

CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing facilities, consolidated billing, and a number of related changes. The PPS system replaces the retrospective cost-based system for skilled nursing facilities under Part A of the program. (Federal Register Vol. 63, No. 91, May 12, 1998, Final Rule.)

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970's, focusing on the areas of nursing facility payment and quality. In addition, it is based on a foundation of knowledge and work by a number of states that developed and implemented similar case mix payment methodologies for their Medicaid nursing facility payment systems.

The current focus in the development of State and Federal payment systems for nursing facility care is based on the recognition of the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs, but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels would be higher than for those residents with less intensive care needs. In a case mix adjusted payment system the amount of reimbursement to the nursing facility is based on the resource intensity of the resident as measured by items on the MDS. Case mix reimbursement has become a widely adopted method for financing nursing facility care. The case mix approach serves as the basis for the PPS for skilled nursing facilities, swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing facilities.

6.2 Utilizing the MDS in the Medicare Prospective Payment System

A key component of the Medicare skilled nursing facility prospective payment system is the case mix reimbursement methodology used to determine resident care needs. A number of nursing facility case mix systems have been developed over the last 20 years. Since the early 1990's, however, the most widely adopted approach to case mix has been the Resource Utilization Groups (RUG-III). This classification system uses information from the MDS assessment to classify SNF residents into a series of groups representing the residents' relative direct care resource requirements.

The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-III groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency or other conditions will be assigned to higher groups in the RUG-III hierarchy. Providing care to these residents is more costly, and is reimbursed on a higher level.

6.3 Resource Utilization Groups Version III (RUG-III)

The RUG-III classification system has seven major classification groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs, and in the Clinically Complex category, by the presence of depression.

One hundred and eight (108) MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the RUG-III Classification system for nursing facilities can be found at the end of this section.

SEVEN MAJOR RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP
Rehabilitation	Residents receiving physical, speech or occupational therapy.
Extensive Services	Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the resident eligible for other RUG categories.
Special Care	Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding.
Clinically Complex	Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot/wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes.
Impaired Cognition	Residents having cognitive impairment in decision-making, recall and short-term memory. (Score on MDS 2.0 cognitive performance scale ≥ 3).
Behavior Problems	Residents displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions
Reduced Physical Functions	Residents whose needs are primarily for activities of daily living and general supervision.

6.4 Relationship Between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

1. ASSESSMENT REFERENCE DATE (ARD)

The ARD must be reported on the Medicare claim. If no MDS assessment was completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

2. THE RUG-III GROUP

The RUG-III group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted MDS assessments. Facilities cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process.

RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
SE1, SE2, SE3
SSA, SSB, SSC
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
BA1, BA2, BB1, BB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
AAA (the default code)

3. HEALTH INSURANCE PPS (HIPPS) CODES

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code, also known as an Assessment Indicator, must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement.

The CMS HIPPS codes contain a three position code to represent the RUG-III of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was completed. Together they make up the 5-position HIPPS code for the purpose of billing

Part A covered days to the Fiscal Intermediary. The charts shown below list the HIPPS codes used by SNFs.

HIPPS codes have been established for each type of assessment used to support Medicare payment. For example, the Medicare reason for assessment on a Medicare 5-Day assessment is “1”, and the HIPPS code is “01”.

Under the SNF PPS, there are situations when two assessments may be needed to fulfill Medicare requirements. Rather than requiring such duplication of effort, providers have the ability to combine assessments (see Chapter 2 for more detailed information). For example, if an OMRA is required during the assessment window for a Medicare 30-Day assessment (i.e., days 21-34), the SNF is required to perform only one assessment. There is no way to code two Medicare Reasons for Assessment. The combined OMRA/30-Day Medicare assessment is coded on the MDS as an OMRA and identified on the Part A billing by using a HIPPS code of “28”. The combined assessment can then be used when billing the Medicare claim. Similarly, if an assessment is a combined OMRA/30-Day and an SCSA, the SCSA is coded as the primary Reason for Assessment. The OMRA is shown as the Medicare Reason for Assessment, and the HIPPS code used for billing is 28.

In addition, 5 new codes have been established for special payment situations. More specific information on the use of these billing codes will be issued in early 2003.

SNF HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

01	5-Day Medicare-required assessment/not an Admission assessment.
02	30-Day Medicare-required assessment.
03	60-Day Medicare-required assessment.
04	90-Day Medicare-required assessment.
05	Readmission/Return Medicare-required assessment.
07	14-Day Medicare-required assessment/not an Admission assessment