acidosis. Diabetic foot care and inspection as diabetes can damage nerves and reduce blood flow to the feet. Complications may lead to amputation.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
   - Blood sugar check results
2. Circulatory Condition:
   - Edema
   - Radial and pedal pulses and any change in sensation noted to extremities
3. Urinary Condition:
   - Characteristics of urine (frequency, amount and color)
4. Endocrine Condition:
   - Hypo or hyperglycemia (action and response)
   - Sliding scale insulin given
4. Eating:
   - Nutritional status, percent of food eaten and appetite
   - Diet currently receiving
5. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
6. Mood:
   - Mood pattern
7. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

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Core Components
IV Therapy

Daily Nursing Skills: Administration of IV therapy, inspection and care of IV site, observation for signs of phlebitis, infiltrate or infection at the site or systemic. Skilled monitor of condition for which the IV therapy was initiated to treat. Monitor signs for fluid overload, full vital signs and patient's tolerance to therapy. Review of pertinent lab results.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs.
2. I&O.
3. IV site, condition of site (redness, tenderness, swelling, drainage).
4. Insertion:
   a. Cannula type, size, length.
   b. Fluid type, rate, ml/hr, flow device, if used.
5. Maintenance:
   a. Q hour inspection of resident (infusion on time).
   b. S/S infiltration (swelling, skin temperature, absence of flash back sluggish flow rate).
   c. Container change or flow rate change.
   d. ml/hr; flow controller device, if used.
6. Discontinuation:
   a. Cannula type, size length – was cannula intact.
   b. Amount of fluid remaining in IV bag.
   c. Condition of insertion site – redness, swelling, tenderness.
   d. Shift note assessment of hydration status, pain status, or infection status post discontinuation of IV
   e. Therapy. Document any signs of exacerbation of conditions recently treated with IV therapy.
7. **Patient/Resident Controlled Analgesia (PCA) Pump.**

   Utilize previous IV therapy guidelines plus:
   1. Amount of pain medication used q shift.
   2. Patient/resident's response to pain medication (adverse and therapeutic).
   3. Patient/resident/family caregiver's understanding of PCA system.
   4. Communication/update with physician.

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Core Components
Joint Replacement: Hip/Knee (1 of 2)

Daily Nursing Skills: High risk for postoperative complications (hypovolemic shock, neurovascular damage, or thromboembolic phenomena) related to surgical trauma, bleeding, edema, improper positioning, or immobility.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Maintain patency of wound drainage device.
3. Assess for neurovascular damage: Monitor pedal pulses, capillary refill time, toe temperature, skin color, foot sensation, and ability to move the toes, dorsiflex the ankle. Compare findings to the other extremity, as well as base line and earlier findings.
4. Documentation notification of MD for regarding positive neurovascular findings: absent or unequal pedal pulses, capillary filling time greater than 3 seconds, cold toes, pale skin, foot numbness, tingling or pain, inability to move toes.
5. Assess for thromboembolic phenomena: response to leg exercises, presence of calf pain, positive Homan's sign, redness and swelling.
6. Record use of elastic stockings, and reapplication.
7. Monitor for signs of fat embolism: Sudden onset of dyspnea, tachycardia, pallor, cyanosis, or pleuritic pain.
8. Administration of anticoagulants: Record clotting studies, record the reporting of findings outside therapeutic range. Document observation for melena, petechiae, epistaxis, hematuria, ecchymosis, or other unusual bleeding.
9. Record maintenance of affected extremity to: Prevent dislocation of the prosthesis, increase mobility through implementation of the rehabilitation plan, and education of the patient concerning rehabilitation. Record progress with progressive ambulation schedule, use of devise and patient response to activity.
10. Assess pain, treatment given for pain and patient response.
11. ROM to unaffected joints.
12. Assess for signs of infection: Fever, chills, purulent drainage, incisional swelling, redness, increasing tenderness.
13. Adherence to hip flexion and adduction restrictions while transferring and ambulating.
14. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.

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Core Components
Joint Replacement: Hip/Knee (2 of 2)

16. Teaching and training activities.
17. Describe current rehabilitation services and progress.
18. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Leg Ulcerations

Daily Nursing Skills: Most leg ulcers result from chronic venous insufficiency, post thrombotic syndrome and/or severe varicose veins. Less commonly, they develop from arterial obstruction. Other causes include burns, trauma, and neurogenic disorders. There is a high risk for secondary bacterial infections of ulcerations. There is a high risk for delayed healing related to secondary infections, compromised circulation, and increased edema. Daily nursing skills include circulation monitoring, wound care, management of pain, management of secondary infections, and edema management.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Description of ulceration in detail: Presence of slough or necrosis, color of wound bed, surrounding tissue integrity, stage, drainage, erythema, odor, and response to current treatment regimen.
3. Pain to affected extremity and response to pain management techniques.
4. Circulation assessment of extremities: Color, sensation, movement, presence or absence of peripheral pulses.
5. Degree of edema and effects of current treatment to reduce edema (medications, positioning, compression).
6. Signs of local or systemic infection.
7. Response to body positioning:
   a. For arterial ulcer: elevate head of bed on 3-6 inch blocks.
   b. For venous ulcer: elevate lower extremities above heart level to decrease edema.
8. Teaching and training: Education in ways to promote comfort, prevent infection, wound care, signs and symptoms to report to healthcare professional, edema management, positioning, activity level and restrictions. Nutritional interventions to promote healing.
9. Modifications in medication and treatment regimen and outcomes.
10. Physician interventions and outcome, referrals and outcomes.
11. Current rehabilitation services and progress.
12. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Liver Failure

Daily Nursing Skills: High risk for hepatorenal failure, disseminated intravascular coagulation, bleeding esophageal varices. Encephalopathy from decreased nitrogen and glucose metabolism and cerebral blood flow, decreased oxygen saturation, and accumulation of nitrogen substances the liver cannot break down (restrict intake of protein). High risk for toxic accumulation of metabolic substances leading to kidney impairment. High risk for fevers and UTI's, respiratory aspiration and pneumonia, spontaneous peritonitis, ascites from cardiovascular and pulmonary compromise.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive **Weekly Notes** should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs monitor daily.
2. Document daily neurological assessments to monitor for encephalopathy.
3. Assessment of pulmonary status daily.
4. Record intake of protein.
5. Observe for signs of UTI; describe output urine color and quality.
6. Monitor for any signs of infection.
7. Gastrointestinal assessment: Auscultate bowel sounds for signs of spontaneous peritonitis.
8. Cardiovascular: Assess for increased peripheral edema and presence of ascites. Closely record fluid and electrolyte balance, record reports to the physician.
9. Document activity, rest increases the kidney perfusion, and excretion of excess fluid.
10. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
11. Assessment for therapeutic response to medication or discontinuance of medication.
12. Daily skin assessment particularly in presence of vascular spiders. Prolonged prothrombin time increases the risk of skin bleeding and breakdown. Malnutrition and ascites predisposes pressure ulcers. Puritis from jaundice can cause discomfort and scratching.
13. Musculoskeletal: Assess muscle wasting and joint pain.
14. Teaching and training activities: Diet compliance, relationship between alcohol and exacerbation of the disease, changes in neurologic status, effects of ascites, need to avoid use of diuretics.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

Harmony Healthcare INTERNATIONAL

Nursing Documentation
Medicare Manual

Core Components
Lung Cancer (Chemotherapy) (1 of 2)

Daily Nursing Skills: High risk for hypoxemia related to aberrant growth of lung tissue, bronchial obstruction, increased mucus production, or pleurisy. High risk for hemorrhage related to depression of platelet production by chemotherapy. High risk for pain associated with involvement of peripheral lung structures, metastasis, or chemotherapy. High risk for infection related to immunosuppression from chemotherapy and malnutrition. High risk for gastrointestinal complications related to chemotherapy: nausea, vomiting, and diarrhea with increased risk for fluid and electrolyte imbalance.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess daily for hypoxemia.
3. Observe for need and effectiveness of oxygen, and need for elevated head of bed during dyspneic episodes.
4. Assess breath sounds, respiratory rate, and chest movements.
5. Observe for dyspnea, complaints of difficulty breathing, SOB, flailing nostrils, and intercostals retractions on inspiration, or bulging on expiration. Teach patient and family reasoning is not increasing the rate of oxygen or concentration over prescribed levels.
6. Encouraged pursed lip breathing, and relaxation techniques, huff coughing, cascade coughing and document practice of techniques taught by therapists in energy conservation techniques and effectiveness.
7. Observe for signs of bleeding, petechiae, ecchymoses, and oozing wounds.
8. Monitor serum platelet counts before during and after chemotherapy as ordered and record. Report oral bleeding, hematuria, indications of blood in stool, signs of CNS bleeding: headache, dizziness or lightheadedness.
9. Assess daily for pain describe treatment and response.
10. Assess for deficits in neurologic functioning: Parasthesias, abnormal deep tendon reflexes, or foot drop.
11. Document protection of area of decreased sensory perception from injury.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Assess and document bowel and bladder elimination pattern.
15. Incorporate teaching of body mechanics and conservation of energy in ADLs to promote comfort and decrease dyspnea.

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Core Components
Lung Cancer (Chemotherapy) (1 of 2)

16. Teaching and training activities: Prevention, detection and management of bleeding, effects of chemotherapy, breathing exercises, instruction regarding medications, use, purpose, adverse effects, pain relief measures, signs and methods to prevent infection, neurologic changes, measures to control nausea, vomiting, to decrease dyspnea, when and how to seek emergency help.
17. Describe current rehabilitation services and progress.
18. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Management and Development of Care Plan (1 of 2)

Daily Nursing Skills: The patient has many services, which do not require the direct skills of a nurse. But the management of the care plan for this patient **requires the skills of a nurse. A person who is not a skilled nurse would not have the capability to understand the relationship among the services and their effect on each other.**

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Document all areas which require service.
3. Nutrition needs: Appetite, dietary pattern, describe specific feeding needs.
4. Elimination: Describe pattern, constipation preventative bowel and bladder routines, incontinence, retention, use of laxatives, enemas, specific need for assistance, and results.
5. Activity pattern, describe any stiffness, and response to ROM, etc., falls prevention or safety strategies and effectiveness.
6. Sleep rest patterns: Describe cycles, techniques used to facilitate adequate patterns.
7. Cognitive perception: Visual sensory deficits and how these trigger need for intervention, describe how staff incorporates techniques in daily treatment of patient.
8. Describe each physical assessment finding which requires daily observation i.e. gastrointestinal, cardiovascular: Patient may have increased pulse rate, have Dx of CHF, have oral medications which control heart rate and blood pressure.
9. Document any potential complications secondary to the primary diagnosis or current physical condition: mental confusion, contractures, fecal impaction, falls and fractures, urine retention, cystitis, UTI, pulmonary emboli, depression, exacerbation of symptoms of secondary diagnosis.
10. Record any high risk for slowed or diminished responsiveness related to cerebral degeneration.
11. Document any high risk for altered thought process related to diminished perception of sensory data.
12. Record any high risk for renal impairment related to physiologic degeneration of nephrons and glomeruli.
13. Document evaluation for high risk for nutritional deficit which places patient at risk for infection. Skin breakdown.

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Core Components
Management and Development of Care Plan (2 of 2)

14. At least once a week list all the non-skilled services which require a skilled nurse to monitor.
15. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
16. Assessment for therapeutic response to medication or discontinuance of medication.
17. Teaching and training activities.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Multiple Sclerosis (1 of 2)

Daily Nursing Skills: Multiple sclerosis or MS is a disease that affects the brain and spinal cord resulting in loss of muscle control, vision, balance, sensation (such as numbness) or thinking ability. With MS, the nerves of the brain and spinal cord are damaged by one's own immune system. Thus, the condition is called an autoimmune disease. Autoimmune diseases are those whereby the body's immune system, which normally targets and destroys substances foreign to the body such as bacteria, mistakenly attacks normal tissues. In MS, the immune system attacks the brain and spinal cord, the two components of the central nervous system. Other autoimmune diseases include lupus and rheumatoid arthritis. Assess and evaluate for Muscle weakness, Decreased coordination, Blurred or hazy vision, Eye pain and Double vision. As the disease progresses, symptoms may include muscle stiffness (spasticity), pain, difficulty controlling urination or difficulty thinking clearly. Late effects can be similar to patients who suffer brain injuries such as CVA's with loss of skeletal muscle control and loss of independence with their activities of daily living.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2. Statements made directly by the patient (if possible) quoted. For instance: "I have been having some tremors in my arms today that caused me to spill my juice this morning."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more unsteady today, unable to participate in her morning bath, dressing, and toileting."
4. Intake and Output Monitoring. ** Extremely important to monitor for dehydration secondary to inability to perform eating tasks without assistance and the high risk for depression based on newly diagnoses MS.
5. Thorough neurological assessment including:
    a. Reported changes in eyesight.
    b. Examination of gait and station.
    c. Assessment of motor function including muscle strength in upper and lower extremities.
    d. Assessment of muscle tone in upper and lower extremities (i.e., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (i.e., tardive dyskinesia).

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Core Components
Multiple Sclerosis (2 of 2)

e. Assessment of higher integrative functions, including
   i. Orientation to time, place and person
   ii. Recent and remote memory
   iii. Attention span and concentration
   iv. Language (i.e. naming objects, repeating phrases, spontaneous speech)
   v. Fund of knowledge (i.e., awareness of current events, past history, vocabulary)

6. Medication changes that my affect assessment findings or indicate improvements/advancement of disease process.
7. Moods and behaviors.
8. ADL participation and number of assistance needed to complete tasks safely (bed mobility, transfer, eating and toileting).
9. Skin assessment findings.
10. Participation in skilled or restorative therapy programs.
11. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

** As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

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Nursing Documentation
Medicare Manual

Core Components
Myocardial Infarction

Daily Nursing Skills: High risk for cariogenic shock related to arrhythmias, impaired contractility or thrombosis, chest pain due to myocardial ischemia, hypoxemia due to ventilation-perfusion imbalance-minimize the risk of further infarction, optimize myocardial oxygen demand-supply ratio, high risk for activity intolerance related to myocardial ischemia, decreased contractility, arrhythmias.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor for use of stimulants or beverages containing caffeine.
3. Encourage patient performance of ADL, assess and document response or intolerance to activity.
4. Monitor vital signs before during and after each exercise session.
5. Stress and monitor avoidance of Valsalva's maneuver and isometric exercises.
6. Administer vasodilator as ordered and monitor for adverse effects particularly hypotension.
7. Teach the patient to monitor pulse rate before and after exercise.
8. Stress and monitor the importance of complying with the activity or exercise program and with rest requirements.
9. Assess daily for chest pain, describe type, location, radiation, precipitating factors, duration, vital signs, discussion with MD and outcome, list treatment and patient's response.
10. Assess daily for anxiety, depression, denial.
11. Increase knowledge of the disease, promote compliance with dietary modifications, stress the importance of hypertension management, smoking cessation, stress reduction.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities: Disease and its implications, measuring radial pulse accurately, medications, purpose, dose, schedule, adverse reactions. Need for risk factor modification, diet, rest and exercise programs.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Neurogenic Bladder/Catheter in Place

Daily Nursing Skills: The muscles and nerves of the urinary system work together to hold urine in the bladder and then release it at the appropriate time. Nerves carry messages from the bladder to the brain and from the brain to the muscles of the bladder telling them either to tighten or release. In a neurogenic bladder, the nerves that are supposed to carry these messages do not work properly. The following are possible causes of neurogenic bladder: diabetes, acute infections, accidents that cause trauma to the brain or spinal cord, genetic nerve problems, heavy metal poisoning. Assess and evaluate for urinary tract infection, kidney stones, chills, shivering, fever, urinary incontinence, small urine volume during voiding, urinary frequency and urgency, dribbling urine, loss of sensation of bladder fullness. The symptoms of neurogenic bladder may resemble other conditions and medical problems.

An indwelling urethral (Foley) catheter is a closed sterile system that is inserted through the urethra to allow for bladder drainage.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - I&O
2. Urinary Reproductive Condition:
   - Urine color, odor and sediment
   - Foley change (size, frequency and reason for change)
   - Foley irrigation (solution used, frequency and reason for irrigation)
3. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
4. Mood:
   - Mood pattern
5. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

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Nursing Documentation
Medicare Manual

Core Components
Observation, Assessment and
Development of a Care Plan (1 of 2)

Daily Nursing Skills: Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation per personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. System assessments:
   Neurological/Cognitive: Pupils, hand grips, cognitive function, orientation, attention, memory, vocabulary, abstract reasoning, judgment, sensory/perception/coordination, thought process, sensation of extremities.
   Cardiovascular: Quality, rate, rhythm, regularity, consistence with respiration, radial pulse, apical pulse, check jugular for distention.
   Respiratory: Lung inspection for color, retraction, bilging, impairment in movement, rate and rhythm of breathing, SOB, dyspnea, sputum production color consistency, amount. Palpation: Areas of tenderness, abnormalities such as masses, presence of fremitus crepitus, symmetrical comparison. Percussion: Determine whether the underlying tissues are air filled, fluid filled or solid. Determine flatness, dullness, resonance, hyperresonance or tympany. Auscultation: Air flow, presence of fluid, mucus or obstruction, compare symmetrical breath sounds for quality, intensity, and location. Note pitch, duration of inspiration/expiration and intensity. Describe any abnormality, any rales, wheezes, rhonchi or pleural friction rubs.
   GI: Abdomen, inspection, auscultation, percussion pulsations.
3. **Pain assessment:** Location, type, severity on 1-10 scale. Exacerbated and relieved by. Change in mentation, objective signs of pain, grimacing, body positioning, altered breathing patterns, moaning.
4. **Skin assessment:** Variation in color, pigmentation, texture, thickness, lesions, pressure sores, puritis, incisions.
5. **Physical and functional status:** Document assistance required for bed mobility, positioning, transfers, ambulation, endurance level with activity and ADLs.

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Core Components
Observation, Assessment and
Development of a Care Plan (2 of 2)

6. **Nutritional and hydration status:** List any eating or swallowing impairment, skin turgor, special dietary needs, percent of meals eaten daily.
7. Response to treatment: Document the patient's response to any change in medication, or treatment.
8. Record all nursing observations, which identify and evaluate that there may be a need to change or modify a patient's treatment; this includes any positive findings in daily assessments, lab results, vital signs.
9. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
10. Assessment for therapeutic response to medication or discontinuance of medication.
11. Teaching and training activities.
12. Describe current rehabilitation services and progress.
13. Discharge planning.

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Nursing Documentation
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Core Components
Pacemaker
(In addition to the listed topics for MI)

Daily Nursing Skills: A pacemaker (or artificial pacemaker, so as not to be confused with the heart's natural pacemaker) is a medical device designed to regulate the beating of the heart. The purpose of an artificial pacemaker is to stimulate the heart when either the heart's native pacemaker is not fast enough or if there are blocks in the heart's electrical conduction system preventing the propagation of electrical impulses from the native pacemaker to the lower chambers of the heart, known as the ventricles. Assess and evaluate surgical wound, vitals are within parameters, activity tolerance, mobility, postural stability, cognitive changes, signs and symptoms of depression.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Skin Condition:
   - Status of surgical incision (redness, warmth, edema, tenderness, drainage, staples or sutures)
   - Site care
2. Follow Up:
   - Next physician follow-up visit
   - Monthly pacemaker checks, include date, time and facility to call including phone number
3. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
4. Mood:
   - Mood pattern
5. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

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Nursing Documentation
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Core Components
Pain Management

Daily Nursing Skills: Skilled assessment of pain symptoms including duration, frequency, intensity, factors that exacerbate complaints of pain and factors that relieve pain symptoms. Impact pain has on mobility, mood, sleep, relationships with others. Response to pharmacology and non-pharmacological interventions. Inadequate pain control can contribute to insomnia, anxiety, depression and hostility.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Type of pain (sharp, pressing).
2. Location.
3. Pain level.
4. Medication (P.O./I.M./S.C. or topical) administration.
5. Is medication effective?
6. How long does it take to relieve pain?
7. Is pain completely relieved?
8. Scheduled pain regimen with complaints or signs of break through pain and need for supplemental medications.
9. Any communication with physician regarding pain management plan and outcome.
10. Monitor mental status for changes related to narcotics.
11. Assessment and implementation of an effective bowel regimen to prevent complications related to narcotic use.
12. Patient education regarding relaxational, diversional exercises, energy conservation and work simplifications strategies.
13. Identify how pain impacts other areas such as immobility, nutrition, insomnia, signs of impaired coping and mood indicators.

Other comfort measures:

1. Position change
2. Back rub
3. Emotional support
4. Relaxational or diversional exercises
5. Observation for respiratory depression

Core Components
Parkinson's Disease (1 of 2)

Daily Nursing Skills: Parkinson's disease (also known as **Parkinson disease** or **PD**) is a degenerative disorder of the **central nervous system** that often impairs the sufferer's **motor skills** and speech. Parkinson's disease belongs to a group of conditions called **movement disorders**. The primary symptoms are the results of decreased stimulation of the motor cortex by the basal ganglia, normally caused by the insufficient formation and action of **dopamine**, which is produced in the **dopaminergic neurons** of the brain. PD is both **chronic** and progressive. PD is the most common cause of **parkinsonism**, a group of similar symptoms. PD is also called "primary parkinsonism" or "idiopathic PD" ("idiopathic" meaning of no known cause). While most forms of parkinsonism are idiopathic, there are some cases where the symptoms may result from toxicity, drugs, genetic mutation, head trauma, or other medical disorders. Assess for complications related to for muscle rigidity, dysphagia, drooling, sign and symptoms of aspiration, fatigue, tremor, postural instability, a slowing of physical movement (**bradykinesia**) and, in extreme cases, a loss of physical movement (**akinesia**). Assess and evaluate secondary symptoms including high level cognitive dysfunction and subtle language problems, disorders of mood, behavior, thinking, and sensation (non-motor symptoms).

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms Q
2. Circulatory Condition Q
3. Muscular Skeletal Condition:
   - Contractures
   - Therapy attendance and response
4. Nervous Condition:
   - Reflex response
   - Tremors
   - Pill rolling
   - Facial mask
   - Teaching done and response
5. Bed Mobility:
   - Amount of assist needed
6. Transfer:
   - Amount of assist needed

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Parkinson's Disease (2 of 2)

7. Locomotion:
    - Amount of assist needed
    - Gait (shuffling, forward leaning, weakness)
    - Falls (summarize)
8. Toilet Use:
    - Amount of assist needed.
9. Personal Hygiene:
    - Amount of assist needed
10. Bathing:
    - Amount of assist needed
11. Eating:
    - Signs and symptoms of swallowing problems
12. Cognitive:
    - Level of orientation
    - Cognitive
13. Emotional:
    - Emotional status
    - Acceptance of disease
14. Elimination:
    - Continence level of bowel and bladder
15. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
16. Mood:
    - Mood pattern

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Core Components
Pelvic or Lumbar Fracture (1 of 2)

Daily Nursing Skills: A pelvic fracture is when one or more of the pelvic (hip) bones are broken. Your pelvis is made up of 5 bones, shaped in a circle. The 5 bones are the sacrum, coccyx (COX-iks), ilium, pubis, and ischium (ISH-e-um). Your pelvis protects and supports organs inside your body. Fracture of one or more parts of the spinal column (vertebrae) of the middle (thoracic) or lower (lumbar) back is a serious injury usually caused by high-energy trauma. People with osteoporosis, tumors or other underlying conditions that weaken bone can get a spinal fracture with minimal trauma or normal activities of daily living. The lumbar spine provides for both stability and support when humans ambulate. Assess and evaluate for signs and symptoms of DVT, immobility, instability, loss of balance, pain, posture, skin integrity, vitals, dizziness, dehydration, sensation, numbness, tingling.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Peripheral pulses
   - CMTS
3. Skin Condition:
   - Skin integrity
   - Status of open areas
   - Potential related concerns
4. Urinary Condition:
   - Presence of urine retention
5. Muscular Skeletal Condition:
   - Pain
   - Attendance at therapy and progress
   - ROM given
6. Digestive Condition:
   - Bowel sounds
   - Constipation
7. Bed Mobility:
   - Amount of assist needed

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Core Components
Pelvic or Lumber Fracture (2 of 2)

8. Transfer:
   - Amount of assist needed
9. Locomotion:
   - Amount of assist needed
10. Dressing:
   - Amount of assist needed
11. Eating:
   - Amount of assist needed
12. Toilet Use:
   - Amount of assist needed
13. Personal Hygiene:
   - Amount of assist needed
14. Bathing:
   - Amount of assist needed
15. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
16. Mood:
   - Mood pattern

Harmony Healthcare INTERNATIONAL

Nursing Documentation
Medicare Manual

Core Components
Permanent Pacemaker Insertion

Daily Nursing Skills: High risk for arrhythmias related to pacemaker malfunctions or catheter displacement. High risk for infection related to surgical disruption of skin barrier. High risk for bleeding, infection (elevated WBC), drainage at insertion site. High risk for vagal-medicate arrhythmias. Observations and assessment for deviation from baseline vital signs which may indicate pacemaker failure of complications.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs, apical pulse.
2. Record pacemaker type, and rate.
3. Administer cardiac medications and effectiveness, and adverse effects.
4. Observe insertion site for redness, swelling, drainage, warmth and local pain.
5. Monitor response to increased activity.
6. Monitor use ROM and restrictions to use of arm, (decrease change of lead displacement).
7. Monitor for S&S of decreased cardiac output, shortness of breath, low or erratic pulse, lightheadedness, chest pain decreased exercise tolerance, prolonged fatigue or weakness, or recurrence of pre-implant symptoms.
8. Assess for vagal-mediated arrhythmias, encourage non-laxative stool softeners.
9. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
10. Assessment for therapeutic response to medication or discontinuance of medication.
11. Teaching and training activities: symptoms of pacemaker failure, complications, limitations and precautions, pulse rate measurement, medications, purpose, dose administration schedule, adverse reactions requiring medical attention. Follow-up pacemaker monitoring with cardiologist.
12. Describe current rehabilitation services and progress.
13. Discharge planning.

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Core Components
Pneumonia (1 of 2)

Daily Nursing Skills: High risk for hypoxemia related to inflammatory response to pathogen and inadequate airway and alveolar clearance, symptoms related to pain fever and pleuritic irritation, activity tolerance from increased oxygen demands and a compromised respiratory system.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Document daily pulmonary assessment.
3. Monitor for need of oxygen or patient's response to medical gases.
4. Record maintenance of oxygen during activity.
5. Observe tolerance of activity. Pulmonary response to physical activity and needs for increased liter flow of oxygen to compensate.
6. Assess for signs of increased fatigue, tachypnea, cyanosis, tachycardia, and other signs of impaired oxygenation.
7. Administer antibiotic therapy as ordered, and results of blood level studies.
8. Monitor and report any adverse effect.
9. Document: LOC, sputum character and color, presence or absence of cough, temperature, pulse, respiratory rate, skin color, breath sounds, and activity level.
10. Document non-invasive measures to promote airway clearance: Deep breathing, coughing, incentive spirometer.
11. Document any postural drainage, percussion or vibration, and the patient's response to the treatment.
12. Assess for need by pulmonary assessment, record gurgling, heard over major airways and any nasotracheal suctioning performed. Record any increase in supplemental oxygen used before and during airway clearance procedures. Describe results and patient's response.
13. Maintain adequate hydration, record I&O.
14. Document patient's progress with mobility, and compliance with recommended rest periods.
15. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
16. Assessment for therapeutic response to medication or discontinuance of medication.

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Core Components
Pneumonia (2 of 2)

17. Teaching and training activities: Pulmonary hygiene, avoidance of infection and irritants, importance of rest, importance of prompt reporting of signs of recurrence of pneumonia and medication regimen.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Psychiatric Disorders

Daily Nursing Skills: High risk for exacerbation of symptoms in mood or behaviors that may negatively impact self or others. Medication management and skilled monitoring of effects. Management in care plan to promote stability of condition. Behavior plans, interventions and need for modification. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

should address **one or more** of these areas of skilled nursing.

1. Complete vital signs.
2. Mental status, level of orientation and decision-making.
3. Behaviors, verbal complaints of physical or emotional distress.
4. Presence of auditory or visual hallucinations and delusional thought process.
5. Sleep pattern signs insomnia and lethargy.
6. Nutritional and fluid intake, signs of inadequate hydration or unplanned weight loss.
7. Affect/insight into condition or limitations.
8. Signs of medical instability related to secondary diagnosis or conditions.
9. Medication compliance, side effects, therapeutic effects, therapeutic drug levels. Change in meds or dosage and patient's response – negative or positive.
10. Interventions with response – negative or positive.
11. Physician visits, medical or psychiatric.
12. Motivation to participate in ADLs, training in skills to return to the community.
13. Social interaction, activity level.
14. Discharge planning, medication teaching, community referrals, caregiver education.

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Nursing Documentation
Medicare Manual

Core Components
Pulmonary Disease

Daily Nursing Skills: High risk for hypoxemia related to inadequate gas exchange. High risk for respiratory infection secondary to limited ability to expand lungs secondary to disease effects. High risk for anxiety and depression.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assessment of lungs:
    a. Auscultation q shift x _____ days.
        1. Presence and location of rales/wheeze/rhonci.
        2. Congestion.
    b. Presence of sternal or intercostal retraction.
    c. Unequal chest expansion.
    d. Distention of next veins.
    e. Ability to cough and deep breathe (sputum, color, consistency, amount).
    f. Response to antibiotic therapy/respiratory treatments and or use of a metered dose inhaler.
3. O2 requirements (liters/minute per delivery device used).
4. Nutritional/hydration status.
5. Activity level and amount of assistance needed. Pulmonary response to physical activity.
6. Endurance – cyanosis/SOB/need for O2, use of accessory muscles.
7. Saturation Rates.
8. Symptoms related to chronic disease effects of air hunger and limitations imposed by disease effects.

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Core Components
Radiation Therapy or Chemotherapy (1 of 3)

Daily Nursing Skills: Chemotherapy refers to drugs that are used to kill microorganisms (bacteria, viruses, fungi) and cancer cells. Most commonly, the term is used to refer to cancer-fighting drugs. Cancer chemotherapy kills or arrests the growth of cancer cells by targeting specific parts of the cell growth cycle. However, normal healthy cells share some of these pathways, and thus are also injured or killed by chemotherapy. This is what causes most side effects from chemotherapy. A patient becomes less resistant to any type of virus of infection putting them at risk for more acute complications.

Radiation therapy is a treatment approach that uses radiation to destroy cancer cells. Radiation therapy is used to fight many types of cancer. Often it is used to shrink the tumor as much as possible before surgery to remove the cancer. Radiation can also be given after surgery to prevent the cancer from coming back. For certain types of cancer, radiation may be the only treatment needed. Radiation treatment may also be used to provide temporary relief of symptoms, or to treat malignancies (cancers) that cannot be removed with surgery.

Radiation therapy can have many side effects. These side effects depend on the part of the body being irradiated and the dose and schedule of the radiation:

- Fatigue and malaise
- Low blood counts
- Difficulty or pain swallowing
- Erythema
- Edema
- The shedding or sloughing-off of the outer layer of skin (desquamation)
- Increased skin pigment (hyperpigmentation)
- Atrophy
- Pruritis
- Skin pain
- Changes in taste
- Anorexia
- Nausea
- Vomiting
- Hair loss
- Increased susceptibility to infection

Core Components
Radiation Therapy or Chemotherapy (2 of 3)

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Edema
   - CMTS
3. Vital statistics/symptoms:
   - Vitals
4. Hydration Condition:
   - Dehydration
5. Circulatory Condition:
   - Edema
   - Ascites
6. Skin Condition:
   - Skin integrity (sloughing, redness, edema, tenderness)
   - Status of open areas
   - Potential related concerns
   - Jaundice
7. Digestive Condition:
   - Pain
   - Nausea/vomiting
   - Nausea medication ordered
8. Eating:
   - Nutritional status
   - Percent of food taken
   - Supplements taken
9. Emotional:
   - Adaptation to changes in body image.
10. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices.
    - Days per week received for more than or equal to 15 minutes

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Core Components
Radiation Therapy or Chemotherapy (2 of 3)

10. Rehab/ Restorative:
    - Attendance at therapy and progress
    - ROM given
11. Mood:
    - Mood pattern.

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Core Components
Rehab for Strengthening Due to Functional Loss (1 of 2)

Daily Nursing Skills: There are multiple health benefits that are derived from endurance training and/or strengthening in the elderly. For example, bone density, insulin sensitivity, and co-morbidities associated with obesity can be effectively managed with resistance exercise when it is conducted on a regular basis. Assess and evaluate signs and symptoms of exacerbation of primary and secondary medical diagnosis related to complications of functional loss and post therapy intervention. Often patients participate with 100% effort in the therapy appointment as they view this as the portal to returning home. Following return to the nursing unit a patient can experience a decline in medical status due to the efforts exerted during a rehabilitation session.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Bed Mobility:
   - Amount of assist needed
3. Transfers:
   - Amount of assist needed
4. Locomotion:
   - Amount of assist needed
   - Endurance
5. Dressing:
   - Amount of assist needed
6. Eating:
   - Amount of assist needed
7. Toilet use:
   - Amount of assist needed
8. Personal Hygiene:
   - Amount of assist needed
9. Bathing:
   - Amount of assist needed

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Core Components
Rehab for Strengthening Due to Functional Loss (1 of 2)

10. Cognitive:
    - Ability to follow directions
11. Muscular Skeletal Condition:
    - Attendance and response to therapy (PT or OT)
12. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
13. Mood:
    - Mood pattern

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Core Components
Renal Failure with Dialysis (1 of 2)

Daily Nursing Skills: High risk for hyperkalemia, related to decreases renal excretion, metabolic acidosis, excessive dietary intake, blood transfusion, catabolism, and noncompliance with therapeutic regimen. High risk for pericarditis, pericardial effusion, and pericardial tamponade related to uremia or inadequate dialysis. High risk for hypertension related to sodium and water retention and malfunction of the renin-angiotensin-aldosterone system. High risk for anemia related to decreased life span of RBC's and blood loss during hemodialysis. High risk for osteodystrophy and metastatic calcification related to hyperphosphatemia, hypocalcemia, abnormal vitamin D metabolism, hyperparathyroidism, and elevated aluminum levels. High risk for nutritional deficit related to anorexia, nausea, vomiting, diarrhea, restricted dietary intake, GL inflammation with poor absorption, and altered metabolism of proteins, lipids and carbohydrates. High risk for altered oral mucous membrane and unpleasant taste related to accumulation of urea and ammonia. High risk for impaired skin integrity related to decreased activity of oil and sweat glands, scratching, capillary fragility, abnormal blood clotting, anemia, retention of pigments, and calcium deposits on the skin.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor and record serum potassium, and report S&S's of hyperkalemia (slow irregular pulse, muscular weakness and flaccidity, diarrhea and ECG changes.)
3. Assess measures for prevention of metabolic acidosis assess prevention measures to avoid catabolism, ensure prescribed amounts of dietary protein and carbohydrates, treatment of infections, prevention of fever.
4. Assess daily for pericarditis (fever, chest pain, friction rub).
5. Assess for paradoxical pulse greater than 10mm Hg., peripheral edema, decrease in sensorium, hypotension, narrow pulse pressure, weak or absent peripheral pulses, cold and poorly perfused extremities, rapid decrease in sensorium, and bulging neck veins (signs of rapidly occurring large tamponade).
6. Dialysis removes sodium and water and controls vascular volume, monitor and record compliance with restrictions to prevent excessive sodium and fluid intake.
7. Assess daily for orthostatic hypotension; teach and record patient compliance with techniques to avoid this.

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Core Components
Renal Failure with Dialysis (2 of 2)

8. Assess daily for S&S's of fluid overload: Hypertensive encephalopathy, vision changes, periorbital, sacral or peripheral edema, headaches blurred vision seizures and blurred vision.
9. Assess the degree of anemia (Hgb. level, RBC) and its physiologic effects: fatigue, pallor, dyspnea, palpitations, ecchymoses, and tachycardia.
10. Assess every shift: Dialysis catheter, AV shunt, bruit and thrill, IV dressing integrity, IV site presence of drainage and redness or warmth.
11. Assess with development of activity and exercise program with regular rest periods to avoid fatigue due to decreased Hgb., decreased tissue oxygenation. Assess the patient's ability to perform ADLs.
12. Describe current rehabilitation services and progress.
13. Intake and output, fluid restrictions, compliance to restriction.

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Core Components
Rheumatoid Arthritis

Daily Nursing Skills: High risk for joint deformity, pain and muscle atrophy. Risk to other body systems as rheumatoid nodules may for in the heart, lungs, and spleen. Manifestations of the multi-system involvement include: Pleuritis, Pulmonary Fibrosis, Pericarditis, Aortic Valve Disease, Lymphadenopathy, Glaucoma, and Spleomegaly. The acute narcotizing vacillates that is common in the autoimmune disorders may result in myocardial infarction, cerebrovascular accident, Kidney damage, and Raynaud's disease. High risk for ineffective pain control, fatigue, negative self-concept, decreased mobility and injuries with the risk for development of skin ulcers and contractures.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Inspection and palpation of the same joints on both sides of the body for symmetry, skin color, size and shape.
3. Inspection of tenderness, heat, and swelling of joints
4. Assess and document limitations of active joint ROM
5. Assess and document pain with ROM
6. Evaluate and document effectiveness of pain relief measures, evaluate type intensity and duration of pain. Teach relaxation techniques and alternate methods of pain control.
7. Assess measures utilized to promote independence. Assist with supportive, assistive measures. Promote frequent position changes and adequate rest periods.
8. Work simplification strategies and assist with ADLs.
9. Comprehensive skin assessments for signs of ulcers related to decreased mobility and contractures.
10. Assess psychological effects imposed by disease with limitations and coping abilities.
11. Assess response to medications, anti-inflammatory medications and side effects.
12. Review and report laboratory results including ESR.
13. Document communication with physician, consults with Rheumatologist, and orthopedic physicians.
14. Discuss current rehabilitation services and response to therapy.
15. Discharge teaching and training, caregiver education.
16. Discharge planning.

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Core Components
Seizure Disorder

Daily Nursing Skills: High risk for trauma related to seizure activity. High risk for aspiration secondary to decreased consciousness following a seizure. High risk for impaired adjustment related to disability requiring change in lifestyle and possible change in independence. High risk for adverse effects of non-therapeutic drug levels.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. Observation of any seizure activity – petit mal or grand mal seizure. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Time began.
2. Symptoms at beginning.
3. Pattern of seizures.
4. Type (grand mal, petit).
5. Type of movements.
6. Unconsciousness (check airway).
7. Incontinence of urine/feces.
8. Size of pupils/fixed in one position.
9. Vital signs post seizure.
10. Duration.
11. Injuries sustained during seizure.
12. PRN post-conclusive medication given.
13. Physician notified.
14. Sleeping afterwards/exhausted. Postictal phase. Level of assist with ADLs required post-seizure.
15. Laboratory results of seizure drug levels.
16. Adverse side effects of seizure drugs.
17. Potential interactions with seizure drugs.
18. Signs of ineffective coping and altered mood secondary to seizure activities.

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Nursing Documentation
Medicare Manual

Core Components
Skeletal Traction

Daily Nursing Skills: Patient is at high risk for skin breakdown or dermatitis under skin traction, complications of immobilization; stasis pneumonia, thrombophlebitis, pressure ulcers, urinary tract infection, calculi, constipation. Altered tissue perfusion, deformity related to traction therapy and underlying pathology.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assessment frequently for pain, deformity, swelling.
3. Neurovascular assessment frequently for motor and sensory function and circulatory status of the affected extremity; color, temperature, motion, capillary refill of peripheral circulation. Assess specific nerves which may be compromised: peroneal, radial, median.
4. Assessment daily of skin condition of the affected extremity, both under skin traction, and around skeletal traction, as well as over bony prominence throughout the body.
5. Pulmonary assessment for signs of complications auscultate the lung fields at least twice daily, document frequency of deep breathing exercises.
6. Assess traction equipment for safety and effectiveness, deformity. Check ropes and pulleys for alignment. Assure that the pulleys are in line with the long axis of the bone, weights are hanging freely, ropes are unobstructed, and not in contact with the bed or equipment.
7. Inspect skin around pin sites frequently for signs of infection or points of contact with external traction devices.
8. Document fluid I&O, and development of an effective bowel program, high fiber diet, avoid high calcium intake.
9. Assess frequently for signs of thrombophlebitis. Color, sensation and movement of affected extremity absence or presence of Homan's sign. Presence of increased edema and tenderness.
10. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
11. Assessment for therapeutic response to medication or discontinuance of medication.
12. Teaching and training activities.
13. Describe current rehabilitation services and progress.
14. Discharge planning.

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Nursing Documentation
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Core Components
Specialty Bed

Daily Nursing Skills: High risk for complications related to the reason the specialty bed is necessary. Local and systemic infection including high risk for osteomyelitis.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs include fever, chills or rigors without elevated temperature.
2. Document at the initiation of use of specialty bed, all other treatments that were unsuccessful, and response.
3. Specify the diagnosis for which use of the bed is indicated, usually stage 3 or 4 decubitus ulcers of the trunk.
4. Describe immobility, and the amount of time the patient is in the bed for each shift. Generally full bed rest with short periods out of bed only for specific periods of essential rehabilitation. Describe psychosocial impact of bed rest status and measures to increase social stimuli.
5. Document skin condition. Identify any new areas of concern.
6. Record nutritional status, appetite, diet, intake.
7. Document elimination patterns, bowel and bladder programs, incontinence, use of laxatives, etc.
8. Document specific ulcer data: Location(s), stage, diameter, depth, size, drainage, color, odor, and any observed changes to the ulcer. Document pain related to ulcer, treatment and response.
9. Document treatment to the ulcer, describe exact treatment, medication, irrigations, dressings, frequency, response to treatment. Document measures to control odors and drainage.
10. Document any changes to the treatment plan as well as the patient's response.
11. Record any discussion with the physician regarding treatment plan or change of plan.
12. Document any consults: Wound care specialist, surgical, dietitian, social worker, wound clinical visits and primary care physician. Reason for consult and outcome.
13. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
14. Assessment for therapeutic response to medication/treatments or discontinuance of medication/treatments.
15. Teaching and training activities.
16. Describe current rehabilitation services and progress.
17. Discharge planning.

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Nursing Documentation
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Core Components
Speech and Language Problems (Aphasia)

Daily Nursing Skills: Aphasia usually results from damage to the left side of the brain, which is the area responsible for language. Some people who have aphasia may not be able to understand written or spoken language, read or write, or express their own thoughts. Recovering from significant injury to the brain may take from days to years. Much of your improvement in motor functioning-walking, using your arms and legs-comes in the early phase of stroke recovery. Provide detailed assessment documentation to support the patient's functional improvements and deteriorations on a daily basis. Assess and evaluate vitals, oral communication, safety, ability to make daily needs known, signs and symptoms of distress, and signs and symptoms of neurovascular episodes.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2 Statements made directly by the patient (if possible) quoted. For instance: "I have been having some tremors in my arms today that caused me to spill my juice this morning."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more unsteady today, unable to participate in her morning bath, dressing, and toileting."
4. Intake and Output Monitoring.
5. It is not unusual that with new CVA's, aphasia is accompanied by dysphagia, thus putting the patient at risk for dehydration, aspiration, and depression. Monitor for all.
6. Detail any communication techniques used by caregivers and patient to assist with making the patient's need known. (i.e., communication boards, sign language).
7. Medication changes that my affect assessment findings.
8. Moods and behaviors.
9. ADL participation and number of assistance needed to complete tasks safely (bed mobility, transfer, eating and toileting).
10. Skin assessment findings.
11. Participation in skilled or restorative therapy programs.
12. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

** As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

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Nursing Documentation
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Core Components
Suctioning (1 of 2)

Daily Nursing Skills: There are many clinical reasons when suctioning (the removal of unwanted secretions from the respiratory tract) is necessary. For instance, patients with chronic lung diseases, respiratory infections (pneumonia, bronchitis) and paralysis require the skills of a clinical professional to at times assist the patient with the removal of such secretions. Suctioning can be performed through the oral route, nasopharyngeal route, or by tracheal aspiration. Medicare recognizes the latter two routes as requiring the skills of a licensed professional to be considered a covered service. Many facilities have policies surrounding the performance of suctioning at the bedside and should include strategies to move secretions through peripheral airways. These measures include: appropriate hydration and adequate humidification of inspired gases (to keep secretions thin); coughing and deep breathing; frequent position changes (may need rotation bed); chest physiotherapy; and bronchodilating agents as ordered. Above all, the ongoing skilled observation and assessment are vital to the task of effective suctioning.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Skin color and temperature
3. Respiratory Condition:
   - Breath sounds
   - Sputum color
   - Head of bed elevated
   - Reason for suctioning
   - Frequency of suctioning
   - Location of suctioning (via nose, oral cavity, tracheostomy, etc.)
   - Characteristic of substance suctioned (color, amount, odor, consistency)
   - Date suction equipment changed
4. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
5. Mood:
   - Mood pattern

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Core Components
Suctioning (2 of 2)

6. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

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Core Components
Teaching and Training

Daily Nursing Skills: High risk for complications related to knowledge deficit for self-care and management of disease process, treatment or conditions. Patient requires teaching and training in the specified area to promote medical recovery, stability and prevention of exacerbation of symptoms and or conditions. Patient requires daily skilled nursing for evaluation of outcomes of teaching and training interventions. There is a high likelihood for the need to modify the teaching and training program to attain the desired outcome. The daily skills of a nurse are required to assess the effectiveness of the teaching and training program.
Examples of Skilled Teaching Activities include:

1. Self-administration of injectable medications
2. A newly diagnosed diabetic with insulin, diet, and foot care
3. Self-administration of medical gases
4. Gait training or prosthetic care
5. Care of a recent ostomy
6. Care of braces, splints or orthotics.
7. Bowel and bladder training
8. Straight catheterizations
9. Tube feeding administration and care

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing Notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Area of teaching or training
2. Current teaching methods
3. Response to current teaching methods
4. Progress with teaching or training methods, or lack of progress
5. Modification to teaching/training interventions and outcomes
6. Caregiver training and progress
7. Discharge plan and progress towards goals.
8. Continued skilled assessment of conditions/ diagnosis that prompted initial admission.
9. Vital signs

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Core Components
Terminal Care

Daily Nursing Skills: At risk for powerlessness related to the inevitability of death. Lack of control over bodily functions, dependence on others for care. At risk for spiritual distress, identity disturbance. High risk for pain related to underlying disease or injury (see specific disease related Guideline). High risk for fluid, volume deficit related to anorexia and dehydration related to imminent death. High risk related to multi-organ failure with end of life disease processes.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Pain assessment frequently, record response to pain relief techniques non-pharmacologic and pharmacologic. Urge calling for medication before pain becomes severe.
3. Document what measures were taken to support or improve the patient's physical or emotional condition.
4. Describe any dysphagia, nausea, anorexia.
5. Document the elimination pattern, and bladder/bowel regimen.
6. Observe and record activity, positioning, its effect on pain.
7. Document the skin condition, measures for comfort and relief of pain.
8. Document the coordination of family involvement.
9. Avoid vigorous fluid replacement record frequent mouth care.
10. Include family in care planning. Ensure unrestricted family involvement and visits.
11. Plan care treatments according to pain, and family involvement.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Document communications with the physician.
15. Describe current rehabilitation services and progress.
16. Discharge plan – terminal care at SNF level vs. home care with necessary referrals.
17. Document systems assessment with changes and interventions to minimize discomfort, pain and distress.

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Nursing Documentation
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Core Components
Total Hip Replacement

Daily Nursing Skills: Patient is at high risk of complications related to surgical procedure, infection. thrombophlebitis, pulmonary embolism, compartment syndrome, unusual bleeding related to anticoagulation therapy, neurovascular complications. Patient is at risk for complications related to decreased physical mobility including pressure ulcers, constipation, and urinary tract infection. Patient is at risk for surgical wound infection and delayed healing of wound. Patient is at risk for dislocation of prosthesis secondary to knowledge deficit or cognitive deficits with total hip precautions.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Condition of surgical site:
   a. Redness, warmth, edema, tenderness, drainage.
   b. Staples/Sutures in place.
3. Amount of assistance required for transfer, ambulation, ADLs, weight bearing limitations and compliance.
4. Total hip precautions:
   a. By staff.
   b. Patient compliance.
5. Anticoagulation signs of bleeding, adjustments in dose, abnormal lab results. Signs of anemia.
6. Pain management and response to pharmacological and non-pharmacological interventions.
7. Skilled assessment for circulatory/neurological complications, monitor/document C.S.M, Homan's Sign, edema and increased pain. Daily skin assessment and preventative measures secondary to reduced mobility.
8. Patient/resident/caregiver teaching of post discharge information on total hip.
9. Attendance of therapies, progress.

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Nursing Documentation
Medicare Manual

Core Components
Total Parenteral Nutrition (TPN) (1 of 2)

Daily Nursing Skills: High risk for sepsis, mechanical injury from catheter, pneumothorax, hemothorax, arterial puncture, air emboli, catheter emboli, catheter and venous thrombosis. Metabolic disorders, hypoglycemia, fluid and electrolyte abnormalities, hyperglycemia, essential fatty deficiency. Neurological abnormalities. High risk for fluid volume excess, or deficit. High risk for nutrition deficit. High risk for infection related to invasive CVC, leukopenia, or damp dressing.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs daily assessment for complications.
2. Record observation for signs of air emboli: Extreme anxiousness, sharp chest pain, cyanosis or churning precordial murmur.
3. Document dressing changes, presence of suture at the site of the CVC, and external catheter length. Signs and symptoms of infection.
4. Record inability to draw blood, complaints of chest pain or burning, leaking fluid, swelling around the catheter, shoulder clavicle and upper extremity.
5. Document visible signs of circulation on the chest wall.
6. Record administration of TPN solution, rate and patient tolerance.
7. Document fluid intake and output accurately.
8. Observe for: hypoglycemia, weakness, agitation, tremors, cold clammy skin, serum glucose levels less than 60 mg/dl and urine tests negative for sugar and acetone.
9. Observe for signs of: hyperglycemia: thirst, acetone breath, diuresis, dehydration, serum glucose level above 200 mg/dl: urine positive for glucose and varying from negative to large amounts of acetone.
10. Assess for hyper osmolar overload: thirst, headache, lethargy, seizures, and urine positive for glucose and negative for acetone.
11. Document observation for electrolyte imbalance: Hypocalcemia (numbness and tingling), hypokalemia (lethargy and confusion), hypokalemia (muscle weakness, cramps, paresthesia, lethargy, confusion, ileus, and arrhythmias), hypomagnesemia (confusion, positive Chovestek's sign and tetany), hyponatremia (lethargy and confusion). Record serum electrolytes as ordered.
12. Record daily weights and exercise.
13. Daily pulmonary assessment.
14. Observe for edema, signs of excess fluid volume.

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Core Components
Total Parenteral Nutrition (TPN) (2 of 2)

15. Observe for thirst and signs of dehydration.
16. Labs as ordered, review with physician and pharmacist, changes to TPN formulator in assessment/tolerance of change in formula.
17. Assessment for therapeutic response to medication or discontinuance of medication.
18. Teaching and training activities.
19. Describe current rehabilitation services and progress.
20. Discharge planning.

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Core Components
Tracheostomy (1 of 2)

Daily Nursing Skills: A tracheostomy is an opening surgically created through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway, and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.

Rubbing of the trach tube and secretions can irritate the skin around the stoma. Daily care of the trach site is needed to prevent infection and skin breakdown under the tracheostomy tube and ties. Care should be done at least once a day; more often if needed. People with new trachs or who are on ventilators may need trach care more often. Tracheostomy dressings are used if there is drainage from the tracheostomy site or irritation from the tube rubbing on the skin.

Some older children and teens have trach tubes with an inner cannula. Some inner cannulas are disposable (DIC: Disposable Inner Cannula). These should be changed daily, discarding the old cannula. Check with your equipment vendor regarding disposable cannulas. For the reusable cannulas, the cannula should be cleaned 1 to 3 times a day and more often if needed. Do not leave the inner cannula out for more than 15 minutes.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
2. Respiratory Condition:
   - Type and size of trach and frequency of change
   - Ability to handle secretions
   - Sputum
   - Lung sounds upon auscultation
   - Antibiotic use
   - Frequency and response to suctioning
   - Oxygen therapy (flow, rate, method of delivery)
   - Weaning from trach
   - Time and frequency of plugging trach
   - Response to weaning
   - Teaching done and response

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Core Components
Tracheostomy (2 of 2)

3. Skin Condition:
   - Condition of skin at trach opening
   - Wound precautions maintained
4. Eating:
   - Nutritional status
   - Percent of food eaten
   - Supplements taken
5. Lab Results:
   - Lab results
6. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
7. Mood:
   - Mood pattern
8. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

Harmony Healthcare INTERNATIONAL

Nursing Documentation
Medicare Manual

Core Components
Traction (1 of 2)

Daily Nursing Skills: Traction uses weights and pulleys to put tension on a displaced bone or joint, such as a dislocated hip, to realign the bone and immobilize it. Traction is also used to keep a group of muscles stretched (such as the lower spinal muscles) to reduce muscle spasm. As a treatment, traction will involve a certain amount of tension to pull the body part into another position, a length of time to use the tension, and a way to maintain the tension. Traction is most often used as a temporary measure when operative fixation is not available for a period of time.

Traction can either be applied through the skin (skin traction) or through pins inserted into bones (skeletal traction). Skin traction is generally less desirable due to the fact that skin can be injured when pressure is applied for extend periods of time. Skin traction called Buck's traction is commonly used in patients who have a hip fracture. Skeletal traction does have the disadvantage of complications associated with pin insertion, and infections can come from the sites of pin insertion.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
2. Circulatory Condition:
   - Distal pulses
   - CMTS
3. Skin Condition:
   - Skin integrity
   - Status of open areas
   - Potential related concerns
4. Muscular Skeletal Condition:
   - Pain
   - Type of traction
   - Special equipment used (special bed, etc.)
   - Amount of weights applied

- Therapy attendance and progress
- Teaching done and response

5. Urinary Condition:
   - Presence of urine retention
6. Bed Mobility:
   - If on bed rest, tolerance of same
   - Amount of assist needed
   - Frequency of repositioning
7. Transfer:
   - Amount of assist needed
8. Locomotion:
   - If out of bed, activity level and tolerance of same
9. Eating:
   - Nutritional status
   - Percent of food eaten
   - Amount of assist needed
10. Personal Hygiene:
    - Amount of assist needed
11. Toilet Use:
    - Amount of assist needed
12. Bathing:
    - Amount of assist needed
13. Cognitive:
    - Cognitive
14. Emotional:
    - Emotional status
15. Elimination:
    - Constipation
    - Diarrhea
    - Incontinence
16. Rehab/Restorative:
    - Rehabilitation or restorative techniques and practices
    - Days per week received for more than or equal to 15 minutes
17. Mood:
    - Mood pattern

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Nursing Documentation
Medicare Manual

Core Components
Urinary Retention

Daily Nursing Skills: High risk for kidney damage and electrolyte imbalance related to inability to empty bladder. High risk for infection secondary to invasive procedures, catheters- indwelling or intermittent, and stasis of urine in the bladder promoting growth of microbes. Skilled assessments and evaluation of signs of bladder distention and evaluation of intake and output measurements. Skilled assessment of symptoms and conditions precipitating urinary retention. Evaluation of laboratory data, neurological assessment and medication effects with voiding pattern.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. The presence of fever, chills, or rigors in the absence of fever. Temp spikes.
3. Intake and output monitoring. Evaluation of relationship of I&O totals.
4. Presence of indwelling catheter or intermittent catheter placement to facilitate emptying of bladder.
5. Removal of catheter and voiding trials with outcome.
6. Effects of medications: Urecholine to initiate voiding by stimulation of the detrusor muscle of the bladder, Prophylactic antibiotic therapy.
7. Voiding patterns: Inability to void (retention), voiding in small frequent amounts (retention with overflow).
8. Pain with voiding for possible UTI or obstructive uropathy.
9. Document sense or need to void or bladder fullness immediately after voiding (retention with overflow).
10. Palpation of bladder for fullness or tenderness.
11. Positional changes to promote voiding and response.
12. Post void residuals and intermittent catheterization results.
13. Document communication with physician, consults- urology, and outcome or change in treatment plans.
14. Teaching and training: Bladder retraining, intermittent catheterizations, prevention of urinary tract infections, adequate fluid intake. Signs of infection and need for prompt medical attention. Caregiver education.
15. Discharge planning and teaching of medications, follow-up care. Home care referrals needed.

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Nursing Documentation
Medicare Manual

Core Components
Urinary Tract Infection

Daily Nursing Skills: High risk for sepsis related exacerbation of symptoms. High risk for recurrent UTI, observation for S&S of recurrence, monitoring of labs, effectiveness of medication, effects of inactivity, decreased nutrition on mobility and endurance.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Temperature.
3. I&O.
4. Signs and symptoms of reaction to medication.
5. Mental status changes.
6. Presence of burning, frequency, urgency.
7. Presence of chills, nausea, vomiting.
8. Presence of visible signs of pyuria or hematuria.
9. Presence of pain, bladder region or back.
10. Signs of urinary retention.
11. Assess for incontinence. Assess need for bladder retraining.
12. Malaise or headache.
13. Collection of urine samples for lab study.
14. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.
16. Signs of reoccurrence post treatment.
17. Teaching and training activities – hygiene and fluid intake.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

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Nursing Documentation
Medicare Manual

Core Components
Ventilator (1 of 2)

Daily Nursing Skills: A medical ventilator is a device designed to provide mechanical ventilation to a patient. In its simplest form, a ventilator consists of a compressible air reservoir, air and oxygen supplies, a set of valves and tubes, and a disposable or reusable "patient circuit". The air reservoir is pneumatically compressed several times a minute to deliver room-air, or in most cases, an air/oxygen mixture to the patient. When overpressure is released, the patient will exhale passively due to the lungs' elasticity, the exhaled air being released usually through a one-way valve within the patient circuit. The oxygen content of the inspired gas can be set from 21 percent (ambient air) to 100 percent (pure oxygen). Pressure and flow characteristics can be set mechanically or electronically.
Observe, assess and document signs and symptoms of hypotension, decreased cardiac output, pneumothorax, subcutaneous emphysema, interstitial pulmonary emphysema, and air embolus, localized pulmonary hyperinflation, nosocomial infections (pneumonia), and increased intracranial pressure (cerebral edema). In addition to these conditions assess and evaluate for skin breakdown and gastric distension. However, these do not occur often and, when they do, are generally not severe.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
2. Hydration Condition:
   - Hydration
3. Circulatory Condition:
   - Head of bed elevated
   - Edema
   - Antibiotic therapy
4. Respiratory Condition:
   - Breath sounds
   - Sputum characteristics
   - Ventilator setting
   - Oxygen therapy (frequency, reason, rate, effectiveness, method of delivery)

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Core Components
Ventilator (2 of 2)

5. Skin Condition:
    - Skin status

6. Bed Mobility:
    - Amount of assist needed
    - Frequency of repositioning (if on bed rest)
7. Transfer:
    - Amount of assist needed
    - Bed rest maintained (if pertinent)
    - Endurance
8. Eating:
    - Amount of assist needed
    - Nutritional status
    - Percent eaten
    - Current diet
9. Toileting:
    - Amount of assist needed
10. Elimination:
    - Continence
11. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
12. Mood:
    - Mood pattern
13. Muscular Skeletal Condition:
    - Attendance at therapy and progress
    - ROM given

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Nursing Documentation
Medicare Manual

Core Components
Wound/Dressing Changes

Daily Nursing Skills: High risk for infection or delayed healing related to impaired skin integrity. High risk for pain related to trauma procedure.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs, presence of fever or chills, rigors without elevated temperature.
2. Site, presence of sutures, staples – integrity.
3. Odor present/absent
4. Drainage (color, amount), warmth, edema.
5. Patient's complaints of pain, action taken, patient's response.
6. Communication with physician and change in treatment plan.
7. Change in status/progress.

Weekly

1. Wound site.
2. Type of wound (e.g., stasis ulcers, incision, pressure ulcer)
3. Size, including length, width, depth.
4. Description of surrounding tissue.
5. Frequency and type of treatment.
6. Progress of wound since previous assessment.
7. Use of special equipment.
8. Other factors:
    a. Nutritional status
    b. Positioning changes (frequency)
    c. Pain management

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Nursing Documentation
Medicare Manual

Medicare Part B Notes

When a long-term care resident has a change of condition (improvement or decline), nursing drives the therapy intervention process. It is imperative that the resident's functional status is documented in a shift note identifying the **change** which facilitated the referral to therapies for a screen and potential initiation of a skilled program.

Harmony recommends that nursing observe the patient when a decline or improvement is identified and document on the specific behaviors which are outside of the norm for the particular patient. Harmony supports documentation by nursing or other department of **three episodes** of functional performance or other area of concern prior to the initiation of therapy. The exception to this suggestion would be the patient who is experiencing difficulty swallowing, choking or aspirating, which should be addressed immediately to ensure that the status change is not self-limiting. The initial date of the change (i.e., first of three notes) is the **onset** date which should be used on the therapy evaluation Forms 700 and 701 (when those forms are being utilized).

Long term residents should be screened on a routine basis (annually at a minimum) by Rehab however; there are other times when patients will be identified by caretaker staff which contributes to improving the quality of care to residents.

- Patients who have experienced falls are ideal candidates for screening by Rehab staff to determine if there are additional interventions to address this high risk problem. Any resident who experiences two falls in a month should be evaluated to determine if there is a specific physical cause for the falls and to assist with interventions and prevention of further falls.

- Any decline in physical functioning of a resident should trigger a rehabilitation evaluation. Though residents are screened on an annual basis and ideally on a quarterly basis, declines in physical functioning can occur in the interim and should be addressed as soon as possible.

- Any significant weight loss may trigger a screen for Occupational Therapy and or Speech Therapy to determine if there are any interventions that may assist the resident with feeding or eating.

- When pressure areas occur, rehabilitation staff should be consulted to determine if there is an alternative way to reduce pressure with positioning devices or specific positioning programs.

- Monitoring and evaluating wheelchair positioning should also be managed by rehabilitation staff to improve positioning and quality of care for residents.

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Nursing Documentation
Medicare Manual

Part B Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature
Note 1	Resident required max @ to feed self today. CNA noted resident had difficulty manipulating fork, spoon and knife. Resident to be monitored in feeding. Signature RN
Note 2	Resident lost 3 pounds and still requires max @ to feed self. Occupational therapy notified. Screen to be performed. Signature RN
Note 3	OT screen indicates further evaluation. OT evaluation ordered. Signature RN
Note 4	OT program 5X/week for 4 weeks. Resident participating in skilled restorative feeding program – breakfast and lunch. Signature RN
Note 5	Resident making significant gains in OT feeding. Requires min @ to feed self and is consuming 100% of meals. Weight gain of one pound this week. Signature RN

Patient Name Harry Harmony **Room #** 313

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MDS Schedule Worksheet

The MDS is the cornerstone of PPS reimbursement methodology and is used to classify residents into resource utilization groups (RUG's) that in turn sets the rate of reimbursement. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses.

A formalized scheduling policy will aid the MDS Coordinator and facility staff in completing timely and accurate MDS assessments.

MDS Schedule Worksheet

Room No.	Beneficiary	Admit Date	5 day	14 day	30 day	60 day	90 day	OMRA

MDS Assessment Completion Schedule

In order to receive Medicare payment under PPS, as of July 1, 1998, facilities must complete the resident assessment date in the required manner and within the prescribed time frame. (Section 1888(e) (6) of the law). Medicare assessments are required from admission through the 100th day of a resident's Medicare stay. In accordance with the Final Rule, Medicare requires scheduled assessments on days 5, 14, 30, 60 and 90. Each assessment pre-determines a specific number of billable days. Not all residents will complete the regular assessment schedule. The Medicare schedule is also affected by clinical changes in the patients care, including changes in the intensity of therapy rendered. The Medicare schedule is altered if one of the following occurs:

- Discharge and/or readmission to the SNF
- Death of a resident
- Late or Missed assessment
- Change in Medical Condition
- Change in intensity of therapy rendered to the patient
- Discontinuation of rehabilitation therapy

During a resident's Medicare Part A stay (newly admitted and/or readmitted residents), facilities are required to submit a full MDS on the following time frame.

MDS Assessment Schedule

MDS Assessment/Type	Assessment Reference Date	Grace Days	MDS Location/Reason for Assessment	Number of Days Coverage	Payment Days
5 day Comprehensive*	1 – 5	Days 6-8	A0310B 01 Medicare 5 day	14	1 - 14
14 day Comprehensive*	13 – 14	Days 15-18	A0310B 02 Medicare 14 day	16	15 - 30
30 day Full	27 – 29	Days 30-33	A0310B 03 Medicare 30 day	30	31 – 60
60 Day Full	57 – 59	Days 60-63	A0310B 04 Medicare 60 day	30	61 – 90
90 Day Full**	87 – 89	Days 90-93	A0310B 05 Medicare 90 day	10	91 - 100

* Comprehensive Assessment = MDS + CAAs. May be completed either on 5 or 14 day assessment
** May also be used as 1st Quarterly Assessment.

MDS Assessment Completion Schedule

- If resident expires or transfers to another facility before day 8, as much of the MDS as possible must be completed to receive RUG classification and for Medicare payment purposes.
- Each MDS assessment will classify the Medicare patient into a RUG-IV group during the patient's Medicare stay, based on patient's needs.
- Each patient's MDS assessment is transmitted to the QIES-ASAP system in accordance with CMS's timetable. After the MDS assessment is locked and ready for transmission, the claims for Medicare payment are sent to the fiscal intermediary on a 30-day cycle. Payment is made according to the RUG-IV group recorded on the claim sent to the fiscal intermediary. In addition to the periods noted above, if there is a significant change in a patient's needs, a facility is required to complete an additional MDS assessment (if that assessment does not coincide with a regularly scheduled assessment) and care plan modifications. Any of the assessments performed may result in a RUG-IV classification change.
- Patients are assessed using full or comprehensive assessments, depending on the stated schedule. The State's RAI constitutes a "comprehensive" assessment, which is required at various periods according to Federal OBRA regulations. A "full" assessment refers to completion of the entire MDS and "comprehensive" refers to completion of the Care Area Assessments (CAAs) and Utilization Guidelines in addition to the entire MDS.

Assessment Completion Dates

The following rules govern when an MDS must be completed for purposes of payment and establishes the process and allotted time that a SNF must follow to "lock" an assessment prior to entering the HIPPS rate code that matches the locked assessment on the CMS 1450 UB04 claim form.

Completion Rule 1: The Medicare required 5 day assessment must be completed within 14 calendar days of the assessment reference date (Item A2300) (i.e., no later than the 22nd day of the covered stay). The completion date is the date recorded in item Z0500 on the current version of the MDS. Please note that when combining the Medicare required 5-day assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

Completion Rule 2: The Medicare required 14 day assessment must be completed within 14 calendar days of the assessment reference date (Item A2300) (i.e., no later than the 32nd day of the covered stay). Please note that when combining the Medicare required 14-day assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

Note: If the 5 day or 14 day Medicare required assessment is also used as the initial admission assessment to meet the clinical MDS requirements, then the assessment must include completion of the CAAs and care plan review and must be completed within 14 calendar days of admission. The day of the admission is day 1. When combining the a Medicare required assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

Completion Rule 3: The Medicare required 30 day assessment must be completed within 14 calendar days of the assessment reference date (Item A2300) (i.e., no later than the 47th day of the covered stay). Please note that when combining the Medicare required 30-day assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

Completion Rule 4: The Medicare required 60 day assessment must be completed within 14 calendar days of the assessment reference date (Item A2300) (i.e., no later than day 77 of the covered stay). Please note that when combining the Medicare required 60-day assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

Completion Rule 5: The Medicare required 90 day assessment must be completed within 14 calendar days of the assessment reference date (Item A2300) (i.e., no later than 107 days after the beneficiary began their covered stay). Please note that when combining the Medicare required 90-day assessment with another OBRA assessment the completion guidelines will be governed by the more stringent of the two assessments completion guidelines.

MDS Assessment Completion Schedule

Assessment Completion Dates (continued)

Completion Rule 6: A Significant Change in Status Assessment (SCSA) must be completed within 14 calendar days of the date that the Interdisciplinary Team determines that there has been a significant change in the resident's condition. This is in accordance with the guidelines for an SCSA that appear in the current version of the Long Term Care Resident Assessment Instrument Users Manual. A significant change in status assessment cannot be completed unless the SNF has first performed the comprehensive initial admission assessment that is required by day 14 of the resident's stay.

Therefore, if the SNF performs a full assessment instead of a comprehensive assessment for the Medicare required 5-day assessment, it cannot perform a significant change in status assessment until the comprehensive initial admission assessment has been completed.

Completion Rule 7: An unscheduled Other Medicare Required Assessment (OMRA), such as the Start of Therapy (SOT) OMRA, the End of Therapy (EOT) OMRA, the End of Therapy Resumption (EOT-R) OMRA, or the Change of Therapy (COT) OMRA must be completed within 14 calendar days of the Assessment Reference Date (ARD).

MDS Assessment Completion Schedule

Assessment Completion Dates (continued)

Within 7 days of completing the assessment in accordance with the completion dates specified above, the SNF must complete the following:

- Encode the MDS and CAA Summary, where applicable, in a machine readable format;
- Run the encoded MDS through edits specified by CMS. The SNF must correct any information on the encoded MDS that does not pass CMS specified edits;
- Lock the edited MDS record;
- Certify that the MDS meets CMS specified edits; and,
- Print the edited MDS and CAA Summary form and place them in the resident's record. The hardcopy of the assessment must match the assessment that the SNF transmits to the State. A SNF must, therefore, correct the hard copy to reflect changes associated with the edit correction process and be able to transmit the edited MDS and CAA Summary form to the State within which the SNF is located within 14 days of the "lock" date.

Scheduled Assessment Completion Schedule
MDS Tracking Guidelines

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days (ARD Can Also be Set on These Days)	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
5-day A0310B = 01 And Readmission/return A0310B = 6	Days 1-5	Days 6-8	Days 1-8	Sets payment rate for Days 1-14	Special instructions for patients who transfer or expire day 8 or earlier. CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission, Annual, SCSA, or SCPA
14-day A0310B = 02	Days 13-14	Days 15-18	Days 13-18	Sets payment rate for days 15-30	CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission, Annual, SCSA, or SCPA. Grace days do not apply when the 14-day scheduled assessments dually coded as an OBRA Admission
30-day A0310B = 03	Days 27-29	Days 30-33	Days 27-33	Sets payment rate for days 31-60	
60-day A0310B =04	Days 57-59	Days 60-63	Days 57-63	Sets payment rate for days 61-90	
90-day A0310B = 05	Days 87-89	Days 90-93	Days 87-93	Sets payment rate for days 91-100	If combined with the OBRA Quarterly assessment the completion date requirements for the OBRA Quarterly assessment must also be met.

Assessment Schedule Alterations

Resident Expires or Transfers

If resident expires or transfers to another facility before day 8, the facility needs to prepare an MDS as completely as possible. This will generate your RUG classification and Medicare payment. The provider may not usually bill for days when an assessment does not exist in the QIES ASAP system, with the exception of a few specific instances.

Physician Hold Occurs or There are 30 Days from A Level of Care Change

Requires start of Medicare assessment schedule from the first day of the Part A Medicare covered stay.

Significant Change in Status (SCSA)

Required when there is a major change in the resident's condition/status, which is not self-limiting and is:

- A decline or improvement in resident's health status
- A change, which will not normally resolve itself without some type of staff intervention
- Affecting more than one area on the resident's health status
- Requiring of interdisciplinary review and/or revision to the care plan

Assessments should be completed as quickly as possible to maintain accurate and resident-specific care planning.

Medicare does allow grace days for assessment completion. If Medicare assessment is completed within the mandated grace period, no facility penalty is assessed under Medicare. Grace days are intended to be used in order to better reflect the clinical status of the patient. Medicare will not initiate reviews of claims based solely on the use of grace days.

Grace Days

Assessment	Grace Days Allowed
5 day	3 days
14*, 30 and 60 day	4 days
90 day	4 days – If Medicare 90 day assessment is used to satisfy the quarterly assessment requirement, the ARD of the quarterly assessment must be no more than 92 days from the ARD of the previous comprehensive or full assessment.

Return to the regular Medicare schedule once the last assessment is completed.
* No grace days allowed if this is a comprehensive assessment.

Unscheduled Medicare PPS Assessments

There are situations when a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments. These assessments are known as unscheduled Other Medicare Required (OMRA) assessments. The facility must perform these assessments under the following circumstances:

1. Significant Change in Status Assessment (for swing bed providers this unscheduled assessment is called the Swing Bed Clinical Change Assessment): This assessment is required to be completed when the SNF interdisciplinary team has determined that the resident meets the significant change guidelines for either improvement or decline.
2. Significant Correction to Prior Comprehensive Assessment: This assessment is required to be completed because the provider discovered that a significant error was made in the prior comprehensive assessment. An error is considered to be significant when it misrepresents the clinical status of the patient. This type of assessment will only be required for OMRA comprehensive assessments, but may have implications on the PPS payment schedule.
3. Start of Therapy Other Medicare Required Assessment (SOT-OMRA): This assessment is required to be completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. The SOT OMRA is an optional assessment, and providers should consider the overall impact to payment when considering completing this assessment.
4. End of Therapy Other Medicare Required Assessment (EOT- OMRA): This assessment is required to be completed in two circumstances: (a) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group, all therapies have ended and the beneficiary continues to receive skilled services. (b) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and did not receive any therapy services for three or more consecutive calendar days. The EOT would be completed to classify the beneficiary into a non-therapy RUG group beginning on the day after the last day of therapy provided.
5. Change of Therapy Other Medicare Required Assessment (COT-OMRA): This assessment is required to be completed when the intensity of therapy, which includes the total reimbursable therapy minutes (RTM), and other therapy qualifiers such as number of therapy days and disciplines providing therapy, changes to such a degree that the beneficiary would classify into a different RUG-IV category than the RUG-IV category for which the resident is currently being billed for the 7-day COT observation period following the ARD of the most recent assessment used for Medicare payment. The requirement to complete a change of therapy is reevaluated with additional 7-day COT observation periods ending on the 14th, 21st, and 28th days after the most recent Medicare payment assessment ARD and a COT OMRA is to be completed if the RUG-IV category changes. If a new assessment used for Medicare payment has occurred, the COT observation period will

restart beginning on the day following the ARD of the most recent assessment used for Medicare payment.

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window. The two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has been completed and an unscheduled assessment falls in the at assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. If the provider performs the Medicare-required scheduled assessment prior to or on the same day as the ARD for the unscheduled assessment, the unscheduled assessment may no longer be required.

Unscheduled Assessment Completion Schedule
MDS Tracking GUidelines

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Start of Therapy OMRA A0310B = 01-07 and A0310C = 1 or 3	5-7 days after the start of therapy. The day of the first therapy evaluation counts as day 1	N/A	N/A	Modifies the payment rate starting on the date of the first therapy evaluation	Optional assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG.
End of Therapy OMRA A0310B = 01-07 and A0310C = 2 or 3	1-3 days after all therapy (PT, OT, SLP) services are discontinued. The first non-therapy day counts as day 1	N/A	N/A	Modifies payment rate starting on the day after the latest therapy end date	Not required if the resident has been determined to no longer meet Medicare skilled level of care. Establishes a new non-therapy RUG. Only required for patients who are classified into Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment. For circumstances when an End of Therapy with Resumption option would be used.

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Change of Therapy OMRA A0310B = 01-07 and A0310C = 4	Day 7 of the COT observation period	N/A	N/A	Modifies payment rate starting on day 1 of that COT observation period and continues for the reminder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other scheduled or unscheduled PPS assessment	Required only if the intensity of therapy during the 7-day look back period would change the RUG category classification of the most recent PPS Assessment. Establishes a new RUG classification.
Significant Change in Status Assessment (SCSA) A0310A = 04	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Swing Bed Clinical Change Assessment (CCA) A0310B = 01-07 and A0310D = 1	Completed by the end of the 14th calendar day after determination that a clinical change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.

Significant Correction to Prior Comprehensive Assessment (SCPA) A0310A = 05	Completed by the end of the 14th calendar day after ID of a significant, uncorrected error in prior comprehensive assessment.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.

*Note: When SCSA, SCPA, and CCA are combined with another assessment, payment rate may not be effective on the ARD. For example, a provider combines the 30-day Medicare-required assessment with a Significant Change in Status assessment with an ARD of day 33, a grace day, payment rate would become effective on day 31, not day 33.

Tracking Records and Discharge Assessment Reporting Schedule

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility, and an assessment of the patient's clinical status when the patient is discharged for any reason other than death. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry ad discharge reporting is required for Swing Bed residents and respite residents.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit Discharge assessments and Entry records every tie until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

Tracking records and discharge assessments reporting are required on all residents in the SNF and swing bed facilities. Tracking records and stand-alone discharge assessments do not impact payment.

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Entry tracking record A0310F = 01	N/A	N/A	N/A	N/A	May not be combined with another assessment
Discharge Assessment A0310F = 10 or 11	Must be set for the day of discharge	N/A	N/A	N/A	May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment
Death in facility tracking record A0310F = 12	N/A	N/A	N/A	N/A	May not be combined with another assessment

[INSERT ENTRY, DISCHARGE, AND REENTRY ALGORITHM, RAI MANUAL PAGE 2-37]

Assessment Indicator (AI) Codes

The last two positions of the HIPPS code represent the Assessment Indicator (AI), which is used to identify the assessment type. The AI code is used to differentiate between the various types of PPS assessments that can be performed during a Medicare PPS stay, and to determine what payment period the associated RUG-IV classification will be used to control payment. The AI code is determined through coding in Section A0310 (Reason For Assessment). The AI code is automatically calculated by the software, and is validated by CMS when the assessment is submitted to the QIES ASAP system. If the submitted AI code is incorrect, the facility will receive a warning on the final validation report (FVR) and the correct code will be provided.

The AI code consists of two digits, a first and second position. In situations where the facility is to bill default rate, such as an early or late assessment, the default AI code of AAA is to be used on the Medicare claim.

The first digit in the AI code identifies scheduled PPS assessments that establish the RUG payment rate for the standard PPS scheduled payment periods. These assessment types include the PPS 5-day, 14-day, 30-day, 60-day, 90-day, and readmission/return. The Omnibus Budget Reconciliation Act (OBRA 1987) required assessments are also included, because they can be used under certain circumstances for payment.

[INSERT TABLE OF FIRST DIGIT AI CODES, RAI 6-8]

The second digit in the AI code identifies the unscheduled assessments used for PPS. Unscheduled PPS assessments are conducted in addition to the required standard scheduled PPS assessments and include the following OBRA unscheduled assessments: Significant Change in Status Assessment (SCSA) and Significant Correction to Comprehensive Assessment (SCPA), as well as the following PPS unscheduled assessments: Start of Therapy OMRA, End of Therapy OMRA, Change of Therapy OMRA. The second digit in the AI code can also be used to indicate a Swing Bed Clinical Change Assessment (CCA). An unscheduled assessment is tied to no particular day in the PPS calendar, and may be required at any time during the patient's Part A stay. Unscheduled assessments may be performed as separate assessments or may be combined with other Medicare-required or OBRA-required assessments.

[INSERT TABLE OF SECOND DIGIT AI CODES, RAI 6-14, 15, 16, 17]

Each MDS 3.0 assessment will calculate at least two Medicare HIPPS codes, which are recorded in Sections Z0100A (Medicare Part A HIPPS code) and Z0150A (Medicare Part A non-therapy HIPPS code). The Medicare Part A HIPS code may consist of any RUG-IV group code. The Medicare Part A non-therapy HIPPS code is restricted to the RUG-IV groups of Extensive

Services and below. The HIPPS code that will be used on the claim depends on the specific type of assessment involved.

The RUG codes in Sections Z0100A and Z0150A are validated by CMS when the assessment is submitted to the QIES ASAP system. Providers must confirm acceptance of the MDS assessment on the Final Validation Report (FVR) prior to billing Medicare Part A for the payment days associated with that assessment. The facility must use the correct HIPPS code on the bill.

The facility is responsible to ensure that all Medicare assessment requirements are met. When the provider fails to meet the Medicare assessment requirements, such as when the assessment is late (as evidenced by the ARD is not set within the prescribed ARD window for the assessment type), the provider may be required to bill the default code for some or all days associated with payment for that assessment. In these situations, the provider is responsible to ensure that the default code and not the RUG group validated by CMS in Sections Z0100A and Z0150A is billed for the applicable number of days.

Early, Missed, and Late Assessments (Non-Compliance with The SNF PPS Assessment Schedule)

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as required by federal law. According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. A SNF must submit a claim using the HIPPS default rate code (i.e., AAA00) when the SNF fails to assess a resident within the assessment window. The default rate takes the place of the otherwise applicable federal rate, and is equal to the rate paid for the RUG-IV classification reflecting the lowest acuity level. Therefore, default rate is often lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

The prescribed assessment window is defined as the allotted days during the covered stay in which the SNF may set the assessment reference date for each Medicare required assessment.

The following section indicates how payment will be made when the assessment reference date on the MDS is out of compliance of the prescribed assessment window for a Medicare required assessment and, therefore, is not timely.

- No retroactive adjustments are made to bills that indicate the default code.

The HIPPS rate calculated from the early or late assessment is used for remaining days in the assessment payment block, if applicable. In the case of a missed assessment, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP system. The provider may not usually bill for days when an assessment does not exist in the QIES ASAP system, with the exception of a few specific instances.

Early Assessment

An assessment must be completed according to the designated Medicare PPS assessment schedule. If a scheduled Medicare-required assessment or an unscheduled Other Medicare Required Assessment (OMRA) is performed earlier than the schedule indicates the provider will be paid at default rate the number of days that the assessment was out of compliance. An assessment is considered to be performed earlier than the schedule indicates if the Assessment Reference Date (ARD) is earlier than the prescribed assessment window for that assessment type. This may be a prescribed set of days of the Medicare PPS schedule, such as for scheduled PPS assessments, or may occur at non-prescribed days during the Medicare PPS schedule, such as for unscheduled PPS assessments.

In the case of an early Change of Therapy (COT) assessment, the early COT ARD would re-set the COT calendar count. The next COT OMRA, if deemed necessary, would have an ARD set for seven days from the early COT ARD.

Early Assessment Example 1: A Medicare-required 14-day assessment with an ARD of Day 12 (one day early) would be paid at the default rate for the first day of the payment block that begins on Day 15.

Early Assessment Example 2: A facility completes a 30-day assessment with an ARD of November 1st, which classifies the resident into a rehabilitation RUG. A COT OMRA is completed for this resident with an ARD set for November 6th, which is Day 5 of the COT observation period. This is an early assessment because the ARD of the COT must always be on Day 7 of the COT observation period, which would have been November 8th. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days the assessment was out of compliance. The next COT observation period would be based from the early COT ARD, and would begin on November 7th and end on November 13th.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

If the ARD of the late assessment is set for prior to the end of the period during which the late assessment would have controlled payment, had the ARD been set timely, and/or no intervening assessments have occurred, the SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window (including grace days when grace days are available for that assessment) and the late ARD (including the late ARD). The SNF would bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.

Late Assessment Example 1: A Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for eight days, and therefore would be paid at the default rate for eight days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. If there are no intervening assessments the late assessment will control the remaining 22 days of payment in the 30-day assessment payment block. An intervening assessment is defined as an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment.

Late Assessment Example 2: A Change of Therapy (COT) OMRA is required on day seven of the COT observation period, which is Day 37 of the Medicare stay. The facility completes the COT OMRA with a late ARD of Day 39. The COT OMRA will be considered two days late and the facility will bill the default rate for two days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment. In this example, the HIPPS code from the late COT OMRA will control payment for at least five days. The next COT observation period will be determined by the ARD of the late assessment, and therefore will begin on Day 40 and end on Day 46.

If the ARD of the late assessment is set after the end of the period during which the late assessment would have controlled payment, had the assessment been completed timely, or in cases where an intervening assessment has occurred and the resident is still on Medicare Part A, the provider must still complete the late assessment. The ARD can be no earlier than the day the error was identified. The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment.

Late Assessment Example 3: A Medicare-required 14-day assessment with an ARD of Day 32 is a late assessment. The default rate will be billed from days 15-30, or all days in which the 14-day assessment would have controlled payment had it been timely. The late 14-day assessment cannot be used to replace the 30-day assessment that is also due at the time of the late assessment. A separate Medicare-required 30-day assessment must also be completed with an ARD within Days 27-33 to be in compliance with the Medicare PPS assessment schedule. The Medicare-required 30-day assessment will control payment Days 31-60, so long as the beneficiary has SNF days remaining, remains eligible for Medicare Part A services, and no intervening assessment has occurred. In this example, the Medicare-required 14-day assessment would be considered "not used for payment" and would control payment for zero days of the Medicare PPS stay. The Medicare-required 14-day assessment would still be required to be completed, despite not controlling payment for any days, to regain compliance with the PPS assessment schedule. The late Medicare-required 14-day assessment would have no impact on the COT observation period calendar, as only an assessment that is used for payment can affect the COT calendar.

Late Assessment Example 4: A Medicare-required 30-day assessment is completed with an ARD of Day 30. Day seven of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the residents last day of therapy was Day 39. On Day 52 the facility determines that a COT should have been completed with an ARD of day 37, but was not. The ARD for the COT is set for Day 52, which is the date that the error was discovered. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. The EOT is considered to be an intervening assessment, and the EOT ARD is prior to the late COT assessment ARD. The facility will bill default for nine days (Days 31-39), which are the days that the late COT controls payment. The facility will begin to bill the HIPPS code from the timely EOT assessment on Day 40, which is the first non-therapy

day and is the first day that the EOT would normally affect payment. The HIPPS code from the EOT will control payment until the next scheduled or unscheduled Medicare-required assessment, or until the patient no longer meets skilled care criteria.

Missed Assessment

An assessment is considered to be missed when the SNF does not set the ARD within the prescribed window and the patient is no longer on Medicare Part A services. If the patient has already been discharged from Medicare Part A services prior to the discovery of the omission of the assessment the facility may not perform the assessment.

In the case of a missed assessment, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP system. The provider may not usually bill for days when an assessment does not exist in the QIES ASAP system, with the exception of a few specific instances of exception.

These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

In situations 2-6, the provider may use the OBRA Admission assessment to bill for all days o covered care associated with the Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. The ARD of the OBRA Admission assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day assessment.

When an OBRA Admission assessment does not exist, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for Days 1-14 or Days 15-30. This assessment may only cover one payment period. If the ARD of the valid OBRA assessment falls outside the ARD window of the 5-day and the 14-day PPS assessments (including grace days), the SNF must bill default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

The following rules will apply to all situations other than exceptions 1-5 (as noted above) when the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the patient is already discharged from Medicare Part A services when the omission was discovered.

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

An unscheduled OMRA assessment that is considered to be missed (the ARD was not set within the defined ARD window for that assessment and the resident has been discharged from Medicare Part A services) cannot be completed. All payment days associated with this assessment will be considered provider-liable. The provider-liable period will continue until another intervening assessment begins to control payment.

ARD Outside The Medicare Part A Benefit

A SNF may not use a date outside the SNF Medicare Part A benefit period as the ARD for a scheduled PPS assessment. The SNF must use a day that is within the 100-day benefit period as the ARD for any scheduled PPS assessment.

A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA). The resident must return to the facility from the LOA on Medicare Part A.

Short Stay Assessment

If the beneficiary dies, is discharged from the SNF, or discharged from Part A level of care on or before the eighth day of covered SNF stay, the resident may be a candidate for the short stay policy. The short stay policy allows the assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident received rehabilitation therapy and was not able to have received five days of therapy due to discharge from Medicare Part A.

To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, the assessment must be a Start of Therapy OMRA, the resident must have been discharged from Part A on or before day 8 of the Part A stay, and the resident must have completed only 1 to 4 days of therapy, with therapy having started during the last 4 days of the Part A stay. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but not combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.
2. **A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare**

Part A covered stay (including weekends). The end of Medicare stay date (A2400C) minus the earliest start date for the three therapy disciplines (O0400A5, O0400B5, or O0400C5) must be 3 days or less.

7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). Therapy is considered to be ongoing when:
   - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
   - The resident's SNF benefit exhausted and therapy continued to be provided, or
   - The resident's payer source changed and therapy continued to be provided.
8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

See below for Medicare Short Stay Assessment Algorithm.

If all eight of these conditions are met, then MDS Item Z0100C (Medicare Short Stay Assessment indicator) is coded "Yes." the assignment of the RUG-IV rehabilitation therapy classification is calculated based on average daily minutes actually provided (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used), and the resulting RUG-IV group is recorded in MDS Item Z0100A (Medicare Part A HIPPS Code).

1. 15-29 average daily therapy minutes ► Rehabilitation Low category (RLx)
2. 30-64 average daily therapy minutes ► Rehabilitation Medium category (RMx)
3. 65-99 average daily therapy minutes ► Rehabilitation High category (RHx)
4. 100-143 average daily therapy minutes ► Rehabilitation Very High category (RVx)
5. 144 or greater average daily therapy minutes ► Rehabilitation Ultra High category (RUx)

[INSERT MEDICARE SHORT STAY ALGORITM, RAI MANUAL PAGE 6-20]

Physician Orders

Physician order changes and visits are indicators of a beneficiary's clinical instability.

The following **are not** order changes:

- Continuation or renewal of existing orders
- Clarifications of existing orders
- A physician's order to continue or renew some specified treatment or regimen is not considered to be an order change, nor would an order written solely to clarify an earlier order
- Sliding scale administrations
- Sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on sliding scale guidelines.

Physician Visits

A physician visit is defined as a partial or full exam at the facility or in physician's office by the following professionals:

- MD, osteopath, podiatrist or dentist
- Primary physician or consultant
- Authorized physician's assistant
- Nurse practitioner working in collaboration with the physician

Physician Visit:

- Full or partial exam at the SNF or physician's office

Therapy Minutes

A therapy minute reflects actual treatment received by the beneficiary, beginning with the first treatment activity or task and ending with the last procedure/apparatus completion.

The minutes of therapy received during the previous seven calendar days, or since admission, whichever is appropriate, are counted and reported on the MDS. The minutes of therapy, like any therapeutic intervention, must be supported by the medical record. For therapy services, key documentation will be in the MDS, therapy progress notes and therapy daily attendance log.

- RUG-IV rehabilitation group minute thresholds are the **minimum** number of minutes required for classification into the group.
- No limits are to be placed on services provided to a beneficiary due to the facility's interpretations of minutes "allowed" by a particular RUG-IV group.
- Therapeutic services performed by students are not counted unless provided under the direct, personal supervision of the licensed, professional therapist.
- Number of days and minutes of actual treatment received by the beneficiary (including set-up) during the 7 day "look-back" period are counted and recorded in Section O of the MDS. No therapy minutes delivered prior to the SNF admission may be counted.
- Treatment days and minutes need not be provided on all of the previous, consecutive days.

Example:

Beneficiary received physical therapy 50 minutes on 2nd and the 4th days of the stay. This will be recorded on the MDS Section O as 2 days and 100 minutes of PT.

- Minutes reported on the MDS are "actual time" and are not rounded to nearest 10 or 15-minute interval.
- PT, OT, ST provided outside the SNF may be counted and recorded on the MDS if provided by qualified staff. For example, transportation time to and from the beneficiary's home before discharge is acceptable if the therapist accompanies the beneficiary and if the time in transport is utilized for education or discussion of the beneficiary's treatment and or goals and for beneficiary/family conferences. (Per State Operations Manual, CMS-Pub. 7, Transmittal #272 p. R64).

Therapy minutes:

- Therapy received during the previous seven calendar days or since admission
- Therapy does not have to be on consecutive days
- RUGs represent minimum requirements
- Must be documented on daily attendance log
- A minute reflects actual treatment time

Reporting Rehabilitative Therapy Minutes on the Minimum Data Set (MDS)

In Section O of the MDS, the clinician records the number of days and minutes of rehabilitative therapy (physical therapy, occupational therapy, speech pathology) received by the individual beneficiary during the past 7 days, and in the case of the Medicare 5 day assessment, since admission to the SNF. The rehabilitative therapy time reported on the MDS is a record of the time the patient spent receiving therapy services, not a record of the therapist's time.

As stated in the Long Term Care Resident Assessment Instrument Questions and Answers, Version 2.0 (dated August 1996), the patient's "therapy time starts when he/she begins the first treatment activity or task and ends when he/she finished with the last apparatus and the treatment is ended." Set up time is included, as is time under the therapists' or therapy assistant's direct supervision.

Whether the time spent evaluating the patient is counted depends on whether it is an initial evaluation or an evaluation performed after the course of therapy has begun. The time it takes to perform an initial evaluation and develop the treatment goals and the plan of care for the patient cannot be counted as minutes of therapy received by the patient. However, reevaluations that are performed once a therapy regime has begun (e.g., evaluating goal achievement as part of the therapy session) may be counted as minutes of therapy received.

The Long Term Care Resident Assessment Instrument Questions and Answers, Version 2.0 also clarifies how to account for therapy provided to an individual with a group setting. It states that if the group has four or fewer participants per supervising therapist (or therapy assistant) then it is appropriate to report the full time as therapy for each patient.

The minutes of therapy provided by at least one supervising therapist (or therapy assistant) within a group of 4 or fewer participants, may be fully counted, provided that those minutes account for no more than 25 percent of the patients' weekly therapy as reported in Section O of the MDS. The supervising therapist may not be supervising any individuals other than the 4 or fewer individuals who are in the group at the time of the therapy session. Group therapy time in excess of the 25 percent threshold cannot be counted.

In addition, all therapy services must meet each of the following criteria in order to be coded on the MDS as rehabilitative therapy:

- The service must be ordered by a physician;
- The therapy intervention must be based on a qualified therapist's evaluation and plan of care as documented in the resident's record; and,
- An appropriate licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with the nursing service.

The directions for completion of Section O instruct the assessor to look back over, the "last 7 calendar days," counting only post admission days and minutes of therapy, when counting the days and minutes of rehabilitation therapy administered. Seven calendar days are, by definition, consecutive days. In the case of a Medicare 5 day assessment, however, the assessor will choose as the assessment reference date (MDS item A2300) any day 1-8 of the stay, and will look back over the last 7 calendar days (or over the days since admission if the assessment reference date is earlier than day 7) and count the number of days upon which more than 15 minutes of therapy were administered, and will count the number of minutes that were provided to the individual patient during those days.

It is irrelevant if there is a break in therapy for a weekend or holiday during that time. For example, if day 5 of the stay is chosen as the assessment reference date, the assessor would look back to admission to count the patient's occupational therapy, physical therapy and speech pathology time. If physical therapy was provided for 50 minutes on both the second and fifth days of the stay, that would be recorded as 2 days of physical therapy and 100 minutes of physical therapy. The actual time that therapy was provided should be recorded.

Group Therapy

Group therapy is defined as a group of four or fewer participants working on the same activity. The group may be led by a professional therapist or a PTA or COTA who is under the professional therapist's supervision. The total number of minutes spent is captured individually on each group member's MDS.

In addition, the following criteria apply:

- The time spent in group therapy only may equal 25% of the beneficiary's weekly therapy program time.
- The 25% limit is applied separately to each individual discipline: PT, OT, ST.
- The supervising therapist may not oversee/supervise any other therapy service provision which providing group therapy supervision.

Group Therapy:

- 4 or fewer beneficiaries
- May only equal 25% of weekly therapy
- 25% applicable per discipline, e.g., ST

Pre-Admission Data

Patients admitted to skilled nursing facilities from acute care hospitals are often most vulnerable in the first days following the transfer. In the first few hours and days, outcomes may hinge upon the quality of information provided in the transfer information.

Recent studies per the AMDA (American Medical Directors Association) have identified problems in current processes for inter-institutional patient transfers. Accompanying documentation is at times inaccurate or incomplete. Consequences of inadequate documentation range from unnecessary repetition of tests to serious adverse drug interactions, to falls, and worse.

The services provided to the patient during hospitalization impact the risk for recurrence in clinical areas as well as potential financial responsibilities of the SNF. For example, the patient treated with IV medications while hospitalized may be at risk for exacerbation of conditions prompting the reordering of costly IV medications in the SNF. Capturing accurate medical acuity for the 5-day assessment may help to mitigate risk of recurrence of the condition that precipitated the hospital stay, and is therefore very important for the development of an accurate care plan.

Harmony stresses the importance of obtaining all available pre-admission data to assist in accurate capture of hospital services. It is crucial to know the dates of procedures and services provided while hospitalized. This information is vital to accurately code the MDS, reflect the medical complexity of the beneficiary, and ensure optimal reimbursement.

The following data from the hospital provides valuable insight into the services provided to the beneficiary during their hospital stay:

- History and Physical
- Discharge Summary
- MAR's (IV medications, IV fluids and medication with high risk for side effects)
- Nursing Graphic flow sheets (temperatures, vital signs)
- Nursing progress notes
- Therapy progress notes

This is not an exhaustive list.

Refer to list on the next page for additional pre-admission data.

Pre-Admission Data

- Admission Sheet
- Anesthesia Record
- Arrhythmia Sheets (from admission)
- Blood Transfusion Sheet (from admission)
- Clinical Record Forms (from admission)
- Daily Flow Sheets (from admission)
- Discharge Summary
- ECT Reports (from admission)
- EEG Reports (from admission)
- EKG Reports (from admission)
- ER Record – including doctor's orders, nursing notes and assessment
- Hemodialysis Flow Sheet (Post Dialysis Report)
- Heparin Med Sheets (from admission)
- History and Physical
- Intake Assessment
- Laboratory Reports (from admission)
- MD Order Sheets (from the month)
- MD Progress Notes (from the month)
- Medication Sheets (from admission)
- Nurse's Notes (from the month)
- Operative Report
- Pathology Reports (from admission)
- Radiology Reports (from admission)
- Rehab Notes (from admission)
- Respiratory Record Documentation (from admission)
- Respiratory/Pulmonary Tests (from admission)

Insert Pre-Admission Screening Form

Page 1

Insert Pre-Admission Screening Form

Page 2

Demand Bill

A beneficiary has the right to request a demand bill for services that the SNF has determined to be noncovered, by indicating his or her wish to do so on the Notice of Noncoverage issued to them. (SNF Manual, Section 356.1)

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR notice received) or 22 (date active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date.

Medical Review Process Under PPS

Medical review of SNF PPS claims will be done in accordance with the MIM-3, Program Integrity Manual, the HCFA Health Insurance Manual, and Program Memoranda.

Types of Medical Review:

- Pre-pay
- Random post-pay
  Random selection of the number of bills believed by the Fiscal Intermediary to be sufficient to ensure that providers are reporting correct information on the MDS and billing for covered SNF PPS services
- Focused Medical Review
- Fiscal Intermediary's are to continue Focused Medical Review (FMR) according to MIM 3939.
- 100 percent of demand bills submitted must be reviewed by the Fiscal Intermediary MR department.

FMR Bill Selection:

- In selecting their overall workload MACs may choose specific claims or target providers that historically bill at a higher volume, are known to be abusive, or are newly participating in Medicare.
- The target portion of review must not exceed 20 percent of the overall workload.

Medical Review Coverage Criteria Per:

- Program Integrity Manual
- MIM-3
- HIM
- Program Memoranda

Medical Record Documentation Requirements

In response to an Additional Documentation Request (ADR) the following documentation is required:

- All applicable MDSs for the claim period billed
- All medical records for 30 days prior to each ARD applicable to this billing period, including but not limited to the following:
  - ♦ Hospital Discharge Summary

Medical Review Process Under PPS (Continued)

- Admission Assessment
- Care Plans
- Progress Notes (Nursing, Rehabilitation)
- Initial therapy evaluations
- Therapy logs to support claim period and MDS coding of minutes in Section O
- Intake and Output Log
- Vital Sign Log
- Weight Records
- Treatment and Medication Sheets
- Provider's written notice(s) of denial to the beneficiary and any reinstatement notices. Include dated verification that the beneficiary or representative received notification or documentation that telephone contact was attempted
- Physician certification

Medical Record Time Frame

- 30 days prior to each ARD and the claim period billed

Requirements for Coverage

In order for a claim to be covered, the stay must meet all three criteria below:

- Level of care requirement as defined by the Final Rule.
- Services must not be statutorily excluded
- Services must be reasonable and necessary

Reminder:

It is important to remember that the medical record must support that:

- Services documented on the MDS were actually delivered
- Services provided were reasonable and necessary for the relevant assessment period.

Review of the 5-day Presumptive Period

The services provided and received during the first days of the post-acute stay are **presumed** to meet the level of care requirements. However, the services upon which classification into one of the upper RUG-IV groups is based must be reasonable and necessary to diagnose or treat the beneficiary's condition.

Medical Review Process Under PPS (Continued)

Continued Coverage Decisions

Continued Medicare coverage for days after the initial post-acute period covered by the presumption is based on the continued need for, and receipt of, a skilled level of care. The reviewer will examine the record regarding the beneficiary's overall clinical status and care needs for the dates of service in review.

Medical Review Decisions

All medical review decisions are made on the basis of medical record documentation from the provider. The provider must demonstrate in it's documentation the medical necessity of the services provided. There are four potential decisions listed below.

1. Services were documented and medically reasonable and necessary.
   The claim is approved for payment.
2. Rehabilitation RUG-IV Groups
   - If rehabilitation is reasonable and necessary, but not at the level billed, the claim will be adjusted for the entire payment period according to a decision matrix (see "Medical Review Decision Matrix")
   - If rehabilitation services are not reasonable and necessary, the reviewer will use the Medical Review decision matrix to reclassify the beneficiary into one of the RUG-IV clinical groups, if appropriate. If there are no criteria upon which to base classification into a clinical group, the claim will be denied.

     Provider is held liable in both cases.
3. Insufficient documentation of services rendered
   Claim is denied in full or part of the entire payment period
   Provider is held liable
4. Lower 14 RUG-IV groups
   - If the care provided was reasonable and necessary and met the SNF Level of Care requirements, then

     The claim is approved for payment
   - If the care was not reasonable and necessary or **did not meet** the SNF level of care requirements, then

     The claim is denied for the entire payment period
     Provider is held liable

Medical Review Decisions:

- Based on provider documentation
- Must demonstrate medical necessity

Beneficiary Notices/ Medical Review Process

Harmony Healthcare INTERNATIONAL

No Pay Bill Tracking Form

Patient Name	LCD Part A	LCD Therapy Part B	Nsg Skill (Y/N)	Describe Skill	Nsg Skill End Date	No Pay Bill Sent Date

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-8917
www.harmony-healthcare.com

Harmony Healthcare INTERNATIONAL

Beneficiary Notices/ Medical Review Process

No Pay Decision Grid

Level of Care	Patient's Medicare SNF Part A Benefits are Exhausted	Patient is in Medicare Certified Area of the Facility*	If in Non-Medicare Area, the Facility Meets the Definition of a SNF**	Is the Inpatient Spell of Illness Continued?	Action
Medicare Skilled	Yes	Yes	N/A	Yes	Submit monthly covered claim.
	No	Yes	N/A	Yes	Submit monthly covered claim.
	Yes	No	Yes	Yes	Submit monthly covered claim.
	No	No	Yes	Yes	The patient must be returned to certified area for Medicare coverage.
	No	No	No	Yes	Facility should determine whether it would be appropriate to send patient back to a certified area for Medicare Coverage.
Not Medicare Skilled	Yes	No	No	No	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim at discharge.
	Yes	Yes	N/A	No	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim at discharge.
	No	Yes	N/A	No	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim at discharge.
	No	No	Yes	No	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay discharge claim.
	Yes	No	Yes	No	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay discharge claim.

* Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness is continued and has no effect on the SNF's action.

** In some states, licensing laws for all nursing homes have incorporated the requirements of the basic SNF definition (Social Security Act §1819 (a)(1)). When this is the case, any nursing home licensed in such a state would be considered to meet this definition (see the CMS Internet-Only Manual, Pub. 100-7, Chapter 2, § 2164).

Notices of Noncoverage

According to the final rule, when the documentation no longer supports the need for, or receipt of a skilled level of care, a decision of noncoverage is made by the reviewer and applied as of that date.

Notices of Noncoverage:

- Issued on the date the medical record documentation no longer supports a skilled level of care or
- When the services rendered do not meet the medical necessity criteria

Medicare Summary Notices (MSN)

The following chart represents the Beneficiary's message on the MSN, and the applicable provider ANSI Reason Code on the Remittance Advice.

Insufficient Information Denial	MSN 9.2 "The item/service was denied because information required to make payment was missing."	ANSI B12 "Claim denied charges" and "Services not documented in patient's medical records."
Partial Payment at Reduced Rate (Matrix)	MSN 15.8 "Information provided does support the level of service down on the claim."	ANSI 57 denied charges" and "the claim/service denied/reduced because the payer deems the information submitted does not support this level of service/this many services/this length of service or this dosage."
Full Denial as Not Medically Reasonable and Necessary	MSN 13.3 or 13.4 "Information provided does not support the need for skilled nursing facility care" or "Information provided does not support the need for continued care in a skilled nursing facility."	ANSI 50 "Claim charges denied" and "These are non-covered services because this is not deemed a medical necessity by the payer."
Demand Bill Agrees With Provider's Determination of Noncoverage	MSN 16.42 "The provider's determination of non-coverage is correct."	ANSI 50 "These are non-covered services because this is not deemed a medical necessity by the payer."
Agree With Noncoverage But the Provider Failed to Issue Proper or Timely Notice	MSN 36.2 "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: a copy of this notice, your provider's bill, a receipt or proof that you have paid the bill."	ANSI 116 "Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."
Improper Placement in a Noncertified Bed	MSN 13.7 "Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items."	ANSI 116 "Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."
Billing Error	MSN 9.4 "This item or service was denied because information required to make payment was incorrect."	ANSI A1 "Claim Denied Charges"

Insert Beneficiary Notice Decision Grid, pg. 1

Insert Beneficiary Notice Decision Grid, pg. 2

Skilled Nursing Liability Notice: This term refers to any SNF liability notice (other than the Expedited Determination notices) that a provider uses to notify the beneficiary that Medicare will probably not cover services. (i.e., Advanced Beneficiary Notice (ABN, Form CMS-10055), Notice of Denial of Medicare Benefits, or "cut letter.")

ED Notices – "Expedited Determination" Notices. Mandatory effective July 1, 2005. The notices consist of a Generic Notice of Medicare Provider Non-Coverage and a Detailed Notice of Medicare Provider Non-Coverage. The Generic Notice is always given in the identified situations. The Detailed Notice is only given if the beneficiary appeals the termination of coverage.

Medical Review Process

6.1 – Medical Review of Skilled Nursing Facility Prospective Payment System (SNFPPS) Bills (Rev.196, Issued: 03-30-07, Effective: 01-01-06, Implementation: 04-30-07)

Effective with cost reporting periods beginning on or after July 1, 1998, Medicare began paying skilled nursing facilities (SNFs) under a Prospective Payment System (PPS). PPS payments are per diem rates based on the patient's condition as determined by classification into a specific Resource Utilization Group (RUG). This classification is done by the use of a clinical assessment tool, the Minimum Data Set (MDS) and is required to be performed periodically according to an established schedule for purposes of Medicare payment. Each MDS represents the patient's clinical status based on an assessment reference date and established look back periods for the covered days associated with that MDS. Medicare expects to pay at the rate based on the most recent clinical assessment (i.e. MDS), for all covered days associated with that MDS. This means that the level of payment for each day of the SNF stay may not match exactly the level of services provided. Accordingly, the medical review process for SNF PPS bills must be consistent with the new payment process. The methodology for medical review of SNFs has changed under the prospective payment system from a review of individualized services to a review of the beneficiary's clinical condition. Medical review decisions are based on documentation provided to support medical necessity of services recorded on the MDS for the claim period billed.

"Rules of thumb" in the MR process are prohibited. MACs must not make denial decisions solely on the reviewer's general inferences about beneficiaries with similar diagnoses or on general data related to utilization. Any "rules of thumb" that would declare a claim not covered solely on the basis of elements, such as, lack of restoration potential, ability to walk a certain number of feet, or degree of stability is unacceptable without individual review of all pertinent facts to determine if coverage may be justified. Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.

All contractors are to review, when indicated, Medicare SNF PPS bills, except for the excluded services identified in §4432(a) of the BBA and regular updates which can be accessed by contractors at:

http://www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp#TopOfPage .

The goal of medical review is to determine whether the services are reasonable and necessary, delivered in the appropriate setting, and coded correctly, based on appropriate documentation. Under PPS, beneficiaries must continue to meet the regular eligibility requirements for a SNF stay as described in CMS IOM Pub. 100-02, chapter 8, §20, such as the 3-day medically necessary hospital stay and admission to a participating SNF within a specified time period (generally 30 days) after discharge from the hospital.

Medical Review Process (Continued)

Under PPS the beneficiary must continue to meet level of care requirements as defined in 42 CFR 409.31. CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the upper 35 RUG groups, this effectively creates a presumption of coverage for the period from the first day of the Medicare covered services up to, and including, the assessment reference date for that assessment (which may include grace days). **This presumption does not arise in connection with any of the subsequent assessments**, but applies specifically to the period ending with the assessment reference date for the initial Medicare required 5-day assessment. See CMS Pub IOM, Chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

In the case described above, where the administrative presumption of coverage exists, contractors shall review the bill and supporting medical information to determine whether the beneficiary did indeed meet the SNF level of care requirement for all days subsequent to the assessment reference date of the Medicare required 5-day assessment. In the case where the beneficiary is correctly classified into one of the lower 14 RUG categories, the contractor shall review the bill and supporting medical information to determine whether the beneficiary met the SNF level of care requirement from the beginning of the stay. If the beneficiary met the level of care requirement, contractors shall also determine whether the furnished services and intensity of those services, as defined by the billed RUG group, were reasonable and necessary for the beneficiary's condition. To determine if the beneficiary was correctly assigned to a RUG group, contractors shall verify that the billed RUG group is supported by the associated provider documentation. Contractors shall consider all available information in determining coverage. This includes the MDS, the medical records including physician, nursing, and therapy documentation, and the beneficiary's billing history.

6.1.1 - Types of SNF PPS Review (Rev.196, Issued: 03-30-07, Effective: 01-01-06, Implementation: 04-30-07)

Contractors shall no longer perform random postpayment reviews specific to SNFPPS bills. Instead, SNFPPS MR should be conducted on a targeted prepayment or postpayment basis. Consider the principles of Progressive Corrective Action (PCA) when conducting MR (See CMS Pub IOM 100-08, chapter 3, §3.11 for information on PCA). Contractors are also required to continue to review 100% of SNF demand bills, from beneficiaries entitled to the SNF benefit. (See B below.)

A. Data Analysis and Targeted (Focused) Medical Review

Contractors are to conduct targeted reviews, focusing on specific program vulnerabilities inherent in the PPS, as well as provider/service specific problems. The reviews should be conducted based on data analysis and prioritization of vulnerabilities.

Medical Review Process (Continued)

- Data Analysis—Conduct data analysis to identify normal practice patterns, aberrancies, potential areas of overutilization, and patterns of non-covered care. Data analysis is the foundation for targeting medical review of claims. As described in CMS PUB IOM 100-08, chapter 2, §2.2, data should be collected and analyzed from a variety of sources, including but not limited to SNF PPS billing information, data from other Federal sources (QIOs, carriers, Medicaid); and referrals from internal or external sources (e.g., provider audit, fraud and abuse units, beneficiary or other complaints) to ensure targeting and directing MR efforts on claims where there is the greatest risk of inappropriate program payment.

- Claim Selection--In selecting their overall workload, contractors may choose specific claims or target providers with high error rates, and must include newly participating providers.

Contractors shall continue to track and report edit effectiveness through the standard activity reports.

6.1.3 - Bill Review Process

A. Obtain Records

Contractors shall obtain documentation necessary to make a MR determination. Medical records must be requested from the provider and the MDS data must be obtained from the national repository. Contractors are to use the MDS as part of the medical documentation used to determine whether the HIPPS codes billed were accurate and appropriate. For claims with dates of service beginning January 1, 2006, contractors must use the MDS extract tool to obtain the MDS from the state repository for each billing period reviewed. Additional information about the use of the FI extract tool can be found in the User's Guide. The tool and guide can be found at http://c1r5u03-web.sdps.org/qiesextract/. Once the clinical reviewer has utilized the FI Extract Tool to obtain the MDS(es) corresponding to the period being reviewed, the reviewer will import the MDS data into the MDS QC Software System to convert it into a readable format to be used, in conjunction with review of the medical record, for the adjustment of the SNF claim. The MDS QC System Software and Reference Manual can be downloaded at http://www.fu.com/fitools/.

Contractors shall also request documentation to support the HIPPS code(s) billed, including notes related to the assessment reference date, documentation relating to the look back periods which may fall outside the billing period under review, and documentation related to the claim period billed. Since the assessment reference date for each MDS marks the end of the look back period (which may extend back 30 days), the contractor must be sure to obtain supporting documentation for up to 30 days prior to the assessment reference date if applicable. The requested documentation may include hospital discharge summaries and transfer forms;

Medical Review Process (Continued)

physician orders and progress notes; patient care plans; nursing and rehabilitation therapy notes; and treatment and flow charts and vital sign records, weight charts and medication records.

Clinical documentation that supports medical necessity may be expected to include: physician orders for care and treatments, medical diagnoses, rehabilitation diagnosis (as appropriate), past medical history, progress notes that describe the beneficiary's response to treatments and his physical/mental status, lab and other test results, and other documentation supporting the beneficiary's need for the skilled services being provided in the SNF.

During the review process, if the provider fails to respond to a contractor's Additional Documentation Request (ADR) within the prescribed time frame, the contractor shall deny the claim. See CMS Pub IOM 100-08, chapter 3, section 3.4.1.2 for information on denials based on non-response to ADRs and 3.4.1.4 for handling of late documentation. If the provider furnishes documentation that is incomplete/insufficient to support medical necessity, adjust the bill in accordance with §1862(a)(1)(A) of the Act.

During the review of demand bills, continue current prepayment or postpayment medical review operating procedures, as described above, if the provider fails to furnish solicited documentation within the prescribed time frames.

B. Make a Coverage Determination

For all selected claims, review medical documentation and determine whether the following criteria are met, in order to make a payment determination:

- **MDS must have been transmitted to the State repository**— The contractor shall require that the provider submit the claim with the RUG code obtained from the "Grouper" software, as instructed in CMS Pub IOM 100-04, chapter 6, § 30.1. Claims for which MDS's have not been transmitted to the state repository should therefore not be submitted to Medicare for payment, and shall be denied. An exception to that instruction occurs in the case where the beneficiary is discharged or dies on or before day 8 of the SNF admission or readmission, as described in the Provider Reimbursement Manual, chapter 28, §2833 F. In that specific case, contractors shall pay claims at the default rate, provided that level of care criteria were met and skilled services were provided and were reasonable and necessary. In all other cases, the contractor shall deny any claim for which the associated MDS is not in the national repository. The contractor shall issue these denials with reason code 16, remark code N29, and shall afford appeal rights.

- **SNF must have complied with the assessment schedule**— In accordance with 42 CFR, §413.343, the contractor shall pay the default rate for the days of a patients care for which the SNF is not in compliance with the assessment schedule.

Medical Review Process (Continued)

- **Level of care requirement must be met**--Determine whether the services met the requirements according to 42CFR §409.31.

  - Under PPS, the beneficiary must meet level of care requirements as defined in 42 CFR §409.31. CMS has established a policy that, when the initial Medicare required 5-day assessment results in a beneficiary being correctly assigned to one of the upper 52 RUG groups, this creates a presumption of coverage for the period from the first day of the Medicare covered services up to, and including, the assessment reference date for that assessment (which may include grace days). **This presumption does not arise in connection with any of the subsequent assessments**, but applies specifically to the period ending with the assessment reference date for the initial Medicare required 5-day assessment. See Pub IOM 100-02, chapter 8, §30.1 for further explanation of the administrative presumption of coverage.

  - Administrative presumption of coverage DOES NOT exist for a beneficiary who is correctly assigned into one of the lower 14 RUG groups on the initial 5-day assessment, so documentation must support that these beneficiaries meet the level of care requirements.

  - For all assessments, other than the initial 5-day assessment, determination of the continued need for, and receipt of, a skilled level of care will be based on the beneficiary's clinical status and skilled care needs for the dates of service under review.

  - The level of care requirement includes the requirement that the beneficiary must require skilled nursing or skilled rehabilitation services, or both on a daily basis. Criteria and examples of skilled nursing and rehabilitation services, including overall management and evaluation of care plan and observation of a patient's changing condition, may be found at 42 CFR §§409.32 and 409.33.

  - An apparent interruption in daily skilled services should not be interpreted to signal an end to daily skilled care. Rather, consideration should be given to the provision of observation and assessment and management and evaluation of the care plan during the review of medical records.

- **The services must not be statutorily excluded**--Determine whether the services are excluded from coverage under any provision in 1862(a) of the Act other than 1862(a)(1)(A).

Medical Review Process (Continued)

- **Services are Reasonable and Necessary**--Determine whether the services are reasonable and necessary under 1862(a)(1)(A) of the Act. In making a reasonable and necessary determination, you must determine whether the services indicated on the MDS were rendered and were reasonable and necessary for the beneficiary's condition as reflected by medical record documentation. If the reviewer determines that none of the services provided were reasonable and necessary or that none of the services billed were supported by the medical record as having been provided, the contractor shall deny the claim in full.

If the reviewer determines that some of the services were not reasonable and necessary, follow the instructions in the following subsection to utilize the MDS QC Software System Software, version FI-5.01 to calculate the appropriate RUG code and pay the claim according to the calculated code for all covered days associated with the MDS.

C. Review Documentation and Enter Correct Data into the MDS QC Software When Appropriate.

If the reviewer determines that coverage criteria are met and services are not statutorily excluded, but some services provided were not reasonable and necessary or were not supported in the medical record as having been provided as billed, the MDS QC System software, version FI-5.01 must be used to calculate appropriate payment. Contractors shall pay claims according to the RUG value calculated using the MDS QC tool, regardless of whether it is higher or lower than the RUG billed by the provider. If none of the services provided were reasonable and necessary, the contractor shall deny the claim in full.

Contractors shall use the MDS QC System Software, version FI-5.01 to review and calculate appropriate payment for SNF claims with dates of service prior to January 1, 2006, which fall into the older, 44-group RUG classification system as well as for those with dates of service on or after January 1, 2006, which fall into the newer, 53-group RUG classification system.

The medical reviewer will examine the medical documentation to make a determination as to whether it supports the data entered into the MDS assessment completed by the provider and extracted from the state repository. If a discrepancy is noted, the reviewer shall enter the correct data reflected in the medical record, according to the instructions in the MDS QC System Software reference manual. The reviewer shall consider all available medical record documentation in entering data into the software. This includes physician, nursing, and therapy documentation, and the beneficiary's billing history. Review of the claim form alone does not provide sufficient information to make an accurate payment determination.

Medical Review Process (Continued)

D. Outcome of Medical Record Review

Once the contractor has:

1. obtained the medical record and electronic MDS submitted to the state by the provider;
2. determined whether coverage criteria are met; and
3. reviewed the medical record, to determine whether services were reasonable and necessary and provided as billed; and
4. entered correct data into the MDS QC tool when discrepancies were noted,

the contractor shall take action to pay the claim appropriately, for the days on which the SNF was in compliance with the assessment schedule (pay the default rate for the days on which the SNF provided covered care, but was not in compliance with the assessment schedule), as described in each of the following situations:

- When the HIPPS Code Indicates Classification into a Rehabilitation Group and:
  - **Rehabilitation Services are Reasonable and Necessary As Documented on the MDS Submitted to the State Repository:** If no discrepancies are noted between the MDS submitted to the state repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the contractor shall verify that the RUG code submitted on the claim matches the RUG code on the MDS imported from the national repository into the MDS QC tool, and:
    - If the facility RUG value obtained through the MDS QC tool matches the RUG code submitted on the claim, the contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of therapy changed during the payment period (e.g. O.T. is discontinued while medically necessary skilled P.T. services continue).
    - If the facility RUG value obtained through the MDS QC tool **does not** match the RUG code submitted on the claim, the contractor shall pay the claim at the appropriate level based on the RUG code on the MDS submitted to the state repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the level of therapy changed during the payment period.
- When the HIPPS Code Indicates Classification into a Clinical Group and:

Medical Review Process (Continued)

- **Services are Reasonable and Necessary As Documented on the MDS Submitted to the State Repository—** If no discrepancies are noted between the MDS submitted to the state repository and the patient's medical record, during the relevant assessment period for the timeframe being billed, the contractor shall verify that the RUG code submitted on the claim matches the RUG code on the MDS imported from the national repository into the MDS QC tool, and:

    - If the facility RUG value obtained through the MDS QC tool matches the RUG code submitted on the claim, the contractor shall pay the claim as billed for all covered days associated with that MDS, even if the level of skilled care changed during the payment period.

    - If the facility RUG value obtained through the MDS QC tool **does not** match the RUG code submitted on the claim, the contractor shall pay the claim at the appropriate level based on the RUG level on the MDS submitted to the state repository (and subsequently obtained through the MDS QC tool) for all covered days associated with that MDS, even if the level of skilled care changed during the payment period.

- **Lower 14 RUG Group Billed - Level of Care Criteria Met--**If the beneficiary *meets* the SNF *coverage* criteria as defined in Section 6.1.3B, *the contractor shall* accept the claim as billed for the *all covered days associated with that MDS*, as long as skilled need remains.

- **Lower 14 RUG Group Billed - Level of Care Criteria Not Met--**If the beneficiary *does* not meet the SNF *coverage* criteria as defined in Section 6.1.3B, *the contractor shall* deny the *claim* in full.

Introduction

Medicare requires that documentation be completed at regular intervals and include specific information.

The information documented needs to be measurable and the goals functional. It should also delineate why your professional experience and intervention are required. In addition, the JCAHO standards are another source that defines documentation requirements.

An evaluation tool must be completed prior to the initiation of skilled therapy services. Medicare does not specify the actual tool the therapy professionals are required to complete for an evaluation. Regardless of the evaluation tool, in order to support services provided the facility must produce the following information for the Medicare Administrative Contractor:

- Physician order(s)
- Signed and dated certification by physician
- Date of evaluation
- Start of care date
- Medical diagnosis
- Treatment diagnosis
- Onset date
- Current level of function
- Prior level of function
- Treatment plan with long and short term goals
- Previous therapy administered to include:
  - Date
  - Diagnosis for treatment
  - Modalities administered
- Progress notes detailing service provided for each date of service billed
- Grid reflecting service/HCPCS

Weekly progress notes are recommended to address the specific goals devised upon evaluation or goals modified during the course of the therapy program. Weekly documentation identifies the patient's progress towards goals outlined on the evaluation. This documentation supports medical necessity for ongoing intervention as well as supports the services provided. The lack of this essential documentation may lead the Medicare Administrative Contractor to determine that services are not reasonable or necessary for the beneficiary.

Progress notes are most supportive with positive and proactive language versus focusing on negative aspects of the therapy programs and reduced outcome. Listing barriers to achieving set

program goals is only pertinent when the note has descriptions of steps taken to aid the patient in overcoming barriers.

The use of progress notes is the therapist's only way to communicate to a Medicare reviewer that a patient benefited from therapy. Progress notes should contain information regarding: functional goals; evidence of skilled service; and changes in levels of independence.

Daily notes should include evidence of skilled service and the patient's response to the treatment. Weekly and monthly progress notes should contain all of the above as well as comparative data.

Abbreviations

Explanation of Abbreviations commonly used in Rehab Charting:

A	Assisted
AAROM	Active Assistive Range of Motion
Abd	Abduction
Add	Adduction
ADL	Activities Daily Living
AFO	Ankle Foot Orthosis
AKA	Above Knee Amputation
ALD	Assistive Listening Device
ALS	Anterior Lateral Sclerosis
Amb	Ambulation
AP	Active and Passive
AROM	Active Range of Motion
(B)	Both/Bilateral
BID	Two Time a Day
BKA	Below Knee Amputation
BUE	Bilateral Upper Extremity
C	Cane
$\overline{c}$	With
COTA	Certified Occupational Therapy Assistant
CP	Cerebral Palsy
Cr Tr	Crutch Training
CVA	Cerebral Vascular Accident
SWD	Short Wave Diathermy
Dx	Diagnosis
ES	Electrical Stimulation
Eval	Evaluation

EXT	Extension
Ext Rot	External Rotation
FLEX	Flexion
Funct Act	Functional Activities
FWB	Full Weight Bearing
Fx	Fracture
HP	Hot Packs
Hx	History
I	Independent
Int Rot	Internal Rotation
IR	Infra Red
KAFO	Knee Ankle Foot Orthosis
L	Left
LB	Low Back
LBQC	Large Based Quad Cane
LE	Lower Extremity
LLC	Long Leg Cast
LLE	Left Lower Extremity
LS	Lumbosacral
LTG	Long Term Goals
LUE	Left Upper Extremity
MD	Muscular Dystrophy
MG	Myasthenia Gravis
MS	Multiple Sclerosis
Max	Maximal
Min	Minimal
Mod	Moderate
MW	Microwave

NA	Not Applicable
NBQC	Narrow Based Quad Cane
NPO	Nothing Orally
NS	No Show
NT	Not Tested
ORIF	Open Reduction Internal Fixation
OTR	Occupational Therapist Registered
OT	Occupational Therapy
PRE	Progressive Resistive Exercise
$\overline{p}$	Post/After
PROM	Passive Range of Motion
PT	Physical Therapy/Therapist
PTA	Physical Therapy Assistant
Pt	Patient
PU Walker	Pick Up Walker
PWB	Partial Weight Bearing
QD	Daily
R	Right
Rehab	Rehabilitation
RLE	Right Lower Extremity
RNA	Restorative Nursing Aide
ROM	Range of Motion
RUE	Right Upper Extremity
RW	Rolling Walker
Rx	Treatment
S	Supervised
$\overline{s}$	Without
SBA	Stand By Assist
SBQC	Small Based Quad Cane

Sdly	Side Living
Sev	Severe
Sh	Shoulder
SLC	Short Leg Cast
SLP	Speech Language Pathologist
SOB	Short of Breath
SSW	Social Service Worker
ST	Speech Therapy
STG	Short-Term Goals
TENS	Transcutaneous Electrical Neural Stimulation
THA	Total Hip Arthroplasty
THR	Total Hip Replacement
TIA	Transient Ischemic Attack
TIW	3 Times a Week
TKR	Total Knee Replacement
TTWB	Toe Touch Weight Bearing
Tx	Traction
tx	Treatment
UE	Upper Extremity
US	Ultra Sound
UV	Ultra Violet
W	Walker
WBAT	Weight Bearing As Tolerated
WC	Wheelchair
WFL	Within Functional Limits
WNF	Within Normal Limits
WP	Whirlpool
Up arrow	Increase
Down arrow	Decrease

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Therapy Documentation

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Physical Therapy
Progress flow sheets

Patient Name: _____
Diagnosis: _____
ICD-9 Code: _____
Payor Source (circle below):
Med A Med B Medicaid HMO

Room #: _____
Admission Date:_____
Frequency/Duration:_____
Expected D/C Date: _____
Primary Therapist: _____

	Initial status date:	Ltg's	Date:	Date:	Date:	Date:
Rolling						
Supine to sit						
Sit to supine						
Sit to stand						
Stand to sit						
Transfers						
Ambulation distance						
Ambulation device						
Ambulation assist						
Strength						
Activity tolerance						
Balance						
Stairs						
W/c mgmnt						
W/c propulsion						
Education/ d/c planning						
Therapist signature						

Comments: _____

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Physical Therapy
Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

Therapy Documentation

Insert

Physical therapy
Progress note

(excel form)

Therapy Documentation

Insert

Physical therapy
700 form

(excel form)

Therapy Documentation

Insert

Physical therapy
701 form

(excel form)

Therapy Documentation

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Occupational Therapy
Progress Flow Sheets

Patient name: _____ room #: _____
Diagnosis: _____ admission date:_____
Icd-9 code: _____ frequency/duration:_____
Payor source (circle below): expected d/c date: _____
Med A Med B Medicaid HMO primary therapist: _____

	Initial status date:	Ltg's	Date:	Date:	Date:	Date:
Ue bathe						
Le bathe						
Ue dress						
Le dress						
Grooming						
Feeding						
Toilet transfer						
Tub transfer						
Balance						
Activity tolerance						
Meal prep						
Hls						
Rue						
Lue						
Splint program development						
Therapist signature:						

Comments: _____

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Occupational Therapy
Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

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Therapy Documentation

Insert

Occupational therapy

Progress note

(excel form)

Therapy Documentation

Insert

Occupational therapy
700 form

(excel form)

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Insert

Occupational therapy
701 form

(excel form)

Therapy Documentation

Insert

Occupational therapy
Sample 701 form

(excel form)

Therapy Documentation

Harmony Healthcare INTERNATIONAL

Speech Therapy
Progress Flow Sheets

Patient Name: _____ Room #: _____
Diagnosis: _____ Admission Date:_____
ICD-9 Code: _____ Frequency/Duration:_____
Payor Source (circle below): Expected D/C Date: _____
Med A Med B Medicaid HMO Primary Therapist: _____

	Initial status date:	Ltg's	Date:	Date:	Date:	Date:
Swallowing						
Expressive Language						
Receptive Language						
Attention						
Orientation						
Short-term Memory						
Reasoning						
Problem-Solving						
Sequencing						
Reading						
Writing						
Math						
Current Diet	Regular	Ground	Dysphagia	Puree		
Current liquids	Thin	Syrup Thick	Honey Thick	Pudding Thick		
Therapists Initials						

Comments: _____

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Speech Therapy
Narrative Progress Notes

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature

Patient Name _____ Room # _____

Harmony Healthcare INTERNATIONAL

Speech Therapy

Progress Note

Date: _____

Date						
Expressive/Recep Language	WFL	MILD	MOD	SEV	%	CUES
Speech Production						
Comprehension						
Names Objects						
Communicates Basic Needs						
Pragmatics						
Memory/Problem Solving						
Recall						
Safety						
Sequencing						
Problem Solving						
Oral Phase	TRACE	POOR	FAIR	GOOD	CUES	
Lip Closure						
Food Clearance						
Chewing						
Tongue Function						
Pharyngeal Phase						
Response After Stimulation						
Chin Tuck						
Head Turn						
Voice Quality After Swallow						
Estimated Transit Time						

Barriers To Function

	Improved	No Change	Declined
Cognition/safety			
Expressive comm.			
Swallowing			
Hearing			
Comprehension			
Sp. production			
Voice			
Attention			

Other:

Comments:

Skilled Services

Functional Improvement

Functional Impairment Remaining

Updated Goals ☐ Continue with Goals ☐ Goals Met

Therapist Signature		Date
Patient Name	HICN	Room Number

Insert

Speech therapy
700 form

(excel form)

Therapy Documentation

Insert

Speech therapy
701 form

(excel form)

Therapy Documentation

Harmony Healthcare INTERNATIONAL

Progress Flow Sheets
Sample

Patient Name: Harry Harmony
Diagnosis: Acute CVA
ICD-9 Code: 436
Payor Source (circle below):
(Med A) Med B Medicaid HMO

Room #: 313
Admission Date: 5/15/06
Frequency/Duration: 5X/week, 6 weeks
Expected D/C Date: 6/28/06
Primary Therapist: KJM

	Initial status date:	Ltg's	Date:	Date:	Date:	Date:
	5/15/06					
Ue bathe	Mod @	(I)	Min @			
Le bathe	Max @	(I)	Mod @			
Ue dress	Mod @	(I)	Min @			
Le dress	Max @	(I)	Mod @			
Grooming	Mod @	(I)	Min @			
Feeding	Min @	(I)	(S) c lip plate and set-up			
Toilet transfer	Max @ s-p w/c c commode	(I)	Mod @ s-p w/c c commode			
Tub transfer	N/a	(I) c tub seat	N/a			
Meal prep	N/a	N/a	N/a			
Hls	N/a	N/a	N/a			
Rue	P + strength	Wfl	F-			
Lue	Wfl	N/a	Wfl			
Therapist signature:						

Comments: 5/15/01 Patient has significant ® sided weakness impacting activities of daily living.

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Therapy Documentation

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Narrative Progress Notes
Sample

Date	Write Weekly Narrative. Note any changes in performance. Discuss each Program being provided. Signature
5/15/13	OT Consult received, chart reviewed and patient greeted. PLAN Complete initial evaluation and devise an appropriate treatment plan. Signature OTR/L
5/17/13	OT Initial evaluation completed and placed into chart. Please refer to separate sheet for details, STG's and LTG's. Signature OTR/L
5/24/13	This 65-year-old male admitted to SNF after acute L CVA c ® hemiparesis. Prior to admission, patient resided at home with wife and lived active lifestyle (walked daily, drove car, I in all activities of daily living). Patient is alert and oriented X3 and states that he is going home. He stated that he would like to be able to toilet independently (OT personal goal). At this time, patient actively participates in OT program 5X/week and is making significant gains. See flow sheet for details. PLAN Continue to tx patient as outlined. Signature OTR/L

Patient Name Harry Harmony **Room #** 313

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Commonly Denied Treatments

1. Activities and exercises to promote overall improvement, general conditioning or endurance without a specific functional gain.
2. Exercise and activities which can be administered by non-skilled persons.
3. Duplicating services as when two disciplines provide the same treatment for the same reason.
4. General range of motion exercise not related to a specific, measured loss of function that can be regained with therapy.
5. Group treatment with group goals and not specific individual treatment goals.
6. Hot packs without any other modality or procedure, commonly referred to as “feel good” hot packs.
7. Limited learning potential for the stated goals.
8. Long term maintenance therapy without the training of caregivers to continue with a program.
9. Poor or fair rehabilitation potential. The lowest potential allowable is “Good for goals as stated”.
10. Ongoing routine training in self care after initial instruction period and improved skills have been taught.
11. Passive range of motion without any other procedure or modality.
12. Repetitive services or treatment with no measured progress.
13. Routine self care training and mobility where self care function would return spontaneously and safely without a skilled therapist.
14. Routine assistance with ambulation that can be performed by an unskilled person.
15. Therapy evaluations and treatment for rehabilitation candidates without the potential to achieve stated goals.
16. Reevaluations unless a significant change has occurred.
17. Treatment of degenerative, chronic or old (more than six months) onset diagnoses where no functional potential exists.
18. Treatments rendered without a physician’s order.
19. Where poor cognitive status would prohibit new learning or adequate participation in the therapy process for the stated goals.
20. When treatment is unsubstantiated with specific and measurable baseline evaluation information.

SNF Prospective Payment System

General Provisions

Section 4432 of the Balanced Budget Act (BBA) of 1997 established provisions for a Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF) under Section 1888(e) of the Social Security Act (the Act) effective with cost reporting periods beginning on or after July 1, 1998. Under these provisions, covered Medicare Part A SNF services are no longer paid based on reasonable cost or through low volume prospectively determined rates, but rather through case-mix adjusted per-diem prospective payment rates for all SNFs. The payment rates (i.e., full Federal rate or transition rate) represent payment in full subject to applicable coinsurance for all costs (routine, ancillary, and capital-related) associated with furnishing covered SNF services to Medicare beneficiaries other than costs associated with operating approved educational activities.

Covered SNF Services

Covered SNF services include post hospital SNF services for which benefits are provided under Medicare Part A and all items and services for which prior to July 1, 1998, payment has been made under Medicare Part B other than the following services furnished to SNF residents during a Medicare Part A stay, regardless of source:

- Physician's services;
- Physician assistant services;
- Nurse practitioner services;
- Clinical nurse specialists services;
- Certified mid-wife services;
- Qualified psychologist services;
- Certified registered nurse anesthetist services;
- Certain dialysis related services and Erythropoietin (EPO) for certain dialysis patients;
- Hospice care related to a terminal condition;
- Ambulance trips that transport the beneficiary to the SNF for admission or from the SNF following discharge; and,
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services furnished to SNF residents during a Medicare Part A covered stay.

Consolidated Billing Requirements Under Part A

Consolidated billing applies to services and supplies that a SNF resident receives while in a SNF PPS Medicare Part A stay.

A beneficiary's status as a SNF resident ends when the beneficiary receives outpatient services from a Medicare participating hospital or Critical Access Hospital (CAH); but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or

comprehensive care plan. The purpose of citing the SNF care plan in the context of an outpatient hospital visit is to clarify that the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit, other than certain specifically excluded services.

Beneficiaries in a Part A Covered Stay

SNFs are required to consolidate billing to their intermediary for their covered Medicare inpatient services. However, certain services that are rendered to SNF inpatients are excluded from the SNF Prospective Payment System (PPS) reimbursement and are also excluded from consolidated billing by the SNF. Those services must be billed to Medicare Part B by the rendering provider and not by the SNF (except screening and preventive services as described in the next paragraph.) A list of services excluded from consolidated billing is found in the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Part A Billing," §§20-20.4.

Screening and preventive services are not included in the SNF PPS amount but may be paid separately under Medicare Part B for Part A patients who also have Part B coverage. Screening and preventive services are covered only under Medicare Part B. Only the SNF may bill for screening and preventive services under Medicare Part B for its covered Medicare Part A inpatients. Bill type 22X is used for beneficiaries in a covered Medicare Part A stay and for beneficiaries that are Medicare Part B residents. TOB 23x is used for SNF outpatients or for beneficiaries not in the SNF or DPU. The SNF must provide the service or obtain it under arrangements.

Coverage, billing and payment guidelines are found in the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," Chapter 17, "Drugs and Biologicals;" and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

There are certain medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B Carrier. Others are services that have been determined to require a hospital setting to assure beneficiary safety. FI or MAC shared systems receive an annual file listing these non-payment HCPCS in November, and, if necessary, a quarterly update via a one time only notification. Physicians, non-physician practitioners, and suppliers billing the carrier, and providers billing the FI or MAC should consult the CMS Website at http://www.cms.hhs.gov/SNFConsolidatedBilling/ for the lists of separately billable services.

Excluded Services From Consolidated Billing

In the outpatient hospital context, this exclusion applies to a number of exceptionally intensive and cost services that lie well beyond the scope of the care that SNFs would ordinarily furnish

and, thus, beyond the scope of the care plan itself, as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance).

Outpatient hospital emergency services are defined in 42 CFR, Section 424.101, as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require the use of the most accessible hospital available and equipped to furnish those services.

This exclusion is not invoked merely because a particular outpatient hospital service does not appear in the individual SNF care plan of the person receiving the service. Rather, the exclusion applies only to those specified categories of service that, by definition, lie well beyond the scope of SNF care plans generally.

In addition to the previously mentioned excluded services, the following services are also excluded from consolidated billing under Medicare Part A:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRI);
- Ambulatory surgery involving the use of an operating room;
- Emergency services;
- Radiation therapy;
- Angiography codes;
- Lymphatic procedures; and
- Venous procedures.

See HCPCS list at end of Section VI.

Services Beyond the Scope of the Medicare Part A SNF Benefit

The following services are beyond the scope of the SNF Medicare Part A benefit and are excluded from payment under Medicare Part A SNF PPS and from the requirement for consolidated billing. These services must be paid to the practitioner or provider that renders them and are billed separately by the rendering provider/supplier/practitioner to the MAC or FI. The SNF may not bill excluded services separately under Medicare Part B for its inpatients entitled to Medicare Part A benefits. HCPCS procedure codes representing these excepted services for services billed to the Carriers, FIs or MACs are updated as frequently as quarterly on the CMS Website at: http://www.cms.hhs.gov/SNFConsolidatedBilling/ Physicians, non-physician practitioners, and suppliers billing the carrier should consult *the above link* for lists of separately billable services. Note*:* There are separate Annual Update files for services billed to Carriers and billed to FIs posted to the website mentioned above. CMS Pub 100-4 Medicare Claims Processing Trans 846.

SNF Coverage Guidelines

Coverage determinations (i.e., level of care determinations) are significantly simplified by adopting the system for classifying residents based on resource utilization known as Resource Utilization Group, Version IV (RUG-IV). SNFs utilize information from the Minimum Data Set (MDS) Version 3.0, Resident Assessment Instrument (RAI), to classify residents into the RUG-IV groups.

Resident Assessment Instrument (RAI)

The Long Term Care Resident Assessment Instrument (RAI) is a three component document consisting of the following:

- Minimum Data Set (MDS);
- Care Area Assessments (CAAs) and Triggers; and
- Utilization Guidelines.

Questions and answers regarding the Long Term Care Resident Assessment Instrument are available on the CMS web site at:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html

Minimum Data Set (MDS)

The Minimum Data Set (MDS), Version 3.0 contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare reimbursement. The MDS consists of the following types of assessments:

- Comprehensive Assessment (MDS plus CAAs)
- Non-Comprehensive Assessments
- PPS Scheduled Assessments
- OMRA Assessments
- Discharge Assessments
- Entry Tracking Forms
- Death in Facility Tracking Form

The software programs used by SNFs to assign patients to appropriate RUG-IV groups based on the MDS 3.0, called Groupers, are available from many software vendors or by accessing the CMS web site at:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

Triggers

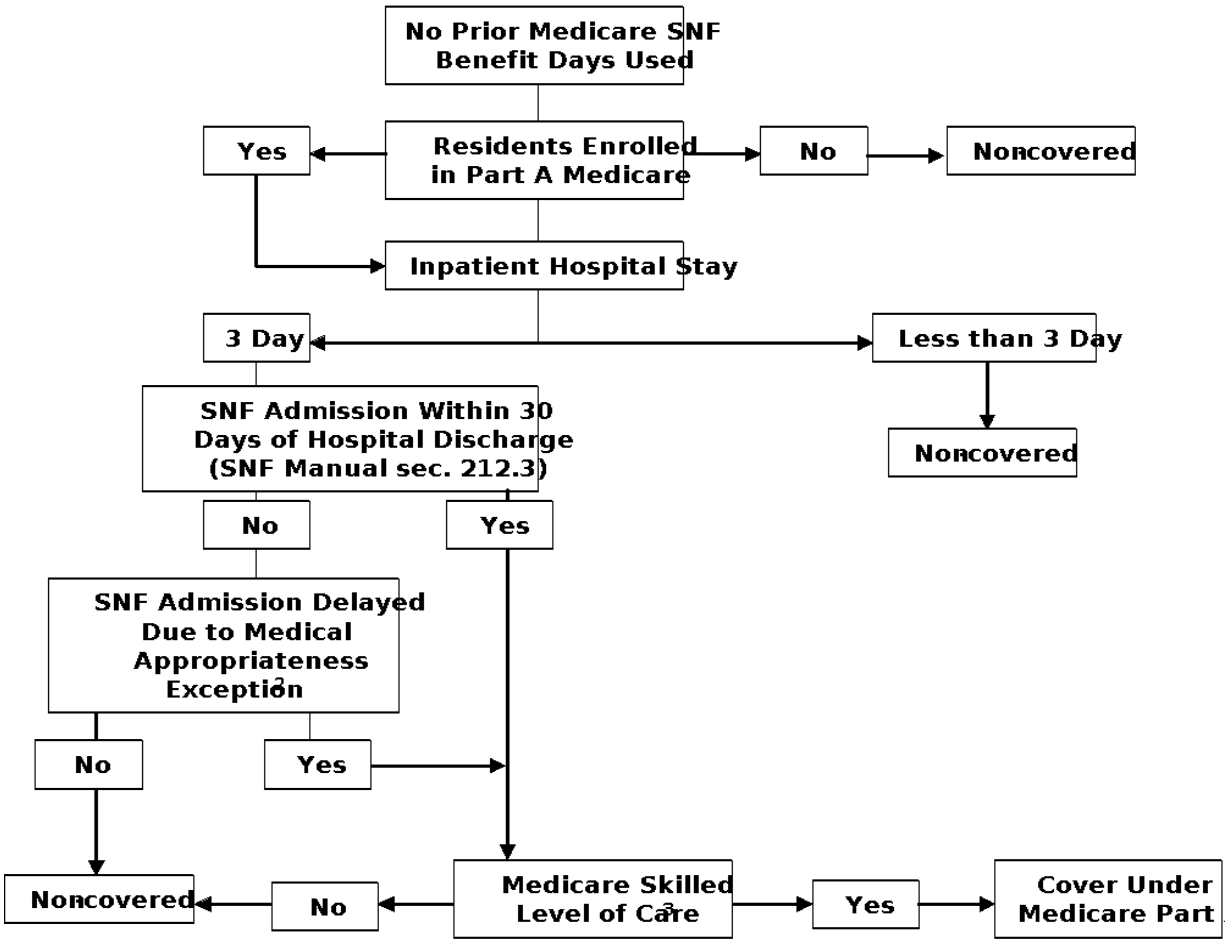
The triggers are specific resident responses for one or a combination of MDS data elements. The triggers identify residents who may either have or be at risk for developing specific functional problems and require further evaluation using the CAAs.

Care Area Assessments (CAAs)

The MDS alone does not provide a comprehensive assessment. The MDS is used for preliminary screening, to identify actual or potential resident problems, strengths and preferences. In addition, the Care Area Assessments provide a framework of problem oriented indicators based on problem identifiers or trigger conditions functioning to facilitate the decision making process and provide a sound basis for the resident care plan.
The following are 20 such identifiers:

- Delirium;
- Cognitive loss/dementia;
- Visual function;
- Communication;
- Activities of Daily Living (ADL) Function/Rehabilitation Potential;
- Urinary Incontinence and Indwelling Catheter;
- Psychosocial Well-Being;
- Mood State;
- Behavior Symptoms;
- Activities;
- Falls;
- Nutritional Status;
- Feeding Tube;
- Dehydration/Fluid Maintenance;
- Dental Care;
- Pressure Ulcer;
- Psychotropic Drug Use;
- Physical Restraints,
- Pain; and,
- Return to Community Referral

MEDICARE BENEFIT PERIOD DECISION TREE



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Federal Register Rules and Regulations

May 12, 1998

The Interim Final Rule implements section 4432 of the Balanced Budget Act of 1997 regarding Medicare payment to skilled nursing facilities. This includes implementation of the Medicare Prospective Payment System (PPS) for the skilled nursing facilities and consolidated billing. The Prospective Payment System (PPS) described in this rule replaces the Retrospective Payment System previously used by Medicare for payment to skilled nursing facilities for Medicare Part A services.

This Interim Final Rule was responded to regarding questions and comments in the July 30, 1999 Federal Register Final Rule. Please refer to the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update beginning on page VI-9 of the manual.

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Federal Register Rules and Regulations

July 30, 1999

The Final Rule responded to comments submitted by the public regarding the Interim Final Rule that implemented the Prospective Payment System for skilled nursing facilities for Medicare Part A services that was legislated in the Balanced Budget Act of 1997. This legislation established the prospective payment system and a consolidated billing provision.

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Reimbursement

Updated Final Rule

Federal Register Rules and Regulations

July 31, 2006

The Updated Final Rule updated the payment rates used under the Prospective Payment System for Skilled Nursing Facilities for fiscal year 2007, effective 10/1/06.

Prospective Payment System and Consolidated Billing For Skilled Nursing Facilities

May 4, 2007

The Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for fiscal year 2008 proposed rule would update the payment rates for PPS for skilled nursing facilities for fiscal year 2008. This proposed rule would also revise and rebase the Skilled Nursing Facility market basket and would modify the threshold for the adjustment to account for market forecast error.

CMS Increases Medicare Payments for Beneficiaries Using Skilled Nursing Facility Care For 2008; Accurate Payments Continue to Ensure Program Efficiency, Quality and Sustainability

Under new Medicare payment rates issued by the Centers for Medicare & Medicaid Services (CMS), Medicare payments for beneficiaries using skilled nursing facility care will increase by approximately $690 million in fiscal 2008. The 3.3 percent increase will be reflected in Medicare payment rates to skilled nursing facilities and hospitals that furnish certain skilled nursing and rehabilitation care to Medicare beneficiaries recovering from serious health problems. The final rule for the skilled nursing facility (SNF) prospective payment system (PPS) was placed on display at the *Federal Register* August 1, 2007.

"These new payment rates reflect our commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the providers who deliver those important services," CMS Acting Administrator Herb Kuhn said. "They will enable nursing homes and Medicare to continue to move forward in providing quality services for patients who need post-acute care. The SNF rule demonstrates our commitment to ensure that Medicare is affordable for current beneficiaries and is sustained for future generations by paying accurately and efficiently."

Under Medicare's SNF PPS, each skilled nursing facility is paid a daily rate based on the relative needs of individual Medicare patients, adjusted for local labor costs. The daily rate covers the costs of furnishing all covered skilled nursing facility services, including routine services such as room, board, nursing services, and some medical supplies together with related costs such as therapies, drugs and lab services; and capital costs including land, buildings and equipment.

CMS uses a skilled nursing facility market basket to measure changes in the prices of an appropriate mix of goods and services included in covered skilled nursing facility stays. The price of items in the market basket is measured each year, and Medicare payments are adjusted accordingly. The final rule revises and rebases the SNF market basket, which currently reflects data from fiscal year 1997, to reflect data from fiscal year 2004.

The new payment rates also continue to include a special adjustment made to cover the additional services required by nursing home residents with HIV/AIDs. "We are confident that the new payment rates will continue to ensure beneficiary access to the important services skilled nursing facilities provide," Mr. Kuhn said.

The following pages contain the SNF PPS final rule (CMS-1545-F) for FY 2008. The final rule was published in the *Federal Register* on Friday, August 3, 2007.

Updated Final Rule
Federal Register Rules and Regulations

August 8, 2008

The Updated Final Rule updated the payment rates used under the Prospective Payment system for Skilled Nursing Facilities for fiscal year 2009, effective 10/1/08.

Elisa/Keri – Do we need this stuff in here????

BIPA

From: Elise D. Smith, J.D., Senior Director of Finance and Managed Care, AHCA

Subject: Questions and Answers on the Skilled Nursing Provisions of the Omnibus Budget Reconciliation Act, H.R. 3194 (Medicare, Medicaid and State Health Insurance Programs (SCHIP) Balanced Budget Refinement Act of 1999, H.R. 3246 (BBRA '99)

DA: December 7, 1999

Introduction

We have received many questions on the various provisions of the BBRA '99. The following Questions and Answers (Q&A) reflect our current understanding of both the skilled nursing facility provisions and HCFA's interpretation of these provisions. HCFA will have to issue a series of Program Memoranda (PMs) to implement the legislation. Therefore, the following answers are subject to any further clarification by HCFA. Attached is a summary chart of the SNF legislation.

Q and A
Going to the Federal Rate – Section 102

1. Q. When can a provider move to the federal rate?

   A. HCFA has indicated that a provider can move to the federal rate at the start of its first cost reporting period on or after January 1, 2000. For example, a provider with a December 31 year end can move to the federal rate starting with its January 1, 2000 cost report; a provider with a June 30 year end cannot move to the federal rate until the start of its July 1 cost reporting period, and a September 30 year end provider cannot move to the federal rate until the start of its October 1, 2000 cost reporting period. AHCA is reviewing this issue to determine if the election can occur prior to the cost reporting period of the facility.

2. Q. How long does a provider have to decide to elect to go to the federal rate?

   A. HCFA has indicated that the provider has 30 calendar days into the cost reporting period to decide and notify its fiscal intermediary of its election to go to the federal rate.

3. **Q. How does provider notify the FI that it wishes to elect the federal rate?**

A. HCFA will shortly issue specific guidance on the requirements related to notification of the FIs. The provider must use this process to notify the FI. Some December 31 year-end providers may be sending a letter to their FI indicating that they wish to elect the federal rate. HCFA cautions that such a letter may not be sufficient and that the prescribed procedures should be used.

4. **Q. Can a provider not elect to go to the federal rate in its second transition year and still be able to elect to go to the federal rate in its third transition year? Can a provider elect to go to the federal rate in its second transition year and reverse that decision in its third transmission year?**

A. There does not appear to be any prohibition in the legislation on a provider postponing its election to go to the federal rate for its third transition year. It is less clear whether a provider may reverse its decision, and HCFA may take the position that it cannot. Hopefully, more details on this issue will be spelled out in HCFA instructions. RUG Add-ons – Section 101.

5. **Q. What RUG categories does the 20% increases affect?**

A. The BBRA '99 provides a 20% increase in the federal adjusted per diem payments for 15 RUG categories covering Extensive Services, Special Care, Clinically Complex, and High Rehabilitation and Medium Rehabilitation – SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC and RMB.

6. **Q. When does the 20% increase take effect?**

A. The increase is for services provided on or after April 1, 2000 and before the later of October 1, 2000 or implementation by the Secretary of a refined case mix classification system.

7. **Q. When will providers know if the Secretary will be ready to implement the case mix refinements?**

A. HCFA has informally indicated that it is on track with the classification modifications and will meet the October 1, 2000 deadline. HCFA will publish the proposed case mix modifications in March of 2000 in a Notice of Proposed Rulemaking and the final modifications in the final rule in July.

8. **Q. What categories does the 4% increases affect?**

A. The BBRA '99 provides an across-the-board 4% increase – the increase is made to the federal adjusted per diem payments for all 45 (44 clinical categories and the default category) RUG categories.

9. **Q. When does the 4% increase take effect?**

A. The 4% increase takes affect in federal fiscal years 2001 and 2002, i.e., October 1, 2000 through September 30, 2002.

10. **Q. Is the 4% add-on to start in October 1, 2000 a substitute for the market basket minus 1% update factor or is it in addition to the market basket minus 1% update factor?**

A. The 4% add-on is in addition to the market basket minus 1% update factor. It does not replace the market basket minus 1% update factor.

11. **Q. Were there any changes to the update factor of market basket minus 1%?**

A. No, as just indicated above, the 4% across the board increase in all RUG rates starting in October 1, 2000 through September 30, 2000 was provided as an addition above the market basket minus 1% update factor which remained untouched. However, Congress in the Conference Agreement language indicated that they believed that the Secretary should ensure the BBA '97 mandate that the SNF market basket index "reflects the changes over time in the prices of an appropriate mix" of goods and services and ensure that modifications adequately reflect the cost of the efficient delivery of medically necessary new medications developed since 1992. Congress stated that it expects the Secretary to:

- evaluate the appropriateness of the SNF market basket index with respect to medications used in the SNF population based on data from the first fiscal year after full implementation of the SNF PPS;
- consider modifications of the current SNF market basket index as appropriate; and
- ensure that the market basket index continues to be responsive to new medications used by the SNF population.

In addition, AHCA has argued to HCFA that the current market basket index seriously understates the actual increase in SNF costs. Among other drawbacks, the current market basket reflects solely input prices and not output prices, i.e., it does not

measure the increase in the intensity of services. AHCA has also argued to HCFA that it has the administrative authority to modify and improve market basket index without further legislation. HCFA has informed AHCA that it is considering issues surrounding a long-term framework which could take into account changes in volume and intensity, and other changes, as well as input prices. AHCA will continue to work with HCFA in order to effect the necessary changes to the market basket in a timely fashion.

12. **Q. What amount is increased by the 20% and 4%?**

A. The 20% and 4% are increases solely of the federal rate. They are increases to the adjusted federal per diem rate. This rate includes the adjustment for case mix, the adjustment for geographic variation in labor costs, and the update factor. The update factor for the federal rate is market basket minus 1% through FY 2002. Starting in FY 2008 (October 1, 2002), the market basket for the federal rate is no longer adjusted by minus 1%.

13. **Q. Are the increases of 20% and 4% built into the base?**

A. No, they are not. They are not compounded, i.e., they are not cumulative. The following is a simplified version of update methodology through FY 2002:

Fiscal Year	Starting Point	Wage Adjustment	BBRA '99 Increase	Payment for the Specific RUG
FY 2000 (April 1, 2000 through September 30, 2000)	Unadjusted federal rate updated by market basket minus 1% and case-mix adjusted (July 30, 1999 Federal Register)	Multiplied by appropriate wage adjustment for the given urban or rural area	Multiplied by 20% for RUGs indicated by BBRA '99	Equals the federal payment rate for the specific RUG in a given urban or rural area
FY 2001	Unadjusted federal rate updated by market basket minus 1% and case-mix adjusted (does not include prior 20% increase)	Multiplied by appropriate wage adjustment for the given urban or rural area	Multiplied by 4% for all RUGs categories	Equals the federal payment rate for the specific RUG in a given urban or rural area
FY 2002	Unadjusted federal rate updated by market basket minus 1%ade case-mix adjusted (does not include prior 4% increase)	Multiplied by appropriate wage adjustment for the urban or rural area	Multiplied by 4% for all RUGs categories	Equals the federal payment rate for the specific RUG in a given urban or rural area

14. **Q. How is the transition rate for providers in their second year of transition established?**

A. The PPS payment will consist of 50% of the provider's facility-specific rate and 50% of the federal rate. Starting in FY 2000 (October 1, 1999), the facility-specific market basket is no longer adjusted by a minus 1%. The update factor for the facility-specific rate is the full market basket increase.

Exclusions to the Federal Rate – Section 103

15. **Q. What services are being excluded from the PPS?**

A. The BBRA '99 excludes the following services from the PPS: ambulance services connected with dialysis, chemotherapy items and administrative services identified by specific codes, radioisotope services identified by specific codes, and customized prosthetic devices identified by specific codes.

16. **Q. Who will bill for the excluded services?**

A. The Part B suppliers of these services will be able to bill Medicare Part B directly. Ambulance companies will now be able to bill for ambulance transportation for SNF dialysis patients, and prosthetics suppliers will be able to bill for the services indicated by the codes in the legislation. Chemotherapy and radioisotope services can be provided and billed by hospital outpatient departments, physicians' offices, or other appropriate suppliers.

17. **Q. Is HCFA required by the BBRA '99 to adjust the PPS payments to account for these exclusions?**

A. Yes, HCFA must adjust PPS payments starting in fiscal year 2001, i.e., starting in October 1, 2000, in order that these reductions be budget neutral.

18. **Q. What will the financial impact of the exclusions be on the federal PPS rate?**

A. The Congressional Budget Office scored these exclusions as having no budgetary affect because of the shift back to Part B billing. However, the exclusions will have some affect on PPS payments. HCFA has not yet determined what the affect will be but has indicated that it believes that it will be small. The Conference Agreement indicates that the intent was to exclude services and costly items that are provided infrequently in SNFs – but, when provided by SNFs, have devastating financial impacts that far exceed the payment received under PPS. The Agreement language calls these services "high cost, low probability events." HCFA appears to be indicating that because of the low frequency of these services in SNFs the adjustment will be de minimis. AHCA will be discussing this issue with HCFA.

19. **Q. Is HCFA prohibited from removing other services from the PPS?**

A. No, HCFA can continued to remove items from the PPS. First, Congress, explicitly in the legislation and Conference Agreement, gives the Secretary, and thus, HCFA, the authority to modify and to add additional items and services in the categories of chemotherapy, radioisotope, and prosthetic items and services. Secondly, HCFA has already indicated in the preamble to the final PPS rule that it has the authority to exclude from PPS items and services that, in its judgment, are within the purview of hospital outpatient departments and not SNFs. It has already excluded several items on this basis in the interim final rule and Program Memorandum A-98-37. AHCA has requested exclusion of further items under this principle which we believe are within the authority of HCFA to exclude.

20. **Q. Will the exclusions provided by the BBRA '99 apply as well to consolidated Part B billing when that is implemented?**

A. Yes, HCFA has indicated that the same exclusions will apply to consolidated Part B billing. Moratorium on Part B Therapy Cap – Section 221.

21. **Q. How long is the moratorium on the Part B therapy caps?**

A. The moratorium is for two years starting with services provided on or after January 1, 2000 and running through December 31, 2001.

22. **Q. What will happen when the moratorium on Part B therapy caps runs out?**

A. Unless there is intervening legislation indicating otherwise, the $1740 cap will automatically be reinstated. The BBRA '99 did not repeal the underlying $1740 therapy cap. Moreover, the implementation of the therapy cap at the end of the moratorium is likely to be the strict cap provided in the Balanced Budget Act (BBA) of 1997 as interpreted by HCFA – an annual per beneficiary limit of $1740 on all Part B outpatient physical therapy services and speech language pathology services; and a separate annual per beneficiary limit on all Part B outpatient occupational therapy services. HCFA had not been able this past year to implement the cap as intended by the BBA '97 and mandated instead that each provider keep track of the cap and not provide services to any beneficiary beyond $1740.

23. **Q. Does the BBRA '99 provide for the development of a substitute for the therapy caps?**

A. Yes, the BBRA '99 provides recommendations from the Secretary for a new payment methodology, but does not provide a date for the implementation of a new system.

The legislation mandates very close study and security of therapy utilization. It provides that:

- The Secretary must conduct, during years 2000 and 2001, focused medical reviews of claims for reimbursement with an emphasis on SNF claims;
- Not later than January 1, 2001, the Secretary shall submit a report to Congress that includes recommendations:
- on the establishment of a mechanism for assuring appropriate utilization of outpatient physical, occupational, and speech language pathology services; and,
- on the establishment of an alternative payment policy for these services based on classification of individuals by diagnostic category, functional status and prior use of services (in both inpatient and outpatient settings and other appropriate criteria in place of the uniform dollar limitations; and
- Not later than June 30, 2001, the Secretary shall submit a report on a study which compares utilization patterns of therapy services provided on or after January 1, 2000 with such patterns for services in 1998 and 1999 and submit recommendations appropriate as a result of the study.

Part B Add-Ons for NHCMQ Demonstration Facilities – Section 104

24. **Q. What is the effective date for the Part B add-ons to the facility-specific rates for the facilities in the Demonstration states?**

A. The BBRA '99 provides that the Part B add-ons are effective as if they had been included in the BBA '97, i.e., payments are retroactive to the initial cost reporting period under PPS for the Demonstration facilities. Consolidated Part B Billing – BBA '97

A. HCFA is currently working on the implementation of consolidated Part B billing. HCFA has indicated that it will be implemented sometime between July and December of 2000. HCFA has reached out to the SNF and supplier industries for input regarding current billing patterns and capabilities, system changes that will be needed, and industry concerns regarding the new system.

25. **Q. Will the exclusions provided by the BBRA '99 apply as well to consolidated Part B billing when that is implemented?**

A. Yes, as indicated above, HCFA has indicated that the same exclusions will apply to consolidated Part B billing. Timeline and HCFA Program Memoranda.

26. Q. What is the timeline of the SNF provisions?

A. The Timeline is as follows:

RUG add-ons – 20% increase in RUGs identified in the BBRA '99	April 1, 2000 through September 30, 2000. (Continues if HCFA fails to make RUG refinements)
4% increase on all 44 RUGs plus default rate	October 1, 2000 to September 30, 2002
Federal rate option	First cost reporting period on or after January 1, 2000 (provider has 30 days into cost reporting period to elect and notify FI)
PPS/consolidated billing exclusions	April 1, 2000
Demonstration facilities Part B add-on	Retroactive to demonstration facilities' first cost reporting period under PPS
Part B therapy cap moratorium	January 1, 2000 through December 31, 2001
Consolidated Part B billing	Possibly between July and December of calendar year 2000

27. Q. What issuances will HCFA have to publish to implement the BBRA '99 and complete implementation of the BBA '97?

A. It would appear that HCFA will have to publish instructions on the following issues through Program Memoranda or other appropriate vehicles:

- Instructions on provider election of the federal rate
- Instructions on moratorium on Part B therapy caps
- Instructions on retroactive application of Part B add-ons for Demonstration facilities
- Instructions on April 1, 2000 20% RUG add-ons
- Instructions on April 1, 2000 PPS exclusions
- Notice of Proposed Rulemaking on refinements to the classification system (NPRM in spring, Final Rule in July, effective date of October 1, 2000)
- Instructions on consolidated Part B billing
- Notice of Proposed Rulemaking and final rule on 4% increase in all rates.

Attachment – BBRA '99 Summary Chart

Omnibus Budget Reconciliation Act (H. R. 3194)

RUG Add-Ons	$200 million in fiscal year 2000 Payment add-ons for 15 RUGs effective April 1, 2000,until Sept. 30, 2000 20% add-ons for RHC, RMC, RMB, SE1, SE2, SE3, SSA, SSB, SSC, CA1, CA2, CC1, CC2, CB1 and CB2. Add-ons pertain to the federal portion of the rate. Continue into fiscal year 2001 if HCFA fails to make adequate RUG refinements
RUG-III Adjustment	Approximately $1.1 billion over 3 years Increases payments for all 45 (44 clinical and the default category) RUGs by 4% Effective between Oct. 1, 2000, and Sept. 30, 2002 The 4% add-ons is in addition to the market basket index minus one percent
Federal Rate Option	$700 million over 3 years Allows SNFs to choose between the higher of current law or 100% of the federal rate for payments Effective for cost reporting periods starting on or after Jan. 1, 2000
Carve-Outs/Exclusions	No Dollar Impact Excludes ambulance services to and from dialysis; prosthetic devices; radioisotopes and chemotherapy from PPS rate Effective for services furnished on or after April 1, 2000
Part $1,500 Caps	$600 million over 3 years Places a 2-year moratorium on implementing the two $1,500 therapy caps effective Jan. 1, 2000, through Jan. 1, 2002
Part B Add-ons for SNFs Participating in the NHCMQ Demonstration Project	$30 million over 3 years A retroactive provision that corrects BBA technical error that denied payment of Part B services to SNFs participating in PPS demonstration projects

PPS Exclusion

Excluded Services	Exclusion Source (effective Date)
Services provided by: ● Physicians ● Midwives ● Psychologists ● Nurse ● Anesthetists ● Certain dialysis-related services and drugs	BBA (July (1998)
Certain outpatient services when provided in a hospital (including associated medically indicated ambulance transport): ● Cardiac catheterization ● Computerized axial tomography (CT) scans MRI ● Ambulatory surgery performed in operating rooms ● Emergency services ● Radiation therapy* ● Angiography* ● Lymphatic and venous procedures*	HCFA Interim Final Rule (July 1998) and HCFA Program Memorandum (November 1998)
Specified chemotherapy items and services: ● Radioisotope services ● Customized prosthetic devices ● Ambulance transportation for dialysis	BBRA (April 2000)
* The Interim Final Rule identified broad service categories of services to exclude. The subsequent Program Memorandum issued by HCFA identified specific billing codes within these broad categories. Source: GAO analysis.	

Note: HCFA defined SNF resident in such a way as to exclude those who are receiving "small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would ordinarily furnish". HCFA Program Memorandum, Transmittal No. A98-37 (Nov. 1998).	

Resource Utilization Groups
Resource utilization group (rug), version iv

The RUG-IV system replaced the RUG-III for Medicare starting on October 1, 2010. For Medicare billing purposes, there is a payment code associated with each of the 66 RUG-IV groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments *timely* are paid a *default* payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities must send each beneficiary's MDS assessment to the State and claims for Medicare payment to the fiscal intermediary (FI) or MAC on a 30-day cycle.

The RUG-IV Classification system utilizes patient characteristics and health status information, e.g., diagnosis, ADL performance ability and treatment received, and places the resident into a resource utilization group for payment purposes.

The RUG-IV classification represents the following:

- Eight major categories representing the first level of classification;
- The categories, except for extensive services are then subdivided into 63 groups based on ADL scores, nursing rehabilitation and signs of depression, taken from MDS data elements; and,
- Arranged in hierarchical order (highest utilization in the top group) based upon amount and type of service or resource utilized.

Beneficiaries that are classified to any of the highest 52 of the 66 RUG-IV groups are considered to meet the SNF level of care definition found in the Medicare Intermediary Manual (MIM). The RUG classification system allows for an expedited determination that a beneficiary in one of the upper 52 groups meets the SNF level of care requirements, and for assignment to an appropriate payment category. However, it does not supersede any coverage requirements related to a specific service, or the overall requirement that the services provided to the beneficiary be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Health Insurance PPS (HIPPS) Code Defined

The Health Insurance PPS (HIPPS) rate code consists of the RUG-IV code, which is obtained from the Grouper software program and a two digit assessment indicator (Attachment M *HIPPS Modifiers*). SNFs must use the version of the Grouper software program identified by HCFA for national PPS as described in the Federal Register for that year. The Grouper translates the MDS data into a case mix-group and assigns the correct RUG-IV code. The assessment indicators were derived by HCFA using the codes in the current version of the RAI.

Both components of the HIPPS rate code must be present on a claim or the claim will be rejected. The grouper will not automatically assign the two-digit indicator. The assessment indicator must be assigned manually, unless the software used by the provider has been updated to include this feature.

The HIPPS rate code that appears on the HCFA 1450 UB04 claim form must match the locked assessment. The SNF cannot put a HIPPS rate code on the HCFA 1450 UB04 claim form that does not match the locked assessment. The first three digits of item T3 (Medicare case-mix) in the current version of the MDS and the first three digits of the HIPPS rate code on the HCFA 1450 UB04 claim form must be identical. The last two digits of item T3 in the current version of the MDS will be "07" while the last two digits of the HIPPS rate code on the HCFA 1450 UB04 claim form will be the two digit assessment indicator which describes the reason for the assessment. A SNF cannot bill for a covered day until that day has actually been used and an assessment has been transmitted for those billable days.

Classification grid
RUG-IV

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Rehabilitation/ Extensive Services				
Ultra High RUX RUL		11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • Received 720 minutes/week minimum AND • At least 1 discipline for at least 5 days AND • 2nd discipline for at least 3 days AND • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND • ADL score > =2	O0400, A,B,C, 1,2,3,3A,4 AND O0100E2,O0100F2 or O0100M2
Very High RVX RVL		11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • Rx 500 minutes/week minimum AND • One discipline at least 5 days/week AND • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND • ADL score > =2	O0400, A,B,C, 1,2,3,3A,4 AND O0100E2,O0100F2 or O0100M2
High RHX RHL		11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • 325 Total Therapy Minutes minimum AND • At least 1 discipline -5 days AND • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND • ADL score > =2	O0400, A,B,C, 1,2,3,3A,4 AND O0100E2,O0100F2 or O0100M2

Classification Grid
RUG-IV

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Rehabilitation/ Extensive Services (Continued)				
Meduim RMX RML		11-16 2-10	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • 150 Total Therapy Minutes minimum AND • At least 5 distinct calendar days of any combination of the three disciplines AND • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND • ADL score> =2	O0400, A,B,C, 1,2,3,3A,4 AND O0100E2,O0100F2 or O0100M2
Low RLX		2-16	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. • 45 minutes Total Therapy Minutes minimum AND • At least 3 distinct calendar days of any combination of the 3 disciplines AND • Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services) AND • Tracheostomy care, ventilator/respirator or isolation for active infectious disease while a resident AND • ADL score > =2	O0400, A,B,C, 1,2,3,3A,4 AND O0100E2,O0100F2 or O0100M2 AND 0500 A-J

Extensive Services qualification based on ADL Sum > 2 and one of the following services:

- Tracheostomy Care
- Ventilator / Respirator OR
- Isolation for active infectious disease while a resident

Classification Grid
RUG-IV

RUG Level	ADL Score	Requirements	MDS 3.0 Section
Special Rehabilitation			
Ultra HIgh RUC RUB RUA	11-16 6-10 0-5	In last 7 days: • Received 720 minutes/week minimum AND • At least 1 discipline for at least 5 days AND • 2nd discipline for at least 3 days	O0400, A,B,C, 1,2,3,3A,4
Very High RVC RVB RVA	11-16 6-10 0-5	In last 7 days: • 500 Total Therapy Minutes minimum AND • At least 1 discipline for at least 5 days	O0400, A,B,C, 1,2,3,3A,4
High RHC RHB RHA	11-16 6-10 0-5	In last 7 days: • 325 Total Therapy Minutes minimum AND • At least 1 discipline for at least 5 days	O0400, A,B,C, 1,2,3,3A,4
Medium RMC RMB RMA	11-16 6-10 0-5	In last 7 days: • 150 Total Therapy Minutes minimum AND • At least 5 distinct calendar days of any combination of the three disciplines	O0400, A,B,C, 1,2,3,3A,4
Low RLB RLA	11-16 0-10	In last 7 days: • 45 minutes Total Therapy Minutes minimum AND • At least 3 distinct calendar days of any combination of the 3 disciplines AND	O0400, A,B,C, 1,2,3,3A,4 AND 0500 A-J

			• Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services)	
Extensive Services				
			Residents receiving the following complex clinical care: • Tracheostomy Care OR • Ventilator / Respirator OR • Isolation for active infectious disease while a resident AND • ADL score >=2 Notes: Qualifiers count for end splits	O0100E2 O0100F2 O0100M2
ES3		2-16	• Tracheostomy care (while a resident) AND • Ventilator / Respirator (while a resident)	O0100E2 O0100F2
ES2		2-16	• Tracheostomy care (while a resident) OR • Ventilator / Respirator (while a resident)	O0100E2 O0100E2
ES1		2-16	• Isolation for active infectious disease (while a resident)	O0100M2

Classification Grid
RUG-IV

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Special Care High				
HE2	Yes	15-16	Residents receiving the following complex clinical care or with a following medical condition: • Comatose and completely ADL dependent • Septicemia • Diabetes with daily injections requiring physician order changes on 2 or more days • Quadriplegia and ADL score > = 5 • Chronic obstructive pulmonary disease and shortness of breath when lying flat • Fever with - Pneumonia - Vomiting - Feeding tube with intake requirements entire 7 Days - Weight loss • Parenteral/IV feedings • Respiratory therapy for 7 days AND • ADL score > =2 Notes: Signs of depression used for end splits; PHQ score =>10	B0100 I2100 I2900; N0350,A,B I5100 I6200, J1100C J1550,A, I2000 J1550, B K0710, A,B,3 K0300 K0510,A,1,2 O0400,D D0300,D0600
HE1	No	15-16		
HD2	Yes	11-14		
HD1	No	11-14		
HC2	Yes	6-10		
HC1	No	6-10		
HB2	Yes	2-5		
HB1	No	2-5		

Special Care Low				
LE2 LE1 LD2 LD1 LC2 LC1 LB2 LB1	Yes No Yes No Yes No Yes No	15-16 15-16 11-14 11-14 6-10 6-10 2-5 2-5	*Residents receiving the following complex clinical care or with a following medical condition:* • Cerebral palsy and ADL score >=5 • Multiple sclerosis and ADL score >=5 • Parkinson's disease and ADL score >=5 • Feeding tube (calories ≥ 51% or calories = 26-50% and fluid ≥ 501 cc) entire 7 Days • Ulcers with 2 or ulcer treatments (M1200A or B,C,E,D,G,H) ▪ 2 or more stage II ▪ 1 or more stage III or IV pressure ulcers ▪ Unstageable secondary to slough/eschar ▪ 2 or more venous/arterial ulcers OR ▪ 1 stage II pressure ulcer AND ▪ 1 venous/arterial ulcer • Foot infection, diabetic foot ulcer or open lesions on the foot with dressing (M1200I) • Radiation therapy while a resident • Respiratory failure and oxygen therapy while a resident • Dialysis while a resident AND • ADL score >=2 Notes: Signs of depression used for end splits; PHQ score =>10	I4400 I5200 I5300 K0710,A,B,3 M0800,A M0800,B,C M1030 M-0800,A M1030 M1040,A,C O0100,B,2 I6300 O0100C O0100,J,2 D0300,D0600

Classification Grid
RUG-IV

RUG Level		ADL Score	Requirements	MDS 3.0 Section
Clinically Complex				
CE2	Yes	15-16	Residents with Extensive Services, Special Care High or Special Care Low qualifier. AND • ADL score = 0-1 OR Residents with any one of the following clinically complex qualifiers: • Pneumonia • Hemiplegia and ADL score >=5 • Surgical wounds or open lesions with surgical wound care OR application of dressing/ointment not to feet (M1200F,G or H) • Burns • Chemotherapy while a resident • Oxygen while a resident • IV medications while a resident • Transfusions while a resident Notes: Signs of depression used for end splits: PHQ score =>10	I2000 I4900 M1040,E M1040,F O0100,A,2 O0100,C,2 O0100,H,2 O0100,I,2 D0300,D0600
CE1	No	15-16		
CD2	Yes	11-14		
CD1	No	11-14		
CC2	Yes	6-10		
CC1	No	6-10		
CB2	Yes	2-5		
CB1	No	2-5		
CA2	Yes	0-1		
CA1	No	0-1		
Behavioral Symptoms and Cognitive				
BB2	*	2-5	Residents having cognitive impairment BIMS score<=9 or CPS >=3 OR • Hallucinations or delusions OR Residents displaying any of the following on 4 or more days over last 7 days: • Physical or verbal behavioral symptoms toward others • Other behavioral symptoms • Rejection of care	C0500,C700,C1000 E0100A E0100B
BB1	**	2-5		
BA2	*	0-1		
BA1	**	0-1		

	* 2 or more Restorative Services 6+ days ** Less Restorative Nursing		• Wandering AND • ADL score <=5 • Notes: Restorative nursing used for end splits. See Reduced Physical Function for restorative nursing services count	E0200,A,B,C E0300 E800 E0900

Classification Grid
RUG-IV

RUG Level	Restorative Nursing	ADL Score	Requirements	MDS 3.0 Section
Reduced Physical Functioning				
E2 PE1 PD2 PD1 PC2 PC1 PB2 PB1 PA2 PA1	* ** * ** * ** * ** * ** *2 or more Restorative Services 6+ days **Less Restorative Nursing	15-16 15-16 11-14 11-14 6-10 6-10 2-5 2-5 0-1 0-1	Residents whose needs are primarily for activities of daily living and general supervision. • Residents not qualifying for other categories • Restorative nursing services: ▪ Current Urinary and/or bowel training program ▪ Passive and/or active ROM ▪ Amputation/prosthesis care training ▪ Splint or brace assistance ▪ Dressing or grooming training ▪ Eating or swallowing training ▪ Transfer training ▪ Bed mobility and/or walking training ▪ Communication training ` Notes: No clinical variables used	0500,A-J H0200C/H0500

RUG-IV 66-Group Model Calculation Worksheet for SNFs

The purpose of this RUG-IV Version 1.00 calculation worksheet for the 66-group model is to provide a step-by-step walk-through to manually determine the appropriate RUG-IV Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to ensure that it represents the standard logic.

In the RUG-IV 66-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups, representing 10 different levels of rehabilitation services. In the 66-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 66-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care High groups, the Special Care Low groups, the Clinically Complex groups, the Behavioral Symptoms and Cognitive Performance groups, and the Reduced Physical Function groups.

There are two basic approaches to RUG-IV Classification:

- Hierarchical classification and
- Index maximizing classification.

The current worksheet was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below (see “Index Maximizing Classification”). Note that the RUG classification used for Medicare PPS Part A billing is based on the index maximizing approach.

Hierarchical Classification: The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the RUG-IV model; the assigned classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-IV model. Then go down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 66 individual RUG-IV groups for which the resident qualifies, assign that group as the RUG-IV classification.

If the resident qualifies in the Extensive Services group and a Special Care High group, always choose the Extensive Services classification because it is higher in the hierarchy. Likewise, if the

resident qualifies for Special Care Low and Clinically Complex, always choose Special Care Low. In hierarchical classification, always pick the group nearest the top of the model.

Index Maximizing Classification: Index maximizing classification is used in Medicare PPS (and most Medicaid payment systems) to select the RUG-IV group for payment. There is a designated Case Mix Index (CMI) that represents the relative resource utilization for each RUG-IV group. For index maximizing, first determine all of the RUG-IV groups for which the resident qualifies. Then, from the qualifying groups, choose the RUG-IV group that has the highest CMI. For Medicare PPS, the index maximizing method uses the CMIs effective for the appropriate Federal Fiscal Year.
While the following worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. For index maximizing, evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, again start at the beginning of the worksheet. Then work down through all of the 66 RUG-IV Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When finished, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

Non-Therapy Classification: In some instances, the SNF provider may be required to report, on the SNF Medicare claim, a non-therapy RUG-IV classification according to the SNF PPS policies (as noted elsewhere in this chapter, Chapter 8 of the **Medicare Benefit Policy Manual**, and Chapter 6 of the **Medicare Claims Processing Manual**). The non-therapy classification uses all the RUG-IV payment items except the rehabilitation therapy Items (O0400A, B, C) to determine a non-therapy, clinical RUG. To obtain a non-therapy RUG with this worksheet, skip Category I (Rehabilitation Plus Extensive Services) and Category II (Rehabilitation) and start with Category III (Extensive Services). Both the standard Medicare Part A RUG reported in Item Z0100A and the Medicare Part A non-therapy RUG in Item Z0150A are recorded on the MDS 3.0. When rehabilitation services are not provided, the standard Medicare Part A RUG will match the Medicare Part A non-therapy RUG.

Calculation Of Total "ADL" Score
RUG-IV, 66-GROUP Hierarchical Classification

The ADL score is a component of the calculation for placement in all RUG-IV groups. The ADL score is based upon the four "late loss" ADLs (bed mobility, transfer, toilet use, and eating), and this score indicates the level of functional assistance or support required by the resident. It is a very important component of the classification process.

Step 1

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I). **Enter the ADL score for each item.**

Self-Performance Column 1 =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A = ___
2	and	(any number)	1	G0110B = ___
3	and	-, 0, 1, or 2	2	G0110I = ___
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

Step 2

To calculate the ADL score for eating (G0110H), use the following chart. Enter ADL score.

Self-Performance Column 1 (G0110H) =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 2, 7, or 8	and	-, 0, 1, or 8	0	G0110H = __
-, 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	-, 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

Step 3

Add the four scores for the total ADL score. This is the **RUG-IV TOTAL ADL SCORE.** The total ADL score ranges from 0 through 16.

TOTAL RUG-IV ADL SCORE _____

Other ADLs are also very important, but the research indicates that the late loss ADLs predict resource use most accurately. The early loss ADLs do not significantly change the classification hierarchy or add to the prediction of resource use.

Calculation of Total Rehabilitation Therapy Minutes

RUG-IV, 66-GROUP Hierarchical Classification

For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and all minutes in group therapy for non-Medicare classification. For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes.

Skip this section if therapy is not provided.

In Steps 1 through 3 in calculating Rehabilitation Therapy Minutes, retain all decimal places in the calculated values. Values where decimal points are retained are indicated by an asterisk (*).

Step 1

Calculate the total minutes for speech-language pathology services as follows:

Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400A3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Speech-Language Pathology Services Minutes* = _____

Step 2

Calculate the total minutes for occupational therapy as follows:

Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400B3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes* = _____

Step 3

Calculate the total minutes for physical therapy as follows:

Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400C3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes* = _____

Step 4

Sum the speech-language pathology services minutes, occupational therapy minutes, and physical therapy minutes and record as Total Therapy Minutes. These are the minutes that will be used for RUG-IV rehabilitation therapy classification (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used).

Total Therapy Minutes^ = _____

Total Therapy Minutes is not rounded. Record only the whole number with all values after the decimal dropped.

Total Rehabilitation Therapy Minutes Calculation Example

Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services during FY2012 (group therapy time is allocated) as follows:

Speech-language Pathology Services:

Individual minutes = 110 (Item O0400A1),
Concurrent minutes = 99 (Item O0400A2),
Group minutes = 100 (Item O0400A3).
Calculate total SLP minutes = 110 + 99/2 + 100/4 = 184.5 (retain the decimal).
Check group proportion (after group allocation) = (100/4)/184.5 = 0.136.
Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25.
Use unadjusted total SLP minutes.

Total Speech-Language Pathology Services Minutes = **184.5** (retain the decimal).

Occupational Therapy:

Individual minutes = 78 (Item O0400B1),
Concurrent minutes = 79 (Item O0400B2),
Group minutes = 320 (Item O0400B3).
Calculate total OT minutes = 78 + 79/2 + 320/4 = 197.5 (retain the decimal).
Check group proportion = (320/4)/197.5 = 0.405.
Adjust OT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Occupational Therapy Minutes = [(78 + 79/2) x 4]/3 = **156.6666** (retain the decimal).

Physical Therapy:

Individual minutes = 92 (Item O0400C1),
Concurrent minutes = 93 (Item O0400C2),
Group minutes = 376 (Item O0400C3).
Calculate total PT minutes = 92 + 93/2 + 376/4 = 232.5 (retain the decimal).
Check group proportion = (376/4)/232.5 = 0.404.
Adjust PT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Physical Therapy Minutes = [(92 + 93/2) x 4]/3 = **184.6666** (retain the decimal).

Total Adjusted Therapy Minutes:

Sum SLP, OT and PT minutes after any adjustment= 184.5 + 156.6666 + 184.6666 = 525.8332

Drop decimals = **525 minutes**

(this is the total therapy minutes value for RUG-IV classification).

Medicare Short Stay Assessment
RUG-IV, 66-GROUP Hierarchical Classification

Step 1

Set the Medicare Short Stay Indicator (Z0100C) as follows:

RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.

2. **A PPS 5-day (Item A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.

3. **The ARD (Item A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare covered stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.

4. **The ARD (Item A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.

5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.

6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A stay (including weekends).** The end of Medicare stay date (Item A2400C) minus the earliest start date for the three therapy disciplines (Items O0400A5, O0400B5, or O0400C5) must be 3 days or less.

7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (Items O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (Item A2400C). Therapy is considered to be ongoing when:
    - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
    - The resident's SNF benefit exhausted and therapy continued to be provided, or
    - The resident's payer source changed and therapy continued to be provided.

8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Item Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

If all eight conditions are satisfied, record "Yes" in the Medicare Short Stay Assessment Indicator Z0100C); otherwise record "No."

Medicare Short Stay Assessment Indicator Yes_____ No_____

Step 2

If the Medicare Short Stay Assessment Indicator is "Yes," then calculate the Medicare Short Stay Average Therapy Minutes as follows:

This average is the Total Therapy Minutes (calculated above in Calculation of Total Rehabilitation Therapy Minutes) divided by the number of days from the start of therapy (earliest date in O0400A5, O0400B5, and O0400C5) through the assessment reference date (A2300). For example, if therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days. Discard all numbers after the decimal point and record the result.

Medicare Short Stay Average Therapy Minutes = _____

See Section 6.4 of the RAI Manual for the Medicare Short Stay Assessment Algorithm.

Category I: Rehabilitation Plus Extensive Services
RUG-IV, 66-GROUP Hierarchical Classification

Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

Step 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, **go to Step #2.**
If the ADL score is less than 2, skip to Category II now.

Step 2

Determine whether the resident is coded for **one** of the following treatments or services:
O0100E2 Tracheostomy care while a resident O0100F2 Ventilator or respirator while a resident O0100M2 Infection isolation while a resident
If the resident does not receive one of these treatments or services, skip to Category II now.

Step 3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

- **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
    1. In the past 7 days:
        Total Therapy Minutes (calculated on page 6-25 – 6-28) of 720 minutes or more
        and
        One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
        and
        A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

RUG IV ADL Score	RUG-IV Class
11-16	RUX
2-10	RUL

- Very High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more

and

At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RVX
2-10	RVL

- High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more

and

At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RHX
2-10	RHL

- Medium Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more

and

At least 5 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RMX
2-10	RML

- Low Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more

and

At least 3 days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4)

and

Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes.

*Restorative Nursing Services
H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

**Count as one service even if both provided.

RUG-IV ADL Score	RUG-IV Class
2-16	RLX

RUG IV Classification_____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

Category II: Rehabilitation

RUG-IV, 66-GROUP Hierarchical Classification

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

Step 1

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

A. **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

   Total Therapy Minutes (calculated on page 6-25 - 6-28) of 720 minutes or more

   and

   One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

   and

   A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more.

RUG-IV ADL Score	RUG-IV Class
11-16	RUC
6-10	RUB
0-5	RUA

B. **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

   Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more

   and

   At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RVC
6-10	RVB
0-5	RVA

C. High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more

and

At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RHC
6-10	RHB
0-5	RHA

D. Medium Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more

and

At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4)

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes.

RUG-IV ADL Score	RUG-IV Class
11-16	RMC
6-10	RMB
0-5	RMA

E. **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more

and

At least 3 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)

and

Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day.

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes.

*Nursing Restorative Services
H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

**Count as one service even if both provided.

RUG-IV ADL Score	RUG-IV Class
11-16	RLB
0-10	RLA

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category III.

Category III: Extensive Services
RUG-IV, 66-GROUP Hierarchical Classification

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

Step 1

Determine whether the resident is coded for **one** of the following treatments or services:

- O0100E2 Tracheostomy care while a resident
- O0100F2 Ventilator or respirator while a resident
- O0100M2 Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category IV now.

Step 2

If at least **one** of these treatments or services is coded and the resident has a total RUG-IV ADL score of 2 or more, he/she classifies as Extensive Services. **Move to Step 3. If the resident's ADL score is 0 or 1, s/he classifies as Clinically Complex. Skip to Category VI, Step 2.**

Step 3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	RUG-IV Class
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Infection isolation* **without** tracheostomy care* **without** ventilator/respirator*	ES1

RUG-IV Classification _____

If the resident does not classify in the Extensive Services Category, proceed to Category IV.

Category IV: Special Care High
RUG-IV, 66-GROUP Hierarchical Classification

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step 1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A,B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score >= 5
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube* K0510A1 or K0510A2 Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:
(1) K0700A is 51% or more of total calories OR
(2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

Step 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step 3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step 2.**

Step 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Step 4

Select the Special Care High classification based on the ADL score and the presence or absence of depression record this classification:

RUG-IV ADL Score	Depressed	RUG-IV Class
15-16	Yes	HE2
15-16	No	HE1
11-14	Yes	HD2
11-14	No	HD1
6-10	Yes	HC2
6-10	No	HC1
2-5	Yes	HB2
2-5	No	HB1

RUG-IV Classification _____

Category V: Special Care Low
RUG-IV, 66-Group Hierarchical Classical

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step 1

Determine whether the resident is coded for one of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score >=5
I5200, ADL Score	Multiple sclerosis, with ADL score >=5
I5300, ADL Score	Parkinson's disease, with ADL score >=5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:
(1) K0700A is 51% or more of total calories OR
(2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.
**Selected skin treatments:
M1200A,B# Pressure relieving chair and/or bed
M1200C Turning/repositioning
M1200D Nutrition or hydration intervention
M1200E Ulcer care
M1200G Application of dressings (not to feet)
M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VI now.

Step 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care Low. **Move to Step 3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex.** Skip to Category VI, Step 2.

Step 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are indentified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Step 4

Select the Special Care Low classification based on the ADL score and the presence or absence of depression; record this classification:

RUG-IV ADL Score	Depressed	RUG-IV Class
15-16	Yes	LE2
15-16	No	LE1
11-14	Yes	LD2
11-14	No	LD1
6-10	Yes	LC2
6-10	No	LC1
2-5	Yes	LB2
2-5	No	LB1

RUG-IV Classification _____

Category VI: Clinically Complex
RUG-IV, 66-Group Hierarchical Classification

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

Step 1

Determine whether the resident is coded for **one** of the following conditions or services:

I2000	Pneumonia
I4900, ADL Score	Hemiplegia/hemiparesis with ADL score >=5
M1040D, E	Surgical wounds or open lesions with any selected skin treatment*
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen therapy while a resident
O0100H2	IV medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments
M1200F Surgical wound care
M1200G Application of dressing (not to feet)
M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VII now.

Step 2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are indentified by the Resident Mood Interview (PHQ-9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, section D. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

Step 3

Select the Clinically Complex classification based on the ADL score and the presence or absence of depression record this classification:

RUG-IV ADL Score	Depressed	RUG-IV Class
15-16	YES	CE2
15-16	NO	CE1
11-14	YES	CD2
11-14	NO	CD1
6-10	YES	CC2
6-10	NO	CC1
2-5	YES	CB2
2-5	NO	CB1
0-1	YES	CA2
0-1	NO	CA1

RUG-IV Classification _____

Category VII: Behavioral Symptoms And Cognitive Performance
RUG-IV, 66-Group Hierarchical Classification

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

Step 1

Determine the resident's ADL score. If the resident's ADL score is 5 or less, go to Step #2.
If the ADL score is greater than 5, skip to Category VIII now.

Step 2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for Item C0100), skip the remainder of this step and proceed to Step 3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Determine whether the resident is cognitively impaired. If the resident's Summary Score is less than or equal to 9, he or she is cognitively impaired and classifies in the Behavioral Symptoms and Cognitive Performance category. Skip to Step 5.

If the resident's summary score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step 3 to check staff assessment for cognitive impairment.

Step 3

Determine whether the resident is cognitively impaired based on the staff assessment rather than on resident interview. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.

The resident is cognitively impaired if **one** of the three following conditions exists:

1. B0100		Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all = 4 or 8)
2. C1000		Severely impaired cognitive skills (C1000 = 3)
3. B0700, C0700, C1000		Two or more of the following impairment indicators are present:
	B0700 > 0	Problem being understood
	C0700 = 1	Short-term memory problem
	C1000 > 0	Cognitive skills problem
		and
		One or more of the following severe impairment indicators are present:
		B0700 >= 2 Severe problem being understood
		C1000 >= 2 Severe cognitive skills problem

If the resident meets the criteria for being cognitively impaired, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Skip to Step 5. If he or she does not present with a cognitive impairment as defined here, proceed to Step 4.

Step 4

Determine whether the resident presents with one of the following behavioral symptoms:

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Proceed to Step 5. If he or she does not present with behavioral symptoms or a cognitive impairment, skip to Category VIII.

Step 5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

Step 6

Select the final RUG-IV Classification by using the total RUG-IV ADL score and the Restorative Nursing Count.

RUG-IV ADL Score	Restorative Nursing	RUG-IV Class
2-5	2 or more	BB2
2-5	0 or 1	BB1
0-1	2 or more	BA2
0-1	0 or 1	BA1

RUG-IV Classification _____

Category VIII: Reduced Physical Function
RUG-IV, 66-Group Hierarchical Classification

Step 1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a RUG-IV ADL score greater than 5, are placed in this category.

Step 2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

Step 3

Select the RUG-IV Classification by using the RUG-IV ADL score and the Restorative Nursing Count.

RUG-IV ADL Score	Restorative Nursing	RUG-IV Class
15-16	2 or more	PE2
15-16	0 or 1	PE1
11-14	2 or more	PD2
11-14	0 or 1	PD1
6-10	2 or more	PC2
6-10	0 or 1	PC1
2-5	2 or more	PB2
2-5	0 or 1	PB1
0-1	2 or more	PA2
0-1	0 or 1	PA1

RUG-IV Classification _____

Certified Bed Change Request

July 24, 2000

To: All Medicaid Certified Nursing Facility (NF) and
Medicare Certified Skilled Nursing Facility (SNF Providers

Re: Provider Letter 00-26 -- Requests for Changes in Bed Size and Changes in Designated Beds Location(s)
(Replaces Provider Letter 99-16)

The purpose of this letter is to inform providers of the Health Care Financing Administration's revised policy regarding the rules for bed changes in Medicare and/or Medicaid distinct parts. These rules are referenced in Section 3202 of the State Operations Manual and became effective June 1, 2000.

The term **distinct part** refers to a **portion** of a facility that is certified to provide either Medicare or Medicaid services or both. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, a separate building, a floor, a hallway or one side of a corridor. Also, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building, or floors or wards that are located throughout several different buildings within the same institutional complex. However, the beds in one certified distinct part must not be commingled with beds in another distinct part, or with non-participating beds.

Changes in Bed Size

A change in bed size, for the purpose of this policy, constitutes an **increase or decrease** in the size of a facility's Medicare and/or Medicaid distinct part. Certified nursing facilities may change the size of its distinct part **up to two times per cost reporting year.** Facilities may submit only one request for a change in bed size at a time. However, two decreases in bed size, within the same cost reporting year, will not be permitted. Facilities that undergo a change of ownership or change their cost reporting year are not exempt from the following bed change procedures:

- Requests for changes in bed size must be **received** in state office **45 calendar days** before

- the first day of its cost reporting year, if the effective date is to be on the first day of the cost reporting year or;

- the first day of a single cost reporting quarter within the same cost reporting year, if the effective date is to be on the first day of the designated cost reporting quarter.

Note: For a facility to change the size of its distinct part up to two times per cost reporting year, the first request must be received in state office 45 calendar days before the first day of the cost reporting year, otherwise, only one change in bed size can be made for that year.

- The request must be accompanied by floor plans and a list that identifies the current bed configuration and proposed bed configuration in order to determine whether the proposed change conforms with the rules for distinct part certification or full participation, whichever applies (see page 3, number 2 for definition of full participation).

- The request must also include a reference to the facility's cost reporting year. If there has been a change in the cost reporting year, submit a copy of the fiscal intermediary's letter approving the change in cost reporting year.

A request for a change in the bed size cannot be approved on a retroactive basis; any change is made on a prospective basis only. The state office Facility Enrollment Section is responsible for advising the intermediary and updating OSCAR/ODIE of any changes in bed size that it approves.

There are certain situations which warrant an exception to the policy. Therefore, even if a facility has been approved for changes in bed size in accordance with the policies articulated above, the facility may be granted an additional change in bed size on the basis of one of the following situations. A bed change request, based on one of the following situations must be received in state office 45 calendar days before the first day of its next cost reporting quarter, along with floor plans and a list that identifies the current bed configuration and proposed bed configuration.

1. Life Safety Code (LSC) Requirements -- An exception may be granted if the request is to reduce the size of its distinct part to avoid being out of compliance with LSC requirements (e.g. sprinkler installation). The proposed bed configuration must be separated from the rest of the facility by a two-hour fire wall, so that there is no danger of the fire spreading from other parts of the facility not meeting the safety requirements. In this case, the proposed reduction in the size of the distinct part may be established with an effective date that is requested by the facility, but the effective date may not be earlier than the date the surveyor has verified that a two-hour fire wall exists. If the reason for the request is to avoid noncompliance with LSC requirements, a full survey by the fire authority must be performed.

2. **Elimination of Distinct Part** -- An exception may be granted if a facility wants to become fully participating. If a facility decides to become fully participating, it cannot return to distinct part certification until, at the earliest, the beginning of its next cost reporting year.

   Note: An institution is **fully participating** when the **entire** institution (**all** beds within the institution or institutional complex) are certified to participate in either the Medicare **or** Medicaid program, **or** both.

   A bed that is both Medicare (SNF) **and** Medicaid (NF) certified is a **dually participating** (SNF/NF) bed. Dually participating beds must also be in a distinct part, that is comprised of only dually participating beds and may not be intermingled with SNF only, NF only or non-participating beds.

3. **Enlargement Through Construction, Purchase or Lease of Additional Space** -- An exception may be granted if the facility requests to increase the size of the distinct part to include space acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

Changes in Designated Bed Locations

A change in designated bed locations, for the purpose of this policy, refers to a change in the location of beds without a change in the **size** of a facility's distinct part. A facility may request a change in designated bed locations as long as there is no change in the number of beds certified to participate in the Medicare and/or Medicaid program, **and** the request is **received** in state office **30 calendar days** before the actual change. In addition, the facility must submit floor plans that identify the current bed configuration and proposed bed configuration in order to determine whether the proposed change conforms with the rules for distinct part certification or full participation, whichever applies. **The request must be approved before the facility makes the change.** No changes may be made on a retroactive basis.

Facilities must adhere to the notification requirements found in 42 CFR 483.10(b)(11)(ii)(A) and the residents rights requirements found in 42 CPR 483.10(o) when requesting bed changes. Facilities must also adhere to the rules on bed allocation, reallocation and decertification found in TAC 19.2332 of the "Nursing Facility Requirements for Licensure and Medicaid Certification."

For any bed change request to be considered complete, **all** accompanying information must be received with a request. Incomplete requests will not be processed. All facilities must refer to the attached procedures ("Instructions for Requesting Changes in Bed Size in Certified Nursing Facilities and Skilled Nursing Facilities" and "Instructions for Requesting Changes in Designated

Bed Location(s) in Certified Nursing Facilities and Skilled Nursing Facilities") when requesting a bed change.

Instructions for requesting a certified bed change in a skilled or nursing facility

The following procedures **must** be followed to process a certified bed change in a nursing facility. **Failure to follow the outlined instructions could jeopardize the requested bed change and the effective date.** Only two changes allowed per year.

Bed change requests must be **received** in State Office 45 calendar days prior to the beginning of the cost reporting quarter that falls within the same cost-reporting year.

A. The request must including the following:

   a. Name and address of facility.
   b. Facility Medicare provider number.
   c. Name of facility's fiscal intermediary.
   d. Facility fiscal year ending date.
   e. Name and telephone number of a contact person who can answer questions about the request.
   f. Tentative effective date.
   g. Cost report period i.e., first day it begins.
   h. Facility floor plan.

B. List of **current** bed types, room numbers, and capacity of each room must be submitted.

SNF - Medicare Only	SNF/NF - Dually Certified	NF - Medicaid Only	Non-Participating License Only
204-2	300-1	400-2	100-2
205-2	301-2	402-2	101-2
206-1	302-2	402-2	102-1
Total 5	5	6	5 = 21

(Totals across must equal the License Capacity of Nursing Facility)

C. List of **requested** bed change must be submitted.
   Follow same procedures as instructed in "B".

D. Date and sign request.

E. Mail request to: (*Massachusetts Only)
Department Public Health
David Brown
Division of Health Care Quality
10 West Street, 5th Floor
Boston, MA 02111

* Mail request to State Department of Health Care Quality

Medicare Administrative Contractor (MAC) Jurisdictions Fact Sheet

Overview:

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) enables the Centers for Medicare & Medicaid Services (CMS) to make significant changes to the Medicare fee-for-service program's administrative structure that will make contracting dynamic, competitive and performance-based. Through implementation of Medicare Contracting Reform, CMS will integrate the administration of Medicare Parts A and B for the fee-for-service benefit to new entities called Medicare Administrative Contractors (MACs). This operational integration will centralize information once held separately, creating a platform for advances in the delivery of comprehensive care to Medicare beneficiaries. These changes to Medicare's administration will continue to benefit Medicare's enrollee population as it increases with the retirement of the Baby Boom generation. On February 7, 2005, CMS submitted a report to Congress describing the benefits of contracting reform and its plans for implementation.

Medicare's fee-for-service plan should be comprehensive and high quality. CMS will achieve this vision with substantial improvement of the current fee for service administrative structure. The Medicare Contracting Reform provision of the Medicare Modernization Act will greatly assist CMS' efforts in this regard.

Between 2005 and 2009, the Centers for Medicare & Medicaid Services (CMS) will be conducting full and open competitions to replace the contractors that currently perform claims processing and related functions for the Medicare program with new MACs that will perform many of the same tasks, but will do so more efficiently. Central to the implementation of the contracting reform is the creation of new jurisdictions to be administered by the MACs. In this fact sheet, CMS defines the new MAC jurisdictions and explains the process that led to these decisions. Once CMS consolidates administration of Part A and Part B into integrated MACs, the following improvements to services for beneficiaries and providers can be expected:

Improved Beneficiary Services

- Most beneficiaries will have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize.
- A/B MACs will be required to develop an integrated and consistent approach to medical coverage across its service area, which benefits both beneficiaries and providers.

Beneficiaries will be able to have their questions on claims answered by calling 1-800-MEDICARE, their single point of contact.

Improved Provider Services

- A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers.
- Competition will encourage MACs to deliver better service to providers.
- Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

The investment for the implementation of Medicare contracting reform will help ensure the program remains an important and secure health plan for beneficiaries, generating significant trust fund and administrative savings over time.

Establishing the MAC Jurisdictions:

CMS designed the new MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The result is jurisdictions that reasonably balance the number of fee-for-service beneficiaries and providers. While these jurisdictions exhibit some variations in size and workload, they are more equalized than the existing fiscal intermediary and carrier workload.

Choosing MAC Contractors

CMS will ensure its MAC contracts focus on three critical areas: customer service, operational excellence, and financial management. The MACs will serve as the providers' primary point-of-contact for enrollment, training on Medicare coverage and billing requirements, and the receipt, processing, and payment of Medicare fee-for-service claims within their respective jurisdictions. These contractors will perform all core claims processing operations for both Part A and Part B. In their capacity as the face of Medicare to the providers, practitioners, and suppliers, MACs will need to maintain a staff of experts knowledgeable in all aspects of the fee-for-service program.

CMS plans to award 19 MACs through a competitive bidding process during the initial implementation phase. These will include 15 A/B MACs servicing the majority of all types of providers (both Part A and Part B), and four specialty MACs servicing durable medical equipment suppliers. CMS is not procuring four specialty MACs to service home health and hospice providers. CMS will consolidate the four home health and hospice jurisdictional claims workloads into the following four A/B MAC workloads:

- Jurisdiction 6 will include home health and hospice Jurisdiction D,
- Jurisdiction 11 will include home health and hospice Jurisdiction C,
- Jurisdiction 14 will include home health and hospice Jurisdiction A and
- Jurisdiction 15 will include home health and hospice Jurisdiction B.

CMS MAC Jurisdictions A/B MAC

Jurisdiction #	States Included in Jurisdiction
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2	Alaska, Idaho, Oregon, and Washington
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
4	Colorado, New Mexico, Oklahoma, and Texas
5	Iowa, Kansas, Missouri, and Nebraska
6	Illinois, Minnesota, and Wisconsin
7	Arkansas, Louisiana, and Mississippi
8	Indiana and Michigan
9	Florida, Puerto Rico, and U.S. Virgin Islands
10	Alabama, Georgia, and Tennessee
11	North Carolina, South Carolina, Virginia and West Virginia
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13	Connecticut and New York
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15	Kentucky and Ohio

DME MAC Jurisdictions

Jurisdiction	States Included in Jurisdiction
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming

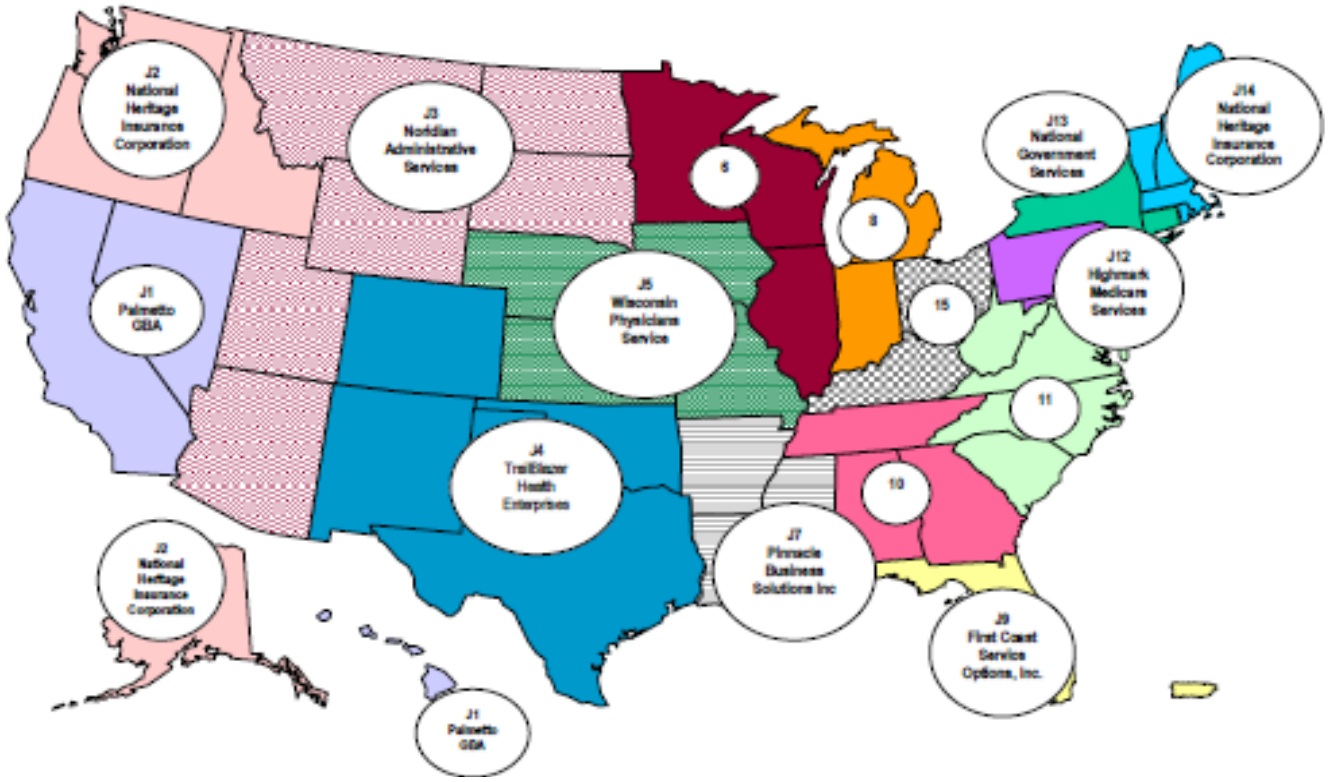
Home Health and Hospice MAC Jurisdiction:

Jurisdiction	States Included in Jurisdiction
A	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, & Vermont
B	Colorado, Delaware, District of Columbia, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, & Wyoming
C	Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, & Texas
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, U.S. Virgin Islands, Wisconsin, & Washington

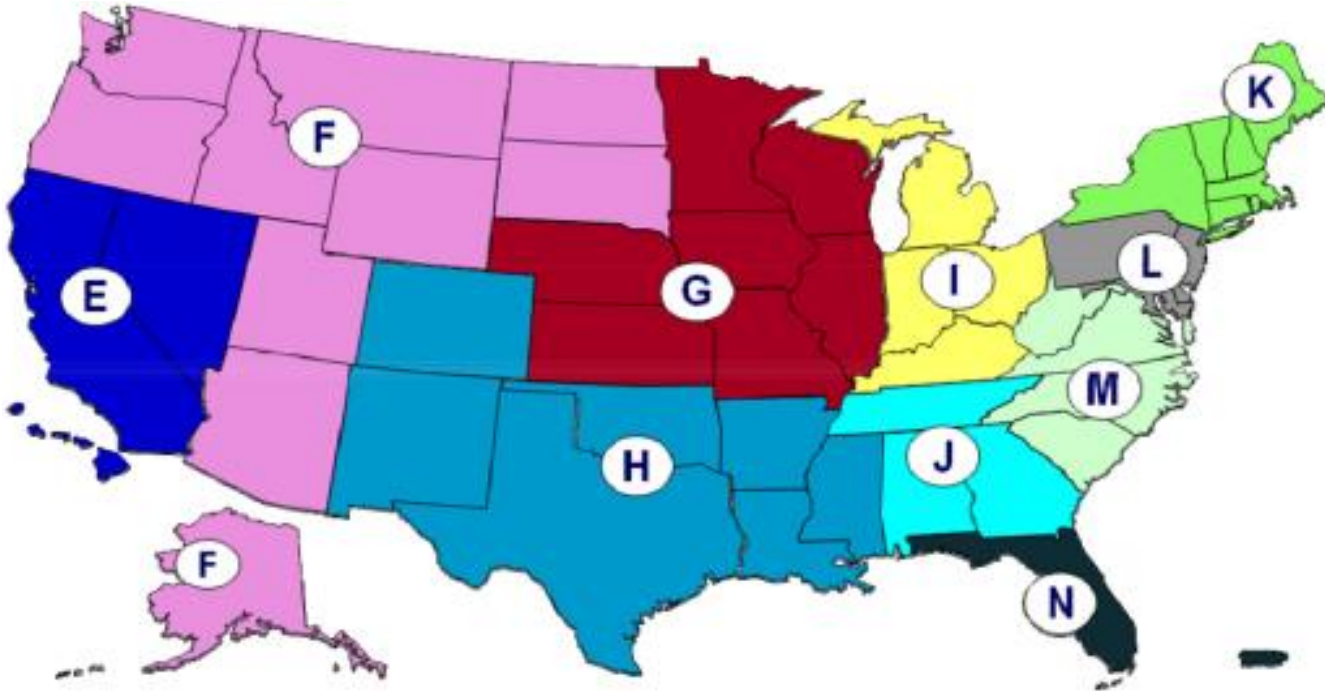
Medicare's MAC Procurement Schedule:

CMS began competing the workloads of the existing fiscal intermediaries, carriers and durable medical equipment regional carriers (DMERCs) with a start-up acquisition and transition cycle. This start-up cycle competed the DMERC workloads and the A/B workload for Jurisdiction 3, a first step that focused on a small discrete workload. That start-up cycle is being followed by MAC acquisition and transition Cycles One and Two. CMS anticipates each of these acquisition cycles will take approximately 9 to 12 months, from solicitation to award. The subsequent activity of transitioning the workload from the existing contractors to the new MACs will total approximately 6 to 13 months for each MAC. Under this schedule, the full fee-for-service workload will be transitioned to MACs by October 2009.

A/B MAC Jurisdictions Map



Consolidated A/B MAC Jurisdictions



Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Medicare Letter and Form
Responsible Party

Complete the grid identifying the facility person responsible for completing the:

- Certification Form
- Beneficiary Voluntary Placement
- Non-certified Bed Letter (Consent Form) (if applicable)
- SNF Determination on Admission
- SNF Determination on Continued Stay
- MSP – Medicare Secondary Payer

Distribution:

→ Original to Administrator
→ Copy to MDS Coordinator
→ Copy to Reimbursement

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Facility Name:_____

Letter / form	Recommended Responsible party	Responsible party and name	Document Location
Certification Form	MDS Coordinator		
Beneficiary Voluntary Placement	Social Worker / Admissions		
Non-certified Bed Letter (Consent Form)	Social Worker / Admissions		
SNF Determination on Admission	Social Worker / Admissions		
SNF Determination on Continued Stay	MDS Coordinator		
MSP - Medicare Secondary Payer	Social Worker / Admissions		

Note: Please give a copy of this form, upon completion, to the Administrator.

Harmony Healthcare INTERNATIONAL

SNF Determination on Admission

Overview

Complete this form when a beneficiary is admitted to the facility and Medicare will NOT pay for services. Examples:

- Qualifying stay NOT met
- Zero days remaining in spell of illness
- Daily skilled services NOT required
- Admitted from home / another SNF 31 days after hospital stay. (i.e., missed 30 day window).

The "SNF Determination on Admission" letter is used when the facility has determined, prior to or upon the day of admission or readmission to the facility, that the services to be rendered will not be covered by Medicare.

Instructions for Completion of Letter

The numbered instructions correspond to the numbered example letter on the previous pages.

1. Facility name and address.
2. Date of admission or readmission.
3. Beneficiary/resident/conservator/legal guardian's name and address.
4. Beneficiary/resident/'s name as shown on the Medicare card.
5. Beneficiary/resident/'s Medicare number as shown on the Medicare card.
6. Same date as number 2.
7. Same date as number 2.
8. Fill in the beneficiary/resident/'s name or the word "YOU" if giving the notice directly to the beneficiary/resident.
9. Select and write in one of the following FULL DENIAL paragraphs: 1,2,6b,7,9,11,12,14,1,16,17,18, or 19 which best explains the reason for non-coverage. (Denial paragraphs follow these instructions.)
10. Signature of administrator or individual completing the forms.
11. This box is checked if the resident/conservator/legal guardian wishes to have the bill for services beyond the day of admission submitted to the intermediary for a coverage decision. This is call a "demand submission" and must be reported to the business office immediately.
12. Name and address of Part A Claims/Carrier.
13. This box is checked when the resident/conservator/legal guardian does not wish to have a "demand" submission sent.

14. The resident/conservator/legal guardian or responsible party signs and dates his own signature. If this is done on the day of admission or readmission, there is no need to complete section "D". NOTE: If resident/conservator/legal guardian or responsible party signs and dates his own signature. If this is done on the day of admission or readmission, there is no need to complete section "D". NOTE: If resident/conservator/legal guardian or responsible party refuses to sign, please not this refusal here.
15. Same date as number three for telephone contact.
16. Name and relationship (if possible) of person contacted or attempted to contact by telephone.
17. Signature of administrative officer or individual who made the telephone contact.
18. Copies must be given or mailed on same date as number 16.
19. Copies must be given or mailed on same date as number 16.
20. Copies must be given or mailed on same date as number 16.

Facility places a copy of this completed letter in the resident's financial folder.

If Section "C" Verification of Notice was not signed and dated on the day of admission or readmission, send the original and a copy to the resident/conservator/legal guardian or responsible party with instructions to date and sign Section "C" and to check "A" or "B", return a signed copy to the facility and to keep the original for his files. When the signed copy is returned to the facility, discard the unsigned copy from the financial folder.

Per Part A Claims/Carrier: If the responsible party does not return eh notification letter signed, we (facility) will not be held liable, as long as we have noted that the notification letter was mailed the same day as the telephone notification was given.

Full Denial Paragraphs

Use Only With "SNF Determination on Admission" Letter.

#1 **Paragraph** - Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

#2 **Paragraph** - Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service). This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

#6 b **Paragraph** - Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

#7 **Paragraph** - Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for residents with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere convenience or for the control of incontinence. Since your catheter was inserted for convenience or the control of your incontinence, we believe that your care is not covered under Medicare.

#9 **Paragraph** - Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (specify) therapist to perform and/or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare. (NOTE: Make sure to fill in the specific therapy discipline in the denial paragraph above).

#11 **Paragraph** - Medicare covers medically necessary skilled care when needed on a daily basis. The (specify service(s) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not

considered a specific and/or effective treatment for your condition. Since the service(s) you received was/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered by Medicare. (NOTE: The specific service(s) must be listed in the space provided.)

#12 **Paragraph** - Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The (specify) therapy services provided is/were not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe your stay is not covered under Medicare. (NOTE: Specify the therapy discipline being used in the space provided.)

#14 **Paragraph** - Medicare covered medically necessary skilled care when needed on a daily basis. Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The medical information does not show medical complications which require the services to be performed on a daily basis. In this care, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare. (NOTE: Fill in the specific skilled service in the space provided.)

#15 **Paragraph** - Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare. (NOTE: Enter the specific therapy discipline in the space provided above.)

#16 **Paragraph** - Medicare covers medically necessary skilled care needed on a daily basis. Although you required skilled nursing services, you do/did not need them on a daily basis. Because you do/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.

#17 **Paragraph** - Our records indicate that you did not have the necessary qualifying three consecutive days hospital confinement.

#18 **Paragraph** - Our records indicate that your 100 Medicare days have been exhausted.

Denial Letters
Notices of Non-Coverage

Harmony Healthcare INTERNATIONAL

From:

Facility (SNF):	(1) *Green Valley Ranch*	Date of Letter:	(2) *September 1, 1996*
Address:	(1) *4215 Green Valley Road*		
City/State/Zip:	(1) *Green Valley, USA 03579*		

To:

Resident/Conservator:	(3) *Mrs. Ima Sample*		
Legal Guardian:	(3) *Mrs. Iwas A. Sample*	Beneficiary:	(4) *Ima R. Sample*
Address:	(3) *124 Mission Loop SE*	Health Ins. Card:	(5) *123-45-6789A*
City/State/Zip:	(3) *Somewhere, USA 544880*	Admission Date:	(6) *September 1, 1996*

On (7) September 1, 1996, we reviewed the medical information available at the time of or prior to your admission, and we believe that the services (8) you needed do not meet the requirements for coverage under Medicare. The reason is: (9) Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, in this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under the provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date on this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes on the reverse side to indicate whether or not you want us to submit your bill to Medicare. Then sign this notice to verify receipt. Return this copy to the facility in the enclosed self-addressed stamped envelope.

(10) _____

Signature of Administrative Officer

■ REQUEST FOR MEDICARE INTERMEDIARY REVIEW *(check one box below)*

(11) ☐ A. I **do** want my bill for services that I receive to be submitted to the intermediary for a Medicare decision. The facility will inform me when a bill is submitted.

- You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.
- If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact:

(12) *Adams Life Insurance Company*
1000 Happy Oaks Lane
Paradise, USA 54490-65

(13) ☐ B. I **do not** want my bill for services I receive, to be submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if a bill is not submitted.

- Beginning October 1, 1989 you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

• VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of non-coverage of services under Medicare on:

(14) _____ (14) _____

Date of receipt Signature of beneficiary or person acting on the beneficiary's behalf

D. This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on:

(15) _____ (16) _____

Date of telephone contact Name of beneficiary or representative contacted

(17)_____

Signature of Administrative Officer

• DATE VERIFIED COPY GIVEN OR SENT TO:

Resident/Conservator/Legal Guardian: (18)

Date given or sent

Responsible Party: (19)

Date given or sent

Physician: (20)

Date given or sent

KEEP A COPY OF THIS FOR YOUR RECORDS

Harmony Healthcare INTERNATIONAL

SNF Determination on Continued Stay

Overview

Complete this form when a beneficiary receiving Part A benefits no longer meets the skilled care criteria. This letter should be completed either prior to the actual anticipated date of change in coverage or on the day of change. You can never backdate a notice of non-coverage.

The "SNF Determination on Continued Stay" letter is used when the facility has determined, after the admission or readmission to the facility, that the services rendered will not be covered by Medicare.

Instructions for Completion of Letter

The numbered instructions correspond to the numbered example letter on the previous pages.

1. Facility name and address.
2. Date of notification to resident.
3. Beneficiary/resident/conservator/legal guardian's name and address.
4. Beneficiary/resident/'s name as shown on the Medicare card.
5. Beneficiary/resident/'s Medicare number as shown on the Medicare card.
6. Date of admission or readmission.
7. Same date as number 2.
8. Fill in the beneficiary/resident/'s name or the word "YOU" if giving the notice directly to the beneficiary/resident.
9. Date on which Medicare services will no longer be covered.
10. Select and write in one of the following FULL DENIAL paragraphs: 3, 4, 5, 6a, 6c, 8, or 13 which best explains the reason for non-coverage. (Denial paragraphs follow these instructions.)
11. Same date as number 2.
12. Signature of administrative officer or individual completing the form.
13. This box is checked if the resident/conservator/legal guardian wishes to have the bill for services beyond the day of "continued stay" submitted to the intermediary for a coverage decision. This is called a "demand submission" and must be reported to the business office immediately.
14. Name and address of Part A Claims/Carrier.
15. This box is checked when the resident/conservator/legal guardian does not wish to have a "demand" submission sent.
16. Date of signature. The resident/conservator/legal guardian or responsible party signs and dates his own signature. NOTE: If resident/conservator/legal guardian or responsible party refuses to sign, please not this refusal here.
17. Same date as number 2.

18. Name and relationship (if possible) of person contacted or attempted to contact by telephone.
19. Signature of administrative officer or individual who made the telephone contact.
20. Copies must be given or mailed on same date as number 20.
21. Copies must be given or mailed on same date as number 20.
22. Copies must be given or mailed on same date as number 20.

Facility places a copy of this completed letter in the resident's financial folder.

If Section "C" Verification of Notice was not signed and dated, send the original and a copy to the resident/conservator/legal guardian or responsible party with instructions to date and sign Section "C" and to check "A" or "B", return a signed copy to the facility and to keep the original for his/her files. When the signed copy is returned to the facility, discard the unsigned copy from the resident's financial folder and replace with the signed copy.

Per Part A Claims/Carrier: If the responsible party does not return eh notification letter signed, we (facility) will not be held liable, as long as we have noted that the notification letter was mailed the same day as the telephone notification was given.

Full Denial Paragraphs

Use Only With "SNF Determination on Continued Stay" Letter.

#3 **Paragraph** - Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service) after (date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (date) is not covered under Medicare.

#4 **Paragraph** - Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning (date) to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe your stay after (date) is not covered under Medicare.

#5 **Paragraph** - Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition, you needed a skilled nurse from (date) through (date) to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by non-skilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare after (date).

#6 a **Paragraph** - Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform the tasks ordered by your physician by (date), but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning (date).

#6 c **Paragraph** - Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning
is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after (date).

#8 **Paragraph** - Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning (date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical

complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after (date).

#13 Paragraph - Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled (specify) therapy from (date) to (date), the medical information shows that the (specify) therapy services after that time is not reasonable in relation to the expected improvement in your condition. In this case, considered reasonable and necessary, we believe, your stay after (date) is not covered under Medicare.

Notice Regarding Medicare Coverage (Non-Certified Bed Letter)

The "Non-Certified Bed" letter apprises the resident that he/she is being placed in a Medicare non-certified bed. The "Notice Regarding Medicare Coverage" (Non-Certified Bed letter) could accompany the following letters: "SNF Determination on Admission" letter or "SNF Determination on Continued Stay" letter.

Note: **The non-certified bed letter should only be given when the resident is actually placed in a medicare non-certified bed.**

When the resident is transferred from the Medicare certified bed to a Medicare non-certified bed (which may or may not occur at the same time a determination of Part A benefits is made), the facility must issue this letter, even if the resident is not currently receiving or has not received Medicare Part A benefits while occupying the Medicare certified bed.

Note: **Failure to issue this letter to the resident upon their admission to a medicare non-certified bed could result in provider liability (not covered under waiver of liability).**

Please note the numbered instructions for the completion of the "Notice Regarding Medicare Coverage" (Non-Certified Bed letter) accompanying the numbered sample letter.

Competency Statement

Competency refers to the resident's capability of understanding that he/she is being placed in a bed for which Medicare will not pay.

Obtain the physician's signature or the letter could be deemed invalid. The signature can be that of the attending physician or the Medical Director if familiar with the resident. The signature can also be in the form of a letter signed by the physician, a physician order, or a note in the physician's progress notes and signed by the physician.

Denial Letters
Notices of Non-Coverage

Harmony Healthcare INTERNATIONAL

From:

Facility (SNF): (1) *Green Valley Ranch*

Street Address: (1) *4215 Green Valley Road*

City/ State/ Zip: (1) *Green Valley, USA 03579*

Date of Notice: (2) *September 7, 1996*

To: **Regarding:**

Responsible Party: (3) *Mrs. Ima Sample* Beneficiary (Resident): (4) *Ima R. Sample*

Street Address: (3) *124 Mission Loop SE* Health Insurance Card (HICNo.): (5) *123-45-6789A*

City/ State/ Zip: (3) *Somewhere, USA 544880* Admission Date: (6) *September 1, 1996*

On **(7) September 7, 1996,** we reviewed your medical information and found that the services furnished (8) *you* no longer qualify as covered under Medicare beginning **(9) September 7, 1996. The reason is: (10) Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning September 1, 1996, to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe your stay after September 7, 1996, is not covered under Medicare.**

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer meet Medicare payment requirements. A bill will be sent to Medicare for the services you received before (11) **September 7, 1996**. Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be non-covered. Medicare will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under the provision of the Medicare law, you do not have to pay for non-covered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were non-covered. You are considered to know that these services were non-covered effective with the date of this notice.

We regret that this may be your first notice of the non-coverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes on the reverse side to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt. Return this copy to the facility in the enclosed self-addressed stamped envelope.

(12)

Signature of Administrative Office

- REQUEST FOR MEDICARE INTERMEDIARY REVIEW *(check one box below)*

(13) ☐ A. I do want my bill for services that I receive, to be submitted to the intermediary for a Medicare decision.

(The facility will inform me when a bill is submitted.)

PLEASE NOTE THE FOLLOWING:
You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made. If you don't receive a formal Notice of Medicare Determination within 90 days of this request, you should contact:

(14) *Adams Life Insurance Company*
1000 Happy Oaks Lane
Paradise, USA 54490-65

(15) ☐ B. I do not want by bill for services I receive to be submitted to the intermediary for a Medicare decision. I understand that I do not have Medicare appeal rights if a bill is not submitted.

- VERIFICATION OF RECEIPT OF THIS NOTICE

C. This acknowledges that I received this notice of non-coverage of services under Medicare on:

(16) _____ (16) _____

Date of Receipt Signature of Resident / Responsible Party

D. This confirms that you were advised of the non-coverage of services under Medicare by telephone on:

(17) _____ (18) _____

Date of Contact Name of beneficiary or representative contacted

(19) _____

Signature of Administrative Officer

- DATE VERIFIED COPY GIVEN OR SENT TO:

Resident: (20)

Date given or sent

Responsible Party: (21)

Date given or sent

Physician: (22)

Date given or sent

KEEP A COPY OF THIS FOR YOUR RECORDS

Harmony Healthcare INTERNATIONAL

MSP (Medicare Secondary Payer)

Medicare is the secondary payer under certain circumstances. SNFs are required to have a process in place for collecting and reporting other primary payer information.

Medicare may be the secondary payer in the following instances:

- A working aged beneficiary 65 and older covered by an Employer Group Health Plan (EGHP);
- A beneficiary under 65 and disabled and covered by a Large Group Health Plan (LGHP);
- A beneficiary entitled to Medicare on the basis of the End Stage Renal Disease (ESRD) benefit and covered by a EGHP;
- Items or services paid by automobile, Personal Injury Protection (PIP), medical, no fault insurance, or liability insurance;
- Items or services paid under the Workers' Compensation (WC) law;
- Items or services paid under the Black Lung program; and
- Items or services paid under the Veterans' Administration (VA) program.

If it is determined that Medicare is the primary payer, SNFs should ask beneficiaries if they were an inpatient of a hospital or SNF during the prior 60 days.

Overview

- On admission or re-admission, complete this form on ALL Medicare entitled residents regardless of bed placement. Incorporate into the admission packet.
- Medicare regulations (42 CFR 489.20(f)) require, as a condition of participation in the Medicare Program, that:
- The Provider agrees "to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented."
- Failure to maintain a system identifying other payers will be viewed as a violation of the provider agreement with Medicare resulting in fines and possible exclusion from the program.
- MSP screening must be completed for all Medicare entitled residents **admitted** or **readmitted** to the SNF (whether to a Medicare certified or non-certified bed).
- If you receive a letter from Medicare requesting this information on a particular claim, you will have 30 days to respond.

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Medicare Secondary Payer (MSP) Screening

Resident Name:_____ Medicare No._____Service Dates:_____

It is important to ask all questions and document all answers regarding MSP. A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information relevant to payment.

Illness/Injury Caused by Accident

1. Is the illness or injury due to any kind of accident?

   - o No - Proceed with question #3 below.
   - o Yes - Medicare may be secondary. Check the appropriate box (A-E), and answer the questions.

   A. Motor Vehicle - Name of resident's automobile insurer:_____
   Automobile insurance is prime: bill them.

   B. Motor Vehicle - Name of third party's liability insurer:_____
   Liability may be primary. After auto medical, bill Medicare conditionally (with documentation) OR liability insurer.

   C. Work related - Name of Worker's Comp. insurer:_____
   Worker's Comp. insurance is primary: bill them.

   D. Slip and fall - Explain where fall occurred:_____
   Determine if liability claim or suit will be filed or if any kind of compensation can be made.

      - No
      - Yes - Give information on third party/insurer/attorney:____

      _____

      _____

      Bill Medicare conditionally (with documentation) OR liability insurer.

   E. Other accident - No third party can pay. Give description of accident and location.

      _____

      _____

Harmony Healthcare INTERNATIONAL

Medicare Secondary Payer (MSP) Screening

Coverage Through Other Governmental Entity

2. A. Does the resident have coverage through the Department of Labor's Black Lung Program or some other federal or state agency program? (Does not include state welfare).

    - o No - Proceed with question #3 below.
    - o Yes - The entity the resident has coverage with must be billed primary to Medicare. Medicare may reject the claim unless the entity pays as primary or submits a denial of the services.

   B. Does the resident have VA coverage because of a service related condition?

    - o No - Proceed with question #4 below.
    - o Yes - VA must be billed primary.

3. Is the resident 65 or above?

    - o No - answer questions #6-#7 only.
    - o Yes - answer questions #4-#5 only.

Employer Group Health Coverage

4. Is the resident employed at the time of this service?

    - o No - What is resident's retirement date? _____ Proceed with question #5 below.
    - o Yes - Give the resident's date of birth (MM/DD/YY)_____ Give the name of resident's company/employer: _____

   A. Does the employer employ 20 or more employees?
    - o No
    - o Yes

   B. Does the resident have Employer Group Health Plan (EGHP) coverage by reason of his/her current employment?

    - o No
    - o Yes - Give the name of the EGHP_____

If the resident answered "yes" to A and B, the EGHP shown is primary to Medicare. Bill them first.

Medicare Secondary Payer (MSP) Screening

5. Does the resident have a spouse who is employed at the time of this service?

   - o No - What is the spouse's retirement date?_____ Proceed with question #6 below.
   - o Yes - Give the resident's date of birth (MM/DD/YY) Give the name of the spouse's company/employer:_____

   A. Does the employer employ 20 or more employees?

   - o No
   - o Yes

   B. Does the spouse have Employer Group Health Plan (EGHP) coverage by reason of his/her current employment which covers the resident?

   - o No
   - o Yes - -Give the name of the EGHP:_____

   If the resident answered "yes" to A and B, the EGHP shown is to be billed before Medicare. If the resident also has an EGHP (see #4 above). Medicare will be billed third.

Employer Group Coverage for those entitled to Medicare solely due to End Stage Renal Disease (ESRD)

6. Is the resident under the age of 65 entitled to Medicare solely because of ESRD (dialysis or kidney transplant)?

   - o No - Proceed with #7 below
   - o Yes - Give the resident's date of entitlement as shown on the Medicare card (MM/YY):

   Are you in the first 18 months of a coordination period?

   - o No - Medicare is primary
   - o Yes

   A. Does the resident have coverage through his/her spouse's, parent's or guardian's Employer Group Health Plan (EGHP)?

   - o No
   - o Yes - Give the resident's date of birth (MM/DD/YY):

B. Does the resident have coverage through his/her spouse's, parent's, or guardian's Large Group Health Plan (LGHP)?

- o No
- o Yes - Give name of each insured whose policy covers the resident.

a. _____
b. _____

Give name of corresponding employer.

a. _____
b. _____

Give name of corresponding LGHP.

a. _____
b. _____

If the resident answered "yes" to both questions, the LGHP(s) is/are primary to Medicare. Bill them. Medicare is secondary.

Resident/Representative Signature: _____

Date: _____

Harmony Healthcare INTERNATIONAL

Beneficiary Voluntary Placement Letter

Overview

Complete this form when a beneficiary refuses to be placed into a certified bed AND the patient required SKILLED services. YOU MUST complete this form in order to receive payment from the secondary payer (i.e., Medicaid).

Instructions for Completion

Numbered instructions correspond to the numbered example letter on the previous pages.

1. Facility name and address.
2. Date voluntary Medicare non-certified bed placement requested.
3. Beneficiary/resident/conservator or legal guardian's name and address.
4. Beneficiary/resident/'s name as shown on the Medicare card.
5. Beneficiary/resident/'s Medicare number as shown on the Medicare card.
6. Date of admission to the Medicare non-certified bed (should coincide with number 2).
7. Reason the beneficiary is consenting to be placed in the Medicare non-certified bed.
   a. because a certified bed was not available or
   b. because you wish a specific non-certified room
8. Signature of Administrator or individual completing this form.
9. Name and address of Part A Claims/Carrier.
10. Beneficiary/resident/'s name. Attending physician is to check competent or incompetent.

Competency Statement

Competency refers to the resident's capability of understanding that he/she is being placed in a bed for which Medicare will not pay.

Obtain the physician's signature or the letter could be deemed invalid. The signature can be that of the attending physician or the Medical Director if familiar with the resident. This signature can also be in the form of a letter signed by the physician, or a physician order or a note in the physician's progress notes and signed by the physician.

If the physician refuses to sign the competency statement, indicate refusal on the form. Record the name of the physician and statement of refusal, then your signature, title and date. Send the physician a copy and place the other copy in the resident's financial folder.

Each facility is responsible for implementing a system to ensure timely signing of these forms. Every attempt should be made to have the resident/responsible party and physician's signature on the same form.

11. Attending physician's signature. This signature can also be in the form of a letter signed by the physician or a signed note in the physician's progress notes.

Note: If the physician refuses to sign the competency statement, note this on the form with the date of contract and signature.

12. Attending physician's address.
13. Write in beneficiary/resident/'s name.
14. Write in beneficiary/resident/'s number.
15. Date the notice was received. The resident/conservator/legal guardian or responsible party signs and dates his own signature.
16. Date of telephone contact, if applicable.
17. Name and relationship (if possible) of person contacted, if applicable.
18. Signature of Administrative Officer or individual making telephone contact.
19. Same date as in number 2.
20. Same date as in number 2.
21. Same date as in number 2.

Place a copy of the completed letter in the resident's financial folder. If section "A" Verification of Notice was not signed and date on the day benefits were waived, send the original and a copy to the conservator/legal guardian or responsible party with instructions to date and sign section "A", return a signed copy to the facility and to keep the original for their files. When the signed copy is returned to the facility, discard the unsigned copy from the financial folder and replace it with the signed copy.

Per Part A Claims/Carrier: If the responsible party does not return eh notification letter signed, we (facility) will not be held liable, as long as we have noted that the notification letter was mailed the same day as the telephone notification was given.

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Notice Regarding Medicare Coverage

(Beneficiary Voluntary Placement Statement)

From:

Facility (SNF): (1) *Green Valley Ranch* Date of Letter: (2) *September 1, 1996*

Address: (1) *4215 Green Valley Road*

City/State/Zip: (1) *Green Valley, USA 03579*

To:

Resident/Conservator: (3) *Mrs. Ima R. Sample*

Legal Guardian: (3) *Mrs. Iwas A. Sample* Beneficiary: (4) *Ima R. Sample*

Address: (3) *124 Mission Loop SE* Health Ins. Card: (5) *123-45-6789A*

City/State/Zip: (3) *Somewhere, USA 544880* Admission Date: (6) *September 1, 1996*

- The medical information available at the time of, or prior to, admission shows that the specific services to be furnished meet the requirements for coverage under Medicare. However, we are placing in you in a Medicare non-certified bed as per your request. You have stated that the reason you do not want the nursing center to bill Medicare for the services you will receive while you are a resident here is: (7) *because you wish a specific Medicare non-certified room*.

In addition, you understand that your voluntary placement in a Medicare non-certified portion of the nursing center will disqualify you from eligibility for Medicare payment for services received while in a Medicare non-certified bed. In addition, your consent to this placement is being given freely.

(8)

Signature of Administrator Officer

The Medicare intermediary serving this nursing center is:

(9) *Adams Life Insurance Company*

1000 Happy Oaks Lane

Paradise, USA 54490-65

- 2. This is to advise that my resident, (10) *Ima R. Sample*, is mentally ☐ competent ☐ incompetent of making the above-decision.

(11) _____ Address: (12) _____

Signature of Physician City/State/Zip: (12)

Resident Name: (13) *Ima R. Sample*

Resident Number: (14)

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Notice regarding medicare coverage

(Beneficiary Voluntary Placement Statement)

- VERIFICATION OF RECEIPT OF THIS NOTICE

A. This acknowledges that I received this notice of non-coverage of services under Medicare on:

(15) _____ (15) _____

Date of receipt Signature of resident/conservator/legal guardian

B. This confirms that you were advised of the non-coverage services under Medicare by telephone on:

(16) _____ (17) _____

Date of telephone contact Name of beneficiary or representative contacted

(18) _____

Signature of Administrative Officer

- DATE VERIFIED COPY GIVEN OR SENT TO:

Resident/Conservator/Legal Guardian: (19)

Date given or sent

Responsible Party: (20)

Date given or sent

Physician: (21)

Date given or sent

Keep A Copy Of This For Your Records

Certification Form

Overview

Notice Regarding Medicare Coverage (Non-Certified Bed Letter)

The "Non-Certified Bed" letter apprises the resident that he/she is being placed in a Medicare non-certified bed. The "Notice Regarding Medicare Coverage" (Non-Certified Bed letter) could accompany the following letters: "SNF Determination on Admission" letter or "SNF Determination on Continued Stay" letter.

Note: **The Non-Certified Bed Letter Should Only Be Given When The Resident Is Actually Placed In A Medicare Non-Certified Bed.**

When the resident is transferred from the Medicare certified bed to a Medicare non-certified bed (which may or may not occur at the same time a determination of Part A benefits is made), the facility must issue this letter, even if the resident is not currently receiving or has not received Medicare Part A benefits while occupying the Medicare certified bed.

Note: **Failure to issue this letter to the resident upon their admission to a medicare non-certified bed could result in provider liability (not covered under waiver of liability).**

Please note the numbered instructions for the completion of the "Notice Regarding Medicare Coverage" (Non-Certified Bed letter) accompanying the numbered example letter.

Competency Statement

Competency refers to the resident's capability of understanding that they are being placed in a bed for which Medicare will not pay.

Obtain the physician's signature or the letter could be deemed invalid. The signature can be that of the attending physician or the Medical Director if familiar with the resident. The signature can also be in the form of a letter signed by the physician, a physician order, or a note in the physician's progress notes and signed by the physician

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Notice Regarding Medicare Coverage (non-certified bed letter)
Consent Form

From:

Facility (SNF): **(1)** *Green Valley Ranch* Date of Letter: **(2)** *September 1, 1996*

Address: **(1)** *4215 Green Valley Road*

City/State/Zip: **(1)** *Green Valley, USA 03579*

To:

Resident/Conservator: **(3)** *Mrs. Ima R. Sample*

Legal Guardian: **(3)** *Mrs. Iwas A. Sample* Beneficiary: **(4)** *Ima R. Sample*

Address: **(3)** *124 Mission Loop SE* Health Ins. Card: **(5)** *123-45-6789A*

City/State/Zip: **(3)** *Somewhere, USA 544880* Admission Date: **(6)** *September 1, 1996*

- 1. We are placing you in a part of this nursing center which is not covered by Medicare because: **(7)** *you do not meet the 30-day transfer requirement.*

Non-qualifying services furnished to a resident in a Medicare non-certified bed are not payable by Medicare. However, you (or someone acting on your behalf) may ask us to file a claim for Medicare benefits. Based on this claim, Medicare will make a formal determination and advise whether any benefits are payable to you. You have been advised of the above and agree to placement in a Medicare non-certified bed.

(8)

Signature of Administrator Officer

The Medicare intermediary serving this nursing center is: **(9)** *Adams Life Insurance Company*

1000 Happy Oaks Lane

Paradise, USA 54490-65

- 2. This is to advise that my resident, **(10)** *Mrs. Ima R. Sample*, is mentally ☐ competent ☐ incompetent of making the above-decision.

(11) _____ Address: **(12)** _____

Signature of Physician City/State/Zip: **(12)** _____

Resident Name: **(13)** *Ima R. Sample*

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Denial Letters
Notices of Non-Coverage

Notice Regarding Medicare Coverage (Non-Certified Bed Letter)
Consent Form

- REQUEST FOR MEDICARE INTERMEDIARY REVIEW *(check one box below)*

(14) ☐ A. I do want my bill for services I continue to receive, to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

- If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact:

(15) *Adams Life Insurance Company*
1000 Happy Oaks Lane
Paradise, USA 54490-65

(16) ☐ B. I do not want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision.

- Beginning October 1, 1989 you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

- VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of non-coverage of services under Medicare on:

(17) _____ **(17)** _____

Date of receipt — Signature of beneficiary or person acting on the beneficiary's behalf

D. This is to confirm that you were advised of the non-coverage of the services under Medicare by telephone on:

(18) _____ **(19)** _____

Date of telephone contact — Name of beneficiary or representative contacted

(20) _____

Signature of Administrative Officer

- DATE VERIFIED COPY GIVEN OR SENT TO

Resident/Conservator/Legal Guardian: **(21)**_____
Date given or sent

Responsible Party: **(22)**_____
Date given or sent

Physician: **(23)**_____
Date given or sent

KEEP A COPY OF THIS FOR YOUR RECORDS

If the physician refuses to sign the competency statement, you must indicate the refusal on the form. Record the name of the physician statement of refusal, and then your signature, title and date. Send the physician a copy and place the original in the resident's financial folder.

Each facility is responsible for implementing a system to ensure timely signing of these forms. Every attempt should be made to have the resident/responsible party and physician's signature on the same form.

The "Notice Regarding Medicare Coverage" letter is given when the resident is admitted/readmitted or transferred to a Medicare non-certified bed.

Important: Do not transfer a resident on the last Medicare covered day.
Instructions for Completion of "Notice Regarding Medicare Coverage (Non-Certified Bed Letter)":

1. Name and address of the facility.
2. Date of admission re-admission or transfer to a Medicare non-certified bed.
3. Beneficiary/resident/conservator/legal guardian's name and address.
4. Beneficiary/resident/'s name as shown on the Medicare card.
5. Beneficiary/resident/'s Medicare number as shown on the Medicare card.
6. Date beneficiary is placed in a Medicare non-certified bed, admission or re-admission.
7. Reason for which the beneficiary/resident is being admitted/re-admitted or transferred to a Medicare non-certified bed. Write in one of the following reasons which best fits the situation.
   a. no prior hospital confinement
   b. does not meet the 30-day transfer requirement
   c. 100 Medicare days are exhausted
   d. no daily skilled care required
   e. resident/family request transfer
   f. resident/has waived Medicare benefits
   g. wishes to return to previous room
8. Signature of Administrator or individual completing this form.
9. Name and address of Part A Claims/Carrier
10. Write in beneficiary/resident/'s name. Physician is to check competent or incompetent.
11. Attending physician's signature. This can also be in the form of a letter or order signed by the physician or a note in the physician's progress notes signed by physician.
12. Attending physician's address.
13. Write in beneficiary/resident/'s name.
14. This box is checked when the resident/conservator/legal guardian wishes to have the bill for services beyond the day of admission submitted to the intermediary for a

coverage decision. This is called a "demand" submission and needs to be reported to the business office immediately.

15. Name and address of Part A Claims/Carrier.
16. This box is checked when the resident/conservator/legal guardian does not wish to have a "demand" submission sent.
17. Date of signature. The resident/conservator/legal guardian or responsible party signs and dates his own signature. If this is done on the day of admission to the non-certified bed, there is no need to complete Section "D".NOTE: If resident/conservator/legal guardian or responsible party refuses to sign, please not this refusal here.
18. Same date as number 2.
19. Name and relationship (if possible) of person contacted or attempted to contact by phone.
20. Signature of administrative officer or individual who made the telephone contact.
21. Same date as number 2.
22. Same date as number 2.
23. Same date as number 2.

Place a copy of the completed letter in the resident's financial folder. If Section "C" Verification of Notice was not signed and dated on the day of admission, send the original and a copy to the beneficiary/resident/conservator/legal guardian or responsible party with instructions to date and sign Section "C", to check "A" or "B", to return a signed copy to the facility, and to keep the original for their files. When the signed copy is returned to the facility, discard the unsigned copy from the financial folder and replace it with the signed copy.

Per Part A Claims/Carrier: If the responsible party does not return eh notification letter signed, we (facility) will not be held liable, as long as we have noted that the notification letter was mailed the same day as the telephone notification was given.

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Denial Letters
Notices of Non-Coverage

Appointment of Representative Form

Social Security Administration
Please read the back of the last copy before you complete this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I **Appointment of Representative**

I appoint this person _____
(Name and Address)
to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title (RSDI) ☐ Title XVI (SSI) ☐ Title IV FMSHA (Black Lung) ☐ Title XVIII (Medicare Coverage)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I am appointing, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address
Telephone Number (with Area Code) ( )	Date

Part II **Acceptance of Appointment**

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

☐ I am an attorney ☐ I am not an attorney (Check one)

Signature (Representative)	Address
Telephone Number (with Area Code) ( )	Date

Part III (optional) **Waiver of Fee**

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (optional) **ATTORNEY'S WAIVER OF DIRECT PAYMENT**

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Attorney Representative)	Date

(See Important Information on Reverse) FILE COPY

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-8917
www.harmony-healthcare.com

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Information for Claimants

What a Representative May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- give us evidence or information to support your claim;
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you tell us that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

- **Filing a Fee Petition**

  Your representative may ask for approval of a fee by giving us a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time he or she spent on each service provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

  We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

What Your Representative(s) May Charge (cont.)

- **Filing a Fee Agreement**

  If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits or $4,000, whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we approve, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. If an attorney represents you and your retirement, survivors, disability insurance, or black lung claim results in past-due benefits, we usually withhold 25 percent of your past-due benefits to pay toward the fee for you,

You must pay your representative directly:

- the rest of the fee you owe

  if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your attorney for you.

- all of the fee you owe

  If we did not without past-due benefits, for example, when your representative is not an attorney or the benefits are supplemental security income; or

  If we withheld, but later paid you the money because your attorney did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

Completing This Form to Appoint A Representative

Choosing To Be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with our representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do on the back of the "Claimant's Copy" of this form.

Paperwork and Privacy Act Notice

The Social Security Administration will recognize someone else as your representative if you sign a written notice appointing that person and, if he or she is not an attorney, that person signs the notice agreeing to be your representative. (You can read more about this in our regulations: 20 CFR §§ 404.1707, 410.684, and 416.1507.) Giving the information this form requests is voluntary. Without it though, we may not work with the person you choose to represent you.

How to Complete This Form

Please print or type. At the top, show your full name and your Social Security number. If your claim is based on another person's work and earnings, also show the "wage earner's" name and Social Security number. If you appoint more than one person, you may want to complete a form for each of them.

Part I Appointment of Representative

Give the name and address of the person(s) you are appointing. You may appoint an attorney or any other qualified person to represent you. You also may appoint more than one person, but see "What Your Representative(s) May Charge" on the back of the "Claimant's Copy" of this form. You can appoint one or more persons in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation, or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns supplemental security income.
- Title IV FMSHA (Black Lung), if your claim concerns black lung benefits under the Federal Mine Safety and Health Act.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.

How to Complete This Form (cont)

If you will have more than one representative, check the block and give the name of the person you want to be the main representative.

Sign your name, but print or type your address, your area code and telephone number and the date.

Part II Acceptance of Appointment

Each person you appoint (named in Part I) complete this part, preferably in all cases. If the person is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part III (optional) Waiver of Fee

Your representative may complete this part if he or she will not charge any fee for the services provided in this claim. If you appoint a second representative or co-counsel who also will not charge a fee, he or she also should sign this part or give us a separate, written waiver statement.

Part IV (optional) Attorney's Waiver of Direct Payment

Your representative may complete this part if he or she is an attorney who does not want direct payment of all or part of the approved fee from past-due retirement, survivors, disability insurance, or black lung benefits withheld.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

Time It Takes to Complete This Form

We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

References

- 18 U.S.C. §§ 203.205, and 207; 30 U.S.C. § 923(b); and 42 U.S.C. §§ 406(a), 1320a-6 and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 410.684 et. seq., and 416.1500 et. seq.
- Social Security Rulings §§ - 10c (C.E. 1988), 85-3 (C.E. 1985), 83-27 (C.E. 1983), and 82-39 (C.E. 1982)

Assignment of Benefits

The authorization letter on the following page should be used in facilities where this information is not included in the admission agreement.

If your facility uses the following letter, type on your letterhead and use as a part of your admission packet. Have all admissions sign the form because residents may change condition at any time and qualify for Part A or Part B. Part B services may be used at some point.

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Denial Letters
Notices of Non-Coverage

(Letterhead)

Statement to Permit Payment of Medicare Benefits to Provider

_____ _____

Beneficiary HIC Number

I request that payment of authorized Medicare benefits be paid to

_____SNF_____ on my behalf for any services

furnished me by _____SNF_____.

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Resident's Signature Resident's Name (Print)

_____

Date

_____ _____

Responsible Party's Signature R.P. Name (Party)

_____

Date

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Denial Letters
Notices of Non-Coverage
Skilled Nursing Beneficiary Notice Guide

Situation	Expedited Determination (ED)	Liability Notice*
21X Type of Bill		
Patient in a SNF inpatient stay where coverage is not met (e.g., no hospital qualifying stay).	None	NEMB-SNF (optional)
Patient in a covered SNF inpatient stay where the patient no longer has Part A coverage (e.g., benefits exhausted) and remains at a skilled level of care.	None	NEMB-SNF (optional)
Patient in a covered SNF inpatient stay where the facility determines the patient no longer meets a covered level of care but remains in the same facility.	Yes – Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	Yes-SNF Determination on Continued Stay (ABN)
Patient in a covered SNF inpatient stay and the patient is transferred to a hospital and is admitted	None	None
Patient in a covered SNF inpatient stay and the patient is transferred to a hospital (outpatient) but later returns to the SNF (same day).	None	None
Patient in a covered SNF inpatient stay and the patient is transferred to another SNF for skilled inpatient services.	None	None
Patient in a covered SNF inpatient stay and the patient is transferred to an inpatient rehabilitation facility	None	None
Patient in a covered SNF inpatient stay and the patient is transferred to an inpatient psychiatric facility	None	None
Patient in a covered SNF inpatient stay where the facility determines the patient no longer meets a covered level of care and is transferred to a nursing facility (lesser level of care).	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS 10124) if indicated	Yes-SNF Determination on Continued Stay (ABN)
Patient in a covered SNF inpatient stay where the facility determines the patient no longer meets a covered level of care and is discharged to home	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	None
Patient in a covered SNF inpatient stay where the facility determines the patient no longer meets a covered level of care and is discharged to home with health services.	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	None

* ABN is not required by the fiscal intermediary; however, an ABD may be required based on State regulations. Wheatlands Administrative Services. A CMS Contracted Fiscal Intermediary. 4/2006

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Denial Letters
Notices of Non-Coverage
Skilled Nursing Beneficiary Notice Guide (Continued)

Situation	Expedited Determination (ED)	Liability Notice*
210 Type of Bill – Non-covered level of care		
Patient in a non-covered level of care in a Medicare certified bed of a SNF and patient is transferred home.	None	None
Patient in a non-covered level of care in a non-Medicare certified bed of a SNF and patient is discharged home.	None	None
Patient is in a non-covered level of care in a Medicare certified bed of a SNF and the patient is transferred to the hospital (acute, rehabilitation or psychiatric) and admitted.	None	None
Patient is in a non-covered level of care in a non-Medicare certified bed of a SNF and the patient is transferred to the hospital and returns to the SNF (leave of absence).	None	None
Patient is in a non-covered level of care in a Medicare certified bed of a SNF and patient is transferred to a nursing facility	None	None

* ABN is not required by the fiscal intermediary; however, an ABD may be required based on State regulations. Wheatlands Administrative Services. A CMS Contracted Fiscal Intermediary. 4/2006

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage
Skilled Nursing Beneficiary Notice Guide (Continued)

Situation	Expedited Determination (ED)	Liability Notice*
22X Type of Bill		
Patient in covered SNF inpatient stay, receiving Part B only services (Part A exhausted), where the facility determines the patient no longer meets a covered level of care but remains in the same facility.	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	Yes-SNF Determination on Continued Stay (ABN)
Patient in covered SNF inpatient stay, receiving Part B only services (Part A exhausted), where the facility determines the patient no longer meets a covered level of care and is transferred to another SNF (at a non-skilled level of care).	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	Yes-SNF Determination on Continued Stay (ABN)
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), where the facility determines the patient no longer meets a covered level of care and is transferred to a nursing facility (non-skilled level of care).	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	Yes-SNF Determination on Continued Stay (ABN)
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), and the patient is transferred to a hospital and is admitted.	None	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), and the patient is transferred to an inpatient rehabilitation facility.	None	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), and the patient is transferred to an inpatient psychiatric facility.	None	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), and the patient is transferred to a hospital (outpatient) but later returns to the SNF (same day).	None	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), and the patient is transferred back to a hospital (outpatient) but later returns to the SNF (leave of absence).	None	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), where the facility determines the patient no longer meets a covered level of care and is discharged home.	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted), where the facility determines the patient no longer meets a covered level of care and is discharged to home with home health services.	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	None
Patient in a covered SNF inpatient stay, receiving Part B only services (Part A exhausted) and the patient's therapy capitation amount is met. Therapy service(s) is/are still medically necessary.	None	NEMB-SNF (optional)

* ABN is not required by the fiscal intermediary; however, an ABD may be required based on State regulations. Wheatlands Administrative Services . A CMS Contracted Fiscal Intermediary. 4/2006

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Denial Letters
Notices of Non-Coverage
Skilled Nursing Beneficiary Notice Guide (Continued)

Situation	Expedited Determination (ED)	Liability Notice*
23X Type of Bill		
Non-patient coming to the SNF to receive skilled services (e.g., therapy) and determination is made that the patient no longer meets covered skilled level of care and continues to receive services.	Yes-Expedited Review Notice (CMS10123); Detailed Notice (CMS10124) if indicated	SNF ABN
Non-patient coming to the SNF to receive skilled services (e.g., therapy) and the patient is skilled level of care (as an inpatient)	None	None
Non-patient coming to the SNF to receive skilled services (e.g., therapy) and the patient is admitted to the hospital and ultimately admitted to the hospital (acute, rehabilitation, psychiatric) as an inpatient	None	None
Non-patient coming to the SNF to receive skilled services (e.g., therapy) and the patient's therapy capitation amount is met. Therapy service(s) is/are still medically necessary.	None	NEMB-SNF (Optional)

* ABN is not required by the fiscal intermediary; however, an ABD may be required based on State regulations. Wheatlands Administrative Services. A CMS Contracted Fiscal Intermediary. 4/2006

Medicare Claims Processing Manual
Chapter 6 - SNF Inpatient Part A Billing

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(Rev. 1450, 02-15-08)

40.8.2 - Billing When Qualifying Stay or Transfer Criteria are Not Met (Rev. 1450; Issued: 02-15-08; Effective: 07-01-08; Implementation: 07-07-08)

SNF providers are required to submit claims to Medicare for beneficiaries that receive a skilled level of care. This includes beneficiaries that do not meet the qualifying stay or transfer criteria. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to update the beneficiary's spell of illness in CWF. SNFs shall follow the billing instructions for benefits exhaust claims provided in section 40.8 of this chapter. This includes the submission of covered claims in order to allow the Medicare systems to deny the claim for the appropriate reason.

Revisions to Expedited Review Notices:

1. The revised Notice of Provider Non-coverage and Detailed Explanation of Provider Non-coverage will no longer require use of the beneficiary's Medicare number as a patient identifier. Instead, providers may use a number that helps to link the notice with a related claim when applicable. This field is now optional and choosing not to enter a number will not invalidate the notice.

2. Changed the term "authorized representative" to "representative" in order to broaden the scope of representatives to include those appointed by other means (e.g. power of attorney, guardianship, etc.).

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Denial Letters
Notices of Non-Coverage

Insert

Notice of exclusions from medicare benefits

Form

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Denial Letters
Notices of Non-Coverage

Insert

Advance beneficiary notice (abn)

Form

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Denial Letters
Notices of Non-Coverage

Skilled Nursing Facility Name & Address:_____

_____

Telephone No. and TTYTDD No. _____

_____

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
Date of Notice:_____

Note: You need to make a choice about receiving these health care items or services.

It is not Medicare' opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you. **(Estimated Cost: $_____)**, in case you have to pay for them yourself or through other insurance you have.
  Your other insurance is:
  _____

- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at Address:
  _____
  _
  _____ or at: Telephone: _____: TTY/TDD:
  _____
- If you receive these items or services, we will submit your claim for them to Medicare.

Please choose one option. Check **one** box. **Date** and **sign** this choice.

- ❑ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.
- ❑ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them.

Patient's Name:_____ **Medicare # (HICN):**_____

_____ _____

Date **Signature of the patient or of the authorized representative**

Form no. CMS-10055
Form Instructions

Detailed Explanation of {Insert Type} Non-Coverage
"The Detailed Notice"
CMS-10124

A Medicare provider must furnish a completed copy of this notice to beneficiaries receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 405.1202(f)(1), and must be provided no later than close of business of the day of the QIO's notification. This is a standardized notice. Providers may not deviate from the content of the form except where indicated. Please note that the OMB control number must be displayed on the notice.

Insert logo here: **Not required**. Providers may elect to place their logo in this space. The name and address of the provider must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number of the provider must appear above the title of the form. **Title--{insert type}:** Insert the kind of service being terminated into the title, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation, or hospice services.

Date: Fill in the date the notice is generated by the provider.

Patient Name: Fill in the beneficiary's full name

Medicare number: Fill in the beneficiary's Medicare number. **{Insert type}** – Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation, or hospice.

Bullet 1 The facts used to make this decision: Fill in the patient-specific information that describes the current functioning and progress of the beneficiary with respect to the services being provided. Use full sentences in plain English.

Bullet 2 The detailed explanation of why the services are no longer covered under Medicare: Fill in the detailed and specific reasons why services are no longer reasonable or necessary for the beneficiary or no longer covered according to the Medicare coverage guidelines. Describe how the beneficiary does not meet these guidelines.

If you would like a copy of the policy: If the provider has not supplied the Medicare guidelines or policy used to decide the termination date, inform the beneficiary of how and where to obtain the policy. The provider should supply a telephone number for beneficiaries to get a copy of the relevant documents sent to the QIO.

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Denial Letters
Notices of Non-Coverage

Insert

Detailed Explanation of Non-Coverage

form

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Denial Letters
Notices of Non-Coverage

Insert

Notice of Medicare Provider Non-Coverage

Form

Denial Letters
Notices of Non-Coverage

Insert

Detailed Explanation of Non-Coverage (Page 2)

Form

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Intermediary Determination of Noncoverage

Name of SNF
Address
Date

To: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), the Medicare intermediary advised us that the services you receive will no longer qualify as covered under Medicare beginning (Date).

The Medicare intermediary will send you a formal determination as to the noncoverage of your stay after (Date). If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

Please verify receipt of this notice by signing below.

Sincerely yours,

_____
Signature of Administrative Officer

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Verification of Receipt of Notice

A. This acknowledges that I received this attached notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or person acting on Beneficiary's behalf)

B. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer

Keep A Copy of This for Your Records

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

UR Committee Determination of Admission

Name of SNF
Address
Date

To: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), our Utilization Review Committee reviewed your medical information available at the time of, or prior to your admission, and advised us that the services (you or beneficiary's name) needed do not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason the services were determined to be noncovered.)

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare Intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

Request For Medicare Intermediary Review

A. I want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

B. I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

Note: You are not required to pay for services until a Medicare decision has been made

Verification of Receipt of Notice

C. This acknowledges that I received the notice of noncoverage of services under Medicare on (date of receipt).

_____

(Signature of Beneficiary or person acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____

(Name of Beneficiary or Representative contacted)

_____

(Signature of Administrative Officer

Keep A Copy of This For Your Records

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

UR Committee Determination of Continued Stay

Name of SNF
Address
Date

To: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), our Utilization Review Committee reviewed your medical information and found that the services furnished (your or beneficiary's name) no longer qualified for payment by Medicare beginning (Date).

The reason for this is: (Insert specific reason services were determined to be noncovered).

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. A bill will be sent to Medicare for the covered services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision you must request that the bill submitted to Medicare include the services our URC determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

SNF Determination ON Admission

Name OF SNF
Address
Date

To: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services (you or beneficiary's name) needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services were determined to be noncovered).

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

Harmony Healthcare INTERNATIONAL

Denial Letters
Notices of Non-Coverage

SNF Determination ON Continued Stay

Name of SNF
Address
Date

To: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), we reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified as covered under Medicare beginning (Date).

The reason is: (Insert specific reason services were considered noncovered).

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____

Signature of Administrative Officer

Medicare Part A Appeals Process

Definition of Appeals

An appeal process is available to providers who are dissatisfied with the determination rendered on their claim. The process consists of five levels. Each level is discussed in detail in below. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. Redetermination, Reconsideration, Administrative Law Judge (ALJ), and Appeals Council requests are applicable to inpatient hospital services and skilled nursing care services. Review and Fair Hearing Appeal requests are applicable to outpatient services.

First Level of Appeal: Redetermination

Providers, suppliers, and beneficiaries that are not satisfied with an initial claim determination may follow the instructions on the Remittance advice or Medicare Summary Notice to request a redetermination of an unfavorable or partially favorable claim decision. Any signed and dated written statement or letter indicating that the beneficiary, his/her authorized representative or provider is expressing dissatisfaction with the initial determination on a claim for skilled nursing care or inpatient services, made to Medicare Part A may constitutes a request for redetermination. A request for a redetermination may be completed using Form CMS-20027. Any requests made not using this form must be submitted in writing and include all of the following specific demographic information related to the claim in question:

1. Beneficiary name;
2. Medicare health insurance claim (HIC) number;
3. The specific service(s) and/or item(s) for which the redetermination is being requested;
4. The specific date(s) of the service; and
5. The name and signature of the party or the representative of the party

Signature Requirements

All appeal requests must be signed by the requestor. Requests received without the appropriate signature are returned. An appeal request submitted with incomplete medical records can result in an unfavorable determination on all or a part of the claim.

Timely Filing:

The time limit for filing a request for redetermination is 120 days from the date of receipt of the Medicare Summary Notice (MSN) or Remittance Advice (RA). The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary. The time limit for filing a request for redetermination may be extended in situations the appellant has established good cause. Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes

Medical Record Requirements

The redetermination level of the appeal process is performed by Medicare Administrative Contractor (MAC) staff member, who was not involved in making the initial claim determination. How the contractor conducts its redetermination depends on the appellant's request and what is at issue. There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the amount paid, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable. If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed. The appellant should submit with the request all medical record documentation that support the medical necessity of the services under appeal. Complete medical records for the dates of service in question may include:

- Itemized statement (detailed listing of all charges) and matching UB92;
- Physician's orders;
- MDS;
- X-ray reports;
- Test results;
- *Hospital discharge summary and history and physical*
- Medical history;
- Documentation of severity or acute onset;
- Consultation reports;
- Billing forms;
- Referrals;
- Initial evaluation/plan of treatment;
- Nurse's notes;
- Copies of communications between physician and/or beneficiary, hospital,
- Laboratory, etc.;
- Progress notes;
- Medication records;

- Ambulance run sheets;
- Visual fields and photos;
- Therapy records;
- Mammogram reports;
- Operative report;
- Pathology report; and
- Denial letter or remittance advice indicating the denial note.

The file should be organized in a manner that supports an efficient review of the record with pages numbered. The provider may also wish to include a cover letter that summarizes the facts of the case and supports why the initial determination of the claim should be overturned.

Redetermination Decisions

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request. The results are compiled in a letter and all appropriate parties are notified. Favorable determinations will be reflected on a future remittance advice.

Second Level of Appeal: Reconsiderations

Any party to the redetermination that is dissatisfied with the results may request a reconsideration of decision. The Qualified Independent Contractor (QIC) will conduct the reconsideration. This Reconsideration process allows for an independent review of the initial determination, including the redetermination. This review will likely include a review of the medical necessity issues by a panel of physicians or other healthcare professionals an indicated by the services.

A request for a redetermination may be completed using Form CMS-20033. Any requests made not using this form must be submitted in writing and include all of the following specific demographic information related to the claim in question:

1. Beneficiary name;
2. Medicare health insurance claim (HIC) number;
3. The specific service(s) and/or item(s) for which the redetermination is being requested;
4. The specific date(s) of the service; and
5. The name and signature of the party or the representative of the party
6. The name of the contractor that perform the redetermination

The reconsideration request should also include a clear explanation of the appellant's reason for disputing the redetermination decision. A copy of the RA or Medicare Reconsideration Notice (MRN) and any other pertinent information that supports the request for reconsideration may also be submitted with the reconsideration request. It is not necessary to submit the entire medical record with this request because when the QIC receives a request for reconsideration, it

will request the case file from the contractor. Any documentation noted as missing in the redetermination decision must be submitted prior to the issuance of the reconsideration decision or it will be excluded from consideration at subsequent levels of appeal.

Timely Filing

The time limit for filing a request for redetermination is 180 days from the date of receipt of the Redetermination decision.

Reconsideration Decisions

The QIC will render its decision in writing to all parties within 60 days of the receipt of the request for reconsideration. If the QIC is unable to render its decision within 60 days, it will inform the appellant of their right to expedite the case to an ALJ appeal.

Third Level of Appeal: Administrative Law Judge (ALJ)

When a claimant is dissatisfied with a reconsideration decision, the next level of appeal is an Administrative Law Judge hearing. To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration*. The appellant must also send a copy of the request for hearing to the other parties.

The request must be made within 60 days from the date the written determination was received. The benefits in question must total $140 or more. The request for an ALJ hearing must be made in writing. For the convenience of parties, HHS provides a form that may be used to request a Medicare ALJ hearing. The contractor provides copies of the form to parties upon request, but there is no requirement that this form be used to make the request. The request must include all of the following:

1. The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,
2. The name and address of the appellant, when the appellant is not the beneficiary,
3. The name and address of the designated representative, if any,
4. The document control number assigned to the appeal by the QIC, if any,
5. The dates of service,
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

Hearing preparation procedures are set by the ALJ. The ALJ will determine whether an in person/telephone hearing is warranted on a case by case basis. In some case the appellant may request the decision be made based on the record in the absence of a hearing.
In most cases the ALJ will render a within 90 days although the timeframe may be extended.

Fourth Level of Appeal: Appeals Council Review

When the dissatisfaction continues after the ALJ's decision, the claimant may request the Appeals Council (AC) to review the decision. The request must be filed within sixty days of the date of the ALJ decision. If a party requests the Appeals Council to review an ALJ's decision, the Appeals Council may review the decision and adopt, modify, or reverse the ALJ's decision, or remand the case to an ALJ for further proceedings.

In general, the Appeals Council will issue its decision with 90 days of the receipt of the request for review.

Fifth Level of Appeal: Judicial Review in U.S. District Court

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court within 60 days of the receipt of the Appeals Council's decision. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S. District Court. The amount remaining in controversy for requests made before January 1, 2013 is $1,400. The amount remaining in controversy is increased annually by the percentage increase in the medical care component

Appointment of Representative

A party to a hearing may appoint an attorney or other individual to act as his/her authorized representative, unless prohibited by law.

A properly completed Appointment of Representative form (CMS – 1696) is *required* if:

- the individual (including an attorney) wishes to act as a claimant's representative in a hearing or further level of appeal; or,
- in the case of PRO determination the beneficiary must execute a form CMS – 1696 The form CMS – 1696 can be obtained through the local Social Security Office. When accepting an appeal request from an appointed representative, the representative form (1696) will be accepted. However, except in the above two examples, a representative can also be appointed by submission of a written statement containing:
- the beneficiary's name, address, telephone number and signature;
- the representative's name, address, telephone number and signature;
- a dated statement indicating that the beneficiary authorized the representative to act on his/her behalf for the claim in question; and,
- a statement that the representative accepts the appointment (plus appropriate waivers of payment and fees if the representative is the physician/supplier or provider who provided the services at issue on appeal).

As the representative, you may exercise any and all rights given to parties on behalf of the person you are representing. You will be notified of any action, request for documentation and claim determination.

Beneficiary Deceased

If the beneficiary is deceased, an appeal request may be filed by the legal representative of the estate. In the absence of a legal representative, the appeal request may be filed by any person who has assumed responsibility for settling the decedent's estate.

Reopenings

A reopening is not an appeal. It is a discretionary action by Medicare if good cause exists. A reopening of an initial claim determination only can take place when all appeal rights have been exhausted or after the time limit for an appeal has expired.

Reopenings are conducted when:

- New and significant material evidence, which was not available when the initial decision was made, is presented;
- Medicare clerical or computational errors were made;
- Errors are identified based on the evidence; or,
- Errors were caused by fraud.

Reopenings can also be made between the review and fair hearing process when:

- Information is submitted supporting a full reversal;
- On Medicare's initiative it is determined that a claim was erroneously paid;
- If it is determined that an entire group of claims were denied because of a systems error or malfunction; or,
- An incorrect interpretation of Medicare law, policy or regulations.

Medicare Fee-For-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Monetary Threshold to be Met
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (AJL) Hearing	60 days from the date of receipt of the reconsideration	At least $140 remains in controversy
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	Review 60 days from date of receipt of DAB decision or declination of review by DAB.	At least $1,400 remains in controversy.*

* Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to File an Appeal

Level	Part A*	Part B
Redetermination	FI or MAC	Carrier
Reconsideration	QIC	QIC
ALJ Hearing	MAC or HHS OMHA Field Office if heard by a QIC	Carrier or HSS OMHA Field Office if heard by a QIC
DAB Review	DAB or ALJ Hearing Office	DAB or ALJ Hearing Office

* Includes part B claims filed with the FI.

Appeals Process Comparison

Additional Documentation Review Tracking Log

Month: _____ Year: _____

Resident	Review Period		Date ADR Received	Date ADR Submitted	ADR Result	Date of denial	Appeal Plan	Date Appeal filed	Appeal Result

Beneficiary Review Meeting

Signature Page

Overview

On a weekly basis, the Medicare team discusses the coverage criteria for each Medicare Part A beneficiary along with an administrative review of the timely completion of MDS assessments, denial letters, certification forms, consent forms, Medicare secondary payer letters and beneficiary voluntary placement letters.

All participants sign for attendance at each weekly Beneficiary Review Meeting.

Beneficiary Review Meeting

Beneficiary Review Signature Page

Facility: _____

Date: _____

Attendees Signatures

Administrator: _____

Director of Nursing: _____

MDS Coordinator: _____

Social Services: _____

Admissions: _____

Restorative Nurses Aide: _____

Business Office: _____

Therapy Representative: _____

Charge Nurse: _____

Charge Nurse: _____

Respiratory: _____

Other: _____

_____

_____

_____

Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983 ♦ Tel: 978-887-8919 ♦ Fax: 978-887-8917
www.harmony-healthcare.com

Beneficiary Review Meeting

Admission Roster

Overview

This roster reviews ALL admissions in past week, where admitted, payer source, proper completion of Medicare letters, therapy needs, etc.

If Medicare Part A Beneficiary, name will also be listed on Part A Roster.

Admissions Roster – April 1, 2001

Harmony Healthcare SNF

Name	Admit Date	Cert Bed	Non-Cert Bed	Qualify for Part A Y/N	Part A Benefits Y/N	MSP	Consent Form	Beneficiary Voluntary Placement	Denial on Admission
Anderson, R	5/1/00	Yes	No	Yes	Yes	5/1/00	N/A	N/A	N/A
Bright, C	5/2/00	No	Yes	No	No	5/2/00	5/2/00	N/A	5/2/00
Hollimon, G	5/6/00	No	Yes	Yes	Yes	5/6/00	5/6/00	5/6/00	5/6/00

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Beneficiary Review Meeting

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Admissions Roster

Date: _____

Facility: _____

Name	Admit Date	Cert Bed	Non-Cert Bed	Qualify for Part A Y/N	Part A Benefits Y/N	MSP	Consent Form	Beneficiary Voluntary Placement	Denial on Admission

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www.harmony-healthcare.com

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Part A Beneficiary Review

Insert Part A Beneficiary Review Log – Sample - Landscape document

Insert Part A Beneficiary Review Log Landscape document

Insert Patient Profile and Status Sheet

Insert Daily Tracker Landscape Document

Harmony Healthcare International (HHI)
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Beneficiary Review Meeting

Commercial/HMO Roster

Overview

Complete on all HMO/Managed Care residents.

Insert Commercial/HMO Roster Landscape Here

Beneficiary Review Meeting

Part B Log

Overview

Complete on all active and potential Part B therapy recipients.

Insert Part B Log Landscape here

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30 Day Denials

Overview

Review all patients discharged off of Medicare Part A within last 30 days. If a resident has a change of condition or skilled services are necessary, the resident can resume Medicare Part A coverage without a three night qualifying stay.

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30 Day Denial Log

Facility: _____

Beneficiary Name	Date Reviewed	Discharge Date	Days Remaining	30 Day Cut Off	Status
Sally Sample	6/22/01	6/15/01	66	7/15/01	

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30 Day Denial Log

Facility: _____

Beneficiary Name	Date Reviewed	Discharge Date	Days Remaining	30 Day Cut Off	Status

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CMS/HCFA Updates

Overview

Discussion of CMS/HCFA Updates and reimbursement memos. Review of help letters and denials discussed during this forum.

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Notes

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Notes

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Beneficiary Review Meeting

Medicare Length of Stay

Policy and Procedure

The most accurate method to calculate the Medicare Average Length of Stay (ALOS) is as follows:

- The mathematical division is straight-forward (i.e., Numerator on top, Denominator on the bottom).
- **Denominator =** Total number of patients **discharged for Medicare** for whatever reason, during the month in question.

  The Denominator would include any Medicare patients who died, were discharged from the facility, exhausted their 100 days, were removed from Medicare coverage for clinical reasons or left the facility AMA. This includes any patient who was covered on Medicare at the beginning of the period and was not covered on Medicare at the end of the period, period!
- **Numerator =** The total number **of Medicare days covered in each patient's spell of illness** for the patients identified in the Denominator.

  The Numerator would include all the covered Medicare SNF days at the facility from the initial date of admission under this spell of illness to the final discharge. The facility should not count days used at another facility.

Examples:

	Admitted	Discharged	Stay
Jane Doe	1/1/96	2/15/96	45 Days
Bill Smith	1/1/96	1/30/96	29 Days
Bill Smith	2/1/96	2/15/96	43 Days

January ALOS	29/1	=	29
February ALOS	45+43/2	=	44

The above policy should assure that all facilities are calculating ALOS the same way and should yield a result that is sufficiently close to what we report on the Medicare cost report at year end.

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Form Instructions

Monthly Summary

1. The purpose of this form is to identify by facility, on a monthly basis, those patients who are no longer covered by Medicare A.
2. The MDS Coordinator from each facility ensures that this information is sent to the VP of Reimbursement by the 5th of each month.
3. Cell Descriptors
   - Patient Name = patient name
   - Primary Diagnosis = primary diagnosis for Medicare A coverage
   - Admission Date = date Medicare A benefits started
   - Discharge Date = date Medicare A benefits ended
   - Medicare LOS = number of days patient was covered by Medicare
   - Discharge Destination = options are: home, hospital, death, another SNF, in-house, other

Annual Overview

1. The purpose of this form is to have a trend report or what is happening with the Medicare discharges from a particular facility. It allows one to analyze the discharges by month with specific details about discharge destinations.
2. Cell Descriptors
   - Average Medicare LOS = facility Medicare LOS for that month (get from mlosglan.wpd form).
   - Number of patients discharged = total number of patients off Medicare for the month (get from mlosglan.wpd form)
   - Destination Breakdown (home, hospital, death, another SNF, in-house, other (get from mlosglan.wpd form).
     - Number = Number of Medicare patients discharged to that destination for the month (total adds to number of patients discharged for the month)
     - Percentage (%) = percentage (0/o) of discharges for that destination
     - LOS = ALOS for those discharge destinations

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Medicare Length of Stay

Facility:_____

Month/year:_____

Patient	Medicare Admit Date	Medicare Discharge Date	Avg Medicare LOS	Total Days	Number of Patients Discharged	Home LOS	Hospital LOS	Death LOS	Other SNF	In-House LOS

Rev 6/06

Beneficiary Review Meeting

Medicare Length of Stay
Annual Overview

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Facility:_____

Month/year:_____

Month	Average Medicare LOS	Number of Patients Discharged	Home LOS	Hospital LOS	Death LOS	Another SNF LOS	In-House LOS	Other (Describe)
January								
February								
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								

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Appendix

Acronyms

ADL	Activities of Daily Living
ALJ	Administrative Law Judge
ANA	American Nurses Association
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1998 (Public Law 105-33)
CFR	Code of Federal Regulations
CPI	Consumer Price Index
CPS	Cognitive Performance Scale
ESRD	End Stage Renal Disease
FI	Fiscal Intermediary
FMR	Focused Medical Review
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
IUB	Health Insurance Benefits
HICN	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
IFR	Interim Final Rule
JCAHO	Joint Commission for the Accreditation of Hospitals and Organizations
LOA	Leave of Absence
LOC	Level of Care
MAR	Medicine Administration Record
MDS 2.0	Minimum Data Set Version 2.0
MEDPAR	Medicare Provided Analysis and Review Form
MIF	Medical Information Form
MIM	Medicare Intermediary Manual
MRQ	Medical Review Questionnaire

Appendix

MSP	Medicare Secondary Payor
NHCMQ	Nursing Home Case-Mix and Quality Demonstration (N4ulti state project)
OBRA 87	Omnibus Budget Reconciliation Act 1987
OMRA	Other Medicare Required Assessment
PM	Program Memorandum
PPS	Prospective Payment System
QC	Qualifying Children
QI	Quality Indicators
RAI	Resident Assessment Instrument
RAPs	Resident Assessment Protocol Guidelines
RUG III	Resource Utilization Group Version III
SCSA	Significant Change in Status Assessment
SMIB	Supplementary Medical Insurance Benefits
SNF	Skilled Nursing Facility
SSA	Social Security Administration
STM	Staff Time Measurement

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Appendix

Glossary of Terms

The following are “brief” definitions of many common terms utilized in Skilled Nursing Facilities. The complete definition of each term can be found in HCFA’s Skilled Nursing Manual Pub. 12. Also included are terms associated with the Resident Assessment Instrument.

Administrative Hearing

If, you have requested a "demand" bill (reconsideration by the intermediary), are still dissatisfied with the determination and the amount in controversy is $ 100 or more, you may request an Administrative Hearing by an Administrative Law Judge of the Bureau of Hearings and Appeals. If you disagree with the Administrative Law Judge's decision, you may request that HCFA's Appeals Council review the decision. If still dissatisfied with the final decision of the Administration, and the amount in controversy is $ 1,090 or more, you may initiate action for Federal court review of your claim

Administrative Law Judge (ALJ)

An Administrative Law Judge is hired by the Social Security Administration. They hold hearings and make determinations regarding the rights of Medicare beneficiaries. The ALJ reviews services covered under Medicare Part A which involve more than $100 and services covered under Part B which involve more than $500 (after the Part B claim has been denied in whole or in part by a Part B Carrier hearing officer).

ADR

Additional Data Request

Air-Fluidized Therapy

Therapy prescribed as treatment for severe skin breakdown.

Ancillary

Services and supplies provided beyond the scope of routine.

Appeals Council

A division of the Social Security Administration which considers appeals from decisions of Administrative Law Judges. The amount in controversy must be at least $500 in Part B cases, $200 in hospital cases (cases initially decided by the Peer Review Organization) and $100 in skilled nursing facility and home health cases (and other cases initially decided by an intermediary).

Assessment Reference Date

The last day of the MDS observation period. This date refers to a specific end-point in the MDS assessment process.

Assignment

When a physician or other health care practitioner or supplier agrees to “accept assignment,” he agrees to be paid directly to Medicare and not to charge the Medicare patient any more for his service than the reimbursement rate (or “reasonable charge” rate) allowed by Medicare. Medicare pays 80% of the “reasonable charge;” the patient is only responsible for the remaining 20%.

Assignment of Benefits

Method whereby a beneficiary requests his/her healthcare benefits be paid to some designated person or provider.

Beneficiary

An individual who is entitled to healthcare benefits.

Benefit Period

The term "benefit period" is synonymous with "spell of illness". "Benefit period" is actually a better term to use when communicating with the public, because the term "spell of illness" could be taken to mean a single illness or a particular period of sickness. The foregoing is not the definition of either "benefit period" or "spell of illness". See "Spell of Illness" below for a more detailed definition.

Carrier

An agent of the federal government, usually an insurance company, which makes Part B Medicare claim determinations, establishes “reasonable charge rates,” and issues payments. The Carrier is also responsible for making decisions when a claimant requests a “review” of a Part B denial. Hearing officers employed by the Carrier are responsible for the Part B hearings which follow unsatisfactory review decisions for cases involving claims of at least $100.

Carrier

The Part B carrier is an organization which has entered into an agreement with HCFA to perform specified administrative functions under the medical insurance program.

Case Mix

A case mix system measures the intensity of care and services required for each resident and then translates it into a payment level. In making this adjustment, the Federal rates incorporated a patient classification system based on intensity of resource use with corresponding payment weights.

Certified Bed

A bed within a long-term care facility, which has been, approved for Medicare Part A usage.

Certified Distinct Part (CDP)
Physical area of the facility, which has been licensed to accommodate skilled Medicare patients. It is usually a wing or group of beds in close proximity to a nursing station. The patients in this area should be the highest acuity patients.

Claimant
An individual requesting reimbursement from Medicare for expenses incurred for medical care (or an individual requesting payment on behalf of a Medicare enrollee).

Coinsurance
The amount a beneficiary must pay as his or her share of the cost of a given service. For example, a beneficiary must pay part of the cost of days 61 through 150 in the hospital, and days 21 through 100 in the skilled nursing facility. There is also a co-insurance (20% of the reasonable charge), which must be paid for Part B services. The coinsurance may be covered by another insurance or Medicaid.

Comprehensive Assessment
A comprehensive assessment is the completion of Resident Assessment Protocols (RAPS) and the entire Minimum Data Set (MDS).

Complex Medical Equipment
An ancillary item that is not routinely utilized in a skilled nursing facility i.e., ventilator or specialty beds.

Conservator
An individual appointed by the court to manage the property and/or personal matters of another person.

Custodial Care
Care required to maintain level of function that does not require the skills of a nurse or therapist.

Deductible
The amount which a beneficiary must pay before Medicare (or other insurance program) will begin to cover the bill. Deductibles must be paid before Medicare will cover services under Part B and hospital care under Part A.

Default Rate
The RUG III default rates take the place of the otherwise applicable Federal rate (it does not supersede the facility specific portion of the blended rate used for the transition period into PPS. Default rates are used when assessments are not completed by SNFs according to the assessment schedule mandated by federal regulations.

Demand Bill
Bill sent to the intermediary at the request of the patient or responsible party for services that the facility has determined to be noncovered.

Denials
See "Notice of Non-Coverage".

Diagnostic Related Groupings (DRGs)
The categories established by Medicare which are used to determine set rates for Medicare reimbursement for most inpatient hospital care. There are approximately 477 categories, or DRGs, each with a set payment rate. These predetermined rates are Medicare's full payment to hospitals for inpatient services, with certain exceptions. For example, rehabilitation hospitals and rehabilitation distinct part units are exempted from the DRGs and the associated standard payment amounts; care for Medicare patients in these facilities is reimbursed by Medicare on a reasonable cost or other basis.

Distinct Part
A unit which is physically and/or operationally separate from the rest of the institution. This can be a separate building, floor, wing or ward. It may consist of several floors or wards. Beds must be physically separate from those units housing all other patients in the institution. If a resident is not in a certified Medicare Skilled bed (distinct part), a facility is not able to bill for skilled care until that resident is physically located in a bed in the distinct part.

Dual Certification
This term applies when all beds within a facility may be utilized as Medicare Skilled beds. This is particularly beneficial to a home when a current resident is transferred to an acute hospital and then returns after a stay of at least three days. That resident can then be placed in his or her same, room rather than undergo a change in room (into a distinct part of the facility).

Durable Medical Equipment (DME)
Equipment, which can stand repeated use, is primarily and customarily used to serve a medical purpose and is generally not useful to a person in the absence of an illness or injury. Examples of DME are hospital beds, wheelchairs, commodes, walkers, etc.

Electronic Medicare Claim Submission (EMC Billing)
Claims submitted to the intermediary electronically.

Eligibility
A person who meets technical and clinical criteria to access their Medicare benefits.

Employee Group Health Plan (EGHP)
Insurance benefits provided through employer of beneficiary and/or spouse.

End Stage Renal Disease (ESRD)
A beneficiary who is under 65 years of age requires hemodialysis or a renal transplant. Medicare becomes secondary to EGHP for the first 18 months. Medicare is primary if the beneficiary is not eligible for EGHP benefits.

Entitlement
A person who meets the criteria which gives them the right to become a Medicare beneficiary.

Explanation of Medicare Benefits (EOMB)
The written notice issued by the intermediary listing services provided, amount billed and payment made by Medicare Part B. This notice is not a bill. The EOMB serves as the "initial determination" for Part B from which a dissatisfied Medicare patient may appeal.

Fiscal Intermediary
An entity, which has contracted with the Health Care Financing Administration to handle claim from providers of care, to make Medicare payments for Part A or Part B benefits, and to perform other related functions as well.

Focused Medical Review
The Health Care Financing Administration (HCFA) has directed fiscal intermediaries to select, by a process called "Focused Medical Review", claims to be reviewed. In order to develop this "Focused Medical Review", the intermediary must:

- Collect data so as to monitor practice patterns and trends, identify areas of potential over-utilization and patterns of non-covered services.
- Analyze the data collected so as to identify and develop or modify criteria to focus on services, procedures or providers etc., which would be most costly to the Medicare program.
- Verify through Medical Documentation that problems do or do not exist.

Focused Medical Review (Continued)
The fiscal intermediary is required to analyze the effects of the focused review criteria and establish audit trails to monitor changes in procedures and practices as a result of the focusing review. If a problem is found, the facility is informed of the specific problem and provided any data and education necessary to enable the facility to change the inappropriate practice patterns.

Appendix

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Full Assessment

A RM assessment is the completion of the entire Minimum Data Set (MDS).

Good Cause

When a claimant files a Request for Reconsideration more than 60 days after receipt of an "initial determination" which denies benefits, or requests a Hearing more than 60 days after receipt of a negative reconsideration decision, he/she must establish "Good Cause" for filing the appeal late. Good cause is defined by federal regulations and includes the fact that illness prevented the beneficiary from making the request on time, the loss of important records, and incorrect information given by Medicare concerning the requirements for the timely filing of an appeal.

Grace Days

Additional days allowed for completion of MDS. Should be used cautiously as constant usage may result in focused review.

HCFA (Health Care Financing Administration)

The Health Care Financing Administration (HCFA) is a division of the Department of Health and Human Services (HHS), and is the administrator of the Federal Government's Medicare program HCFA's mission is to set the standards and requirements for the Medicare Program, provide the funds for its implementation and maintenance and to oversee the operation of the Program at the Federal level. Changed name to CMS, Centers for Medicaid & Medicare Systems.

Health Care Financing Administration (HCFA)

The federal agency that administers the Medicare program. The agency is a division of the United States Department of Health and Human Services.

Health Insurance Claim Number (HIC Number)

A social security number assigned by the HCFA that identifies the beneficiary's entitlement to Medicare benefits. This number appears on the beneficiary's health insurance (Medicare) card. The beneficiary's Medicare number is not necessarily his/her social security number.

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) is a private organization funded by premiums paid by enrollees; these fees, paid in advance, cover most of an HMO enrollee's health care costs. The HMO provides most of the health care services needed by its members. Many HMOs enter into a contract with HCFA to provide Medicare covered services to enrolled Medicare beneficiaries.

Help Letter

A computer generated letter from the intermediary identifying an error/omission on the bill or requesting supporting documentation from the provider.

Homebound
A patient who does not have the sustained capability to receive medical care outside the home. For example, the patient cannot leave home without the use of a wheelchair, walker, or the assistance of another person. Leaving home is contraindicated or requires a considerable and taxing effort and absences are infrequent or for short durations. A patient does not have to be bed-bound in order to be homebound.

Home Health Agency
An agency, public or private, which provides home health services (for example: nursing, therapy, aide services) to patients who are homebound. To receive Medicare coverage for home health services, the services must be provided by, or under arrangements with, a Medicare certified home health agency.

Home Health Aide
An individual trained in methods of assisting patients who, under supervision of a registered nurse, performs simple procedures for patients. Procedures include extensions of therapy services, ambulation, exercises, personal care, assistance with medications that are ordinarily self-administered and household services essential to health care at home. The Home Health Aide is responsible for reporting changes in the patient's condition and/or needs, and completing appropriate reports.

Hospice
An organization, public or private, which provides palliative and supportive care to terminally ill beneficiaries in the home, or on an inpatient basis. The hospice facility must have a contract with Medicare Part A. If Hospice is being billed, the patient can not use skilled nursing facility Part A benefits at the same time.

Initial Determination
An initial determination is the first formal decision regarding Medicare coverage or entitlement. A beneficiary may appeal a negative initial determination. Part A initial determinations are issued by the fiscal intermediary or Peer Review Organization; Part B initial determinations are issues by the carrier. A decision regarding Medicare coverage by the provider's utilization review committee or similar group is not an initial determination. Generally, an individual must have received an initial determination in order to appeal a Medicare denial.

Inpatient
An individual admitted to a hospital, skilled nursing facility, or other health care institution for treatment.

Intermittent
Home health care provided as much as once a day for a predictable period of time or as little as once every 60 days.

Appendix

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International Classification of Diseases 9th Edition (ICD-9)

Diagnostic listing that identifies codes for reporting diagnosis. The coding and terminology provides a uniform language that will accurately designate primary and secondary diagnosis on claim forms.

Leave of Absence (LOA)

Period of time away from the SNF (Therapeutic pass), ordered by a physician.

Licensed Personnel

Care given by or under the supervision of a physician, nurse or therapist.

Limited Charge

The amount of physician who does not accept assignment, may bill a Medicare beneficiary. This limit is set pursuant to federal law.

Managed Care

An alternative health care delivery that may require prior authorization and ongoing review.

Medicaid

A state-funded insurance plan (welfare, agency). Titles vary among states.

Medical Appropriateness Exception

There are times when it would be inappropriate from a medical standpoint, to begin treatment within 30 days after hospital discharge. In order to qualify to begin skilled treatment more than 30 days after discharge from the hospital and have that treatment covered as Part A, the following conditions must be met:

1. It must be medically predictable at the time of hospital discharge that a covered level of skilled nursing facility care will be required within a stated period of time.
2. A notation as to #1 above, must be made in discharge summary.
3. A notation regarding #1 above, should be made in physician orders.
4. The treatment at the skilled nursing facility must be for a condition, for which hospital care was given.
5. The resident must begin receiving such care within the stated time frame.

Medicare Claim Determination

The written notice of denial of Medicare coverage issued by the intermediary or Peer Review Organization (PRO). This notice serves as the "initial determination" which is necessary to request a "reconsideration," the first step in a Medicare appeal.

Appendix

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Medicare Risk
An insurance plan chosen by the Medicare beneficiary to administer Medicare Part A and Part B benefits. The insurance plan must be contracted with the HCFA to administer Medicare benefits and is in most cases an HMO.

Medicare Secondary Payor (MSP)
A situation in which Medicare is not the primary payor. Bill other insurance first.

Medigap Insurance
This term refers to private insurance which covers the "gaps" in Medicare (such as deductibles and coinsurance amounts) these policies generally do not pay when Medicare refuses coverage.

MIF
Medical Information Form (MIF) is the Blue Cross form pertaining to a calendar month during a given resident's Medicare stay in a skilled nursing facility. It contains the medical information necessary to support the claim made on the HCFA form, UB92, and must be completed and submitted within 21 days of the date Blue Cross requests it. If the MIF supports the coverage decision, the claim is released for payment. If any portion of the claim is denied, the facility is notified.

Minimum Data Set (MDS)
A set of screening, clinical and functional status elements used in the assessment of residents in long term care facilities. It is the foundation of the comprehensive assessment for all the Resident Assessment Instrument (RAI).

MRQ
Medical Review Questionnaire (MRQ) is the same as the MIF, except that it is the form required by Mutual of Omaha. The layout of the form is different but it serves the same purpose.

Note that all fiscal intermediaries utilize a form similar in nature and format to the MIF and the MRQ.

Multi-Disciplinary Rehabilitation
A combination of physical therapy, occupational therapy, speech language pathology services, or other skilled rehabilitative or medical services.

Non-Certified Bed
A bed in a nursing facility which has not been approved for Medicare reimbursement.

Notice of Non-Coverage
Also referred to as "denials". The letter which is issued to the beneficiary and/or responsible party giving notification of a change in level of care which will result in a change of pay source.

Occupational Therapy
The medically prescribed treatment concerned with improving or restoring physical functioning which has been impaired by illness or injury, or where function has been permanently lost or reduced by illness or injury.

Other Medicare Required Assessment (OMRA)
An ONIRA is a full assessment and is required when a significant change in status assessment is not warranted but a discontinuation of all rehabilitative services has occurred.

Outpatient
An individual who is not admitted as an “inpatient” to an institution but rather is registered at the institution as an “outpatient” or “day patient,” who receives services, not just suppliers, from the institution, and who is not expected to stay in the institution past midnight.

Part A
Part A is Medicare's hospital insurance and helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care.

Part B
Part B is Medicare's medical insurance coverage and helps pay for medically necessary doctor's services, home health care, hospital outpatient services and those services and supplies not covered under Part A. It is an elective supplemental medical insurance and, as such, there is a charge for this coverage in the form of a monthly premium, an annual deductible and a co-payment for each service.

Participating Provider
A hospital, skilled nursing facility, home health agency, hospice, or provider of health services under Medicare Part B, who meets Medicare’s conditions of participation and who is authorized by HCFA to participate in Medicare and to receive payment for services covered by Medicare.

Part-Time
Home health care provided for less than 8 hours per day. If the threshold criteria are met, Medicare coverage, even for services provided 7 days per week, is available if the care is provided for less than eight hours p/day.

Physician Directed Rehabilitation Program (PDRP)
An interdisciplinary inpatient rehabilitation program directed by a physician.

Practical Matter
When considering a patient for admission into a skilled nursing facility, you must consider the practicality of the patient receiving the scheduled services in a skilled nursing facility. Are there alternative facilities or services which could be considered and are these options a more economical alternative?

Primary Insurance
The insurance plan that must be billed first.

Prior Authorization (Prior Approval/Pre-Authorization)
Process of obtaining approval for coverage prior to admission and the utilization of benefits.

PRO (Peer Review Organization)
The organization which is under contract with the Medicare administration to monitor the quality, necessity, and appropriateness of the health care provided to Medicare patients in hospitals. The PRO issues the initial determinations and reconsideration decisions in hospital cases.

Prospective Payment System (PPS)
The reimbursement method used by the Medicare program to pay for most inpatient hospital services. Payment is made according to a predetermined diagnosis-related group (DRG) amount figured according to the average cost of caring for patients with the same diagnosis in the past. Rehabilitation hospitals, and rehabilitation distinct-part units, long term care hospitals, and certain other specialty hospitals are exempted from the PPS.

Provider
A physician, supplier, skilled nursing facility, home health agency, hospice, or hospital providing services. A "Participating Provider" or "Medicare-certified Provider" meets Medicare's conditions of participation and is authorized to participate in Medicare and to receive payment for services covered by Medicare.

Reasonable Charge
(Sometimes referred to as the "approved" or "allowable" charge). The Medicare reimbursement rate established by the Medicare Carrier for physicians, health care practitioners, and suppliers which is the lesser of the actual charge, the customary charge made by the practitioner or supplier for similar services, the prevailing charge in the locality for similar services, and other necessary appropriate factors. The "reasonable charge" is almost always less than the provider's actual charge.

Reasonable and Necessary
As a practical matter, it must be reasonable and necessary that a resident be in a skilled nursing facility to receive the services he/she is scheduled to receive. Another consideration is the frequency of the service being given. Could the resident progress just as well receiving the service a couple of days per week rather than daily? Many services offered in a skilled nursing facility are also available on an outpatient basis.

Reconsideration
The first step in the appeals process for Medicare Part A.

Resident Assessment Instrument (RAI)
A tool to capture as much information as possible on every long term care resident. It is designed to enhance access to care, improve the equity and predictability of payment amounts, streamline the payment and quality process, and ultimately improve the quality of resident care.

Resident Assessment Protocols (RAPs)
Structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about a resident. RAPs help identify social medical and psychological problems and form the basis for individualized care planning.

Resource Utilization Groups (RUGS)
A forty-four group classification and resource index system for Medicare, and, a collapsed 34-group system for all other nursing home residents. RUGs are used to set predetermined rates for a large portion of payment amounts to SNFs, under the Medicare program, and to nursing facilities for the Medicaid program. RUG classifications re based on the resident's clinical conditions, the extent of services needed and the resident's functional status.

Review
The first step in the appeals process for Medicare Part B.

Routine Services
Services and supplies associated with the daily care of a patient including, nursing, housekeeping, laundry, dietary, social services and medical records.

Secondary Insurance
A plan that has responsibility for payment of eligible charges not covered by primary payor.

Significant Change in Status Assessment (SCSA)
Required when there is a major change in the resident's condition/status, which is noted on a consistent basis and is: a) a decline or improvement in resident's health status, b) a change, which will not normally resolve itself without some type of staff intervention, c) affecting more than one area on the resident's health status and d) requires interdisciplinary review and/or revision to the care plan.

Skilled Care
Care which requires the skills of technical or professional personnel in order to ensure its safety and effectiveness, and is furnished directly by, or under the supervision of, such personnel. (Nurses and physical or occupational therapists are examples of professional personnel.)

Skilled Nursing Facility
An institution (or a distinct part of an institution), which has a transfer agreement in effect with one or more participating hospitals and which is primarily engaged in providing skilled nursing

care and related services to inpatients who require medical or nursing care, or rehabilitation services.

Contained in the policies governing the skilled nursing care and other services it provides, a skilled facility must ensure that every patient is under the supervision of a physician, provide 24 hour nursing service, have at least one registered professional nurse employed full time, maintain clinical records on patients, to name just a few.

Skilled Nursing Facility Manual

HCFA's Skilled Nursing Facility Manual that identifies the Medicare regulations for use of benefits in a skilled nursing facility. HCFA Publication #12 (Formerly HIM-12) is available through the Government Printing office.

SNF Benefit Period

Medicare may cover up to 100 days in a "benefit period" or "spell of illness" (see below). The first 20 days are completely covered by Medicare. Days 21 through I 00 require a coinsurance amount payable by the patient or co-payer to the nursing facility.

The longest time period, for which Medicare will pay during a particular spell of illness, is 100 days. In a skilled nursing facility, a spell of illness or benefit period begins on the first day of admission to the facility. Any days spent in a hospital do not count towards the 100 days of skilled nursing benefits. A spell of illness ends either upon the completion of 100 days of skilled coverage followed by a minimum 60-day break in any skilled service, or the discontinuation of coverage for any other reason followed by a minimum 60-day break in any skilled service.

Speech Therapy

Services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and the diagnosis and treatment of swallowing disorders.

Spell of Illness

A beneficiary/resident is eligible for 100 days of care in a skilled nursing facility during a benefit period/spell of illness. A spell of illness is broken when a resident **does not receive a covered level of care for a minimum of 60 days.** The resident is not required to leave the facility, nor does the individual have to be in a Medicare certified bed during these 60 days. The only stipulations are that the resident **neither require nor receive** covered care for this 60 consecutive day period. In order to qualify for a new benefit period, the resident must complete a new 3 -day hospital stay. A resident is able to have more than one benefit period per year so long as the stipulations for a new spell of illness are met.

SSA

Social Security Administration

Subacute Facility

A subacute skilled nursing facility is licensed as a Medicare skilled nursing facility. They follow the same rules and regulations as the skilled nursing facility. The subacute skilled nursing facility delivers a level of care to residents, who are too sick to return home, but not sick enough to remain in the hospital This care is delivered at a cost, which is less than that of an acute care hospital stay. Subacute residents are usually unstable, and in need of multiple skilled services and/or extensive rehabilitation therapy.

Subrogation

A procedure under which a provider can recover from third parties the full or part of benefits paid to an insured.

Supplemental Insurance Policy

An insurance policy that may be a beneficiary's coinsurance, deductible and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the policy pays for the portion of the cost of services not covered by Medicare.

Technical Denial

A technical denial occurs when a Medicare beneficiary has exhausted his or her benefits, or has not had the qualifying three-day hospital stay required for Medicare Part A coverage. If a denial is a technical denial a facility must issue a denial of coverage notice, but the facility is not required to notify the resident of his or her right to request a demand bill. It is apparently the responsibility of the resident to know about this right.

Three Day Prior Hospitalization

Must be three (3) consecutive calendar days - midnight census - not counting the day of discharge, **and** the qualifying hospital stay must have been medically necessary. If the stay is denied by the Medicare Peer Review Organization (PRO), then the time spent in the hospital will not count as part of the three-day qualifying period.

Title XVIII

The Medicare program, authorized by Title XVIH of the Social Security Act, for SNF services effective January 1, 1967, helps pay medical costs for people 65 years and older and for about 3 million disabled people.

Title XIX

Medicaid is a federally aided, State administered, medical assistance program intended, among other things, to provide the poor with access to mainstream health care. It became effective on January 1, 1966, under the authority of Title XIX of the Social Security Act (42 U.S.C. 1396). Each State designs and manages its Medicaid program within broad federal guidelines administered by the Health Care Financing Administration. Title XIX requires States to provide certain basic services to the majority of Medicaid recipients. These services include inpatient and outpatient hospital, home health, physician, and SNF services.

Transfer Rule

Applied to any resident entering a skilled nursing facility. The rule states that a patient must be admitted to a certified bed within 30 days of the last Medicare covered day in a hospital or skilled nursing facility.

Triggers

Triggers identify one or more MDS item responses, specific to a resident, which WM alert you to the resident's possible problems, needs or strengths. The specific MDS response indicates that clinical factors are present which may, or may not, represent a condition that should be addressed in the care plan. Triggers flag conditions necessary for the interdisciplinary team members to consider in making care planning decisions.

UB04 (Uniform Billing Form)

UB04 stands for the HCFA, Uniform Bill approved in 2004. It is the same as the HCFA1450. It is used by private insurers as well as, government programs, to pay inpatient and outpatient health care services nationwide.

Utilization Review

A formal review of the use of Medicare services for appropriateness on a concurrent and retrospective basis.

Veterans Administration (VA)

A federal government insurance program providing benefits for qualifying veterans. Requires that facility have contract with a local VA program. Prior authorization required. Bills are sent directly to the VA.

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Appendix

Abbreviations

Charting Abbreviations

The following list of commonly used abbreviations may be used in the documentation of patient care. Abbreviations save time, but their excessive use should be discouraged because of the wide variations in meaning. When ambiguity is likely, terms should be spelled out to make the documentation more accessible to others.

A	(1) alert or (2) assessment (SOAP)
a	(1) before or (2) artery
AAROM	active assistive range of motion
ABD	abduction, abdominal
A.C.	(1) air conduction or (2) acromioclavicular (joint)
ac	before meals
AC> BC	air conduction greater than bone conduction
accom	accommodation
AD	right ear (auris dextra)
ADD	adduction, Attention Deficit Disorder
ADJ	adjustable
ADM	admission
ADL	activities of daily living
AE	above elbow
AF	atrial fibrillation
af	atrial flutter
AFO	ankle-foot orthosis
AJ	ankle jerk
AK	above knee
AKA	above knee amputation
AM	morning
amb	ambulation, ambulate
AMI	(1) anterior myocardial infarction or (2) acute myocardial infarction
amt	amount
A&O	alert and oriented
AROM	active range of motion
AS	left ear

AU	(1) both ears (aures unitas), (2) each ear (auris uterque)
Aud	(1) auditory or (2) audiology
Aud Haluc	auditory hallucinations
audio	audiogram
B	both
B > A	bone greater than air
bal	balance
B&B	bowel and bladder
BC > AC	bone conduction greater than air conduction
BE	below elbow
b.i.d.	twice daily
bil	bilateral
b.i.w.	twice a week
BK	below knee
BKA	below-knee amputation
BLE	bilateral lower extremities
BOT	base of tongue
BP	blood pressure
BR	bed rest
B.R.	bathroom
BUE	both upper extremities
$\overline{c}$	with
C	complaint
Ca	(1) carcinoma, (2) cancer
CAD	coronary artery disease
cath	catheter
CBR	complete bed rest
CBS	chronic brain syndrome
CHD	(1) coronary heart disease, (2) chronic heart disease, or (3) congenital heart disease
CHF	congestive heart failure
CHI	closed head injury
CN	cranial nerve
c/o	complains of

c̄ OJ	with orange juice
comm	community
COPD	chronic obstructive pulmonary disease
COTA	certified occupational therapy assistant
CPM	continuous passive motion
C.P.T.	chest physical therapy
CVA	cerebral-vascular accident
DC	discharge
D/C	discontinued
d/c	discharged
Decr	decreased
deg	degenerative
DF	dorsiflexion
DI	diabetes insipidus
dias.	diastolic
DJD	degenerative joint disease
DOB	date of birth
DOI	date of injury
DTR	deep tendon flexes
Dx	diagnosis
ed	education
EENT	eye, ear, nose and throat
elev	elevation
end	endurance
ENT	ear, nose and throat
eval	evaluation
ever	eversion
EWHO	elbow wrist hand orthosis
ext	(1) external or (2) extension
ext rot	(1) external or (2) extension
F	(1) female or (2) fair
FAM	family
FC	(1) Foley catheter or (2) family conference
FCN	function

FDS	flexor digitorum superficialis
FES	functional electrical stimulation
FI	fluid
fl. dr.	fluid dram
fl. oz.	fluid ounce
fids	fluids
flex	flexion
fluoro	fluoroscopy
FN	fairly nourished
OF	foot orthosis
FOM	floor of mouth
Ft.	foot
Func	function
FWB	full weight-bearing
Fx	fracture
HBP	high blood pressure
HEENT	head, eyes, ears, nose and throat
HL	(1) hearing loss or (2) hearing level
HNP	herniated nucleus pulposus (herniated disk)
h/o	history of
HOB	head of bed
HP	hot pack
H&P	history and physical
HR	heart rate
HTN	hypertension
HVGS	high-voltage galvanic stimulation
Hx	history
IDDM	insulin-dependent diabetes mellitus
Inc	increased, incontinent
inf	inferior
INJ	injury
Int	internal
inv	inversion
I&O	intake and output

IR	internal rotation
Jt.	joint
KJ	knee jerk
LBP	low pack pain
LP	lumbar puncture
l	ligament
LE	lower extremity
LLE	left lower extremity
LO	loss of hearing
LOS	length of stay
LS	lumbosacral
LS sp	lumbosacral spine
L sp	lumbar spine
LT, Ⓛ	left
LTM	long-term memory
LUE	left upper extremity
M	male
MAFO	molded ankle-foot orthosis
max	maximal
MI	myocardial infarction
min	(1) minute or (2) minimal
mo	months
mod	moderate
NA	not applicable
NDT	neural developmental treatment
neg	negative
NPO	nothing by mouth
N/S	normal saline
Nsg	nursing
NWB	non-weight bearing
OA	osteoarthritis
OBS	organic brain syndrome
OT	occupational therapy
OOB	out of bed

p̄	after
pc	after meals
PF	plantar flexion
PH	past history
PMH	past medical history
PNF	proprioceptive neuromuscular facilitation
PO	postoperative
po	by mouth
pos	positive
p.o.s.	pressure of speech
p.p.	after meals
Prog	prognosis
PROM	passive range of motion
PSIS	posterosuperior iliac spine
PT	physical therapy
PTB	patellar tendon-bearing
PVD	peripheral vascular disease
q	every or each
qd	every day
qid	four times daily
qiw	four times a week
Ⓡ	right
ref	referred
rehab	rehabilitation
ROM	range of motion
RX	treatment
S	subjective (SOAP)
s̄	without
S+S	signs and symptoms
SACH	solid ankle cushion heels
SCI	spinal cord injury
Shx	social history
SI	sacroiliac
sl	slightly

sl bd	sliding board
SLB	short-leg brace
SLP	speech-language pathology
SLR	straight leg raising
SNF	skilled nursing facility
SOAP	subjective, objective, assessment and plan
ST	speech therapy
Staph	staphylococcus
STM	short-term memory
Sublin, SL	sublingual
SX	symptoms
SYN	synergy
Tab	tablet
TENS	transcutaneous electrical nerve stimulation
THA	total hip arthroplasty
THR	total hip replacement
TIA	transient ischemic attack
tiw	three times a week
TJ	triceps jerk (reflex)
TKR	total knee replacement
TMJ	temporal mandibular joint
TO	telephone order
tol	tolerated
T SP	thoracic spine
Tx	treatment
UE	upper extremity
UNK	unknown
US	ultrasound
USI	urinary stress incontinence
UTI	urinary tract infection
UV	ultraviolet
VC	(1) verbal cues, or (2) vocal cord
VO	verbal order
VS	vital signs

Appendix

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w/	with
WB	weight-bearing
WC	wheelchair
WFL	within functional limits
wk	week
WN	well-nourished
w/o	without
WP	whirlpool
wt	weight
X3	oriented to time, person and place
YO	years old
yr	year
↑	increase
↓	decrease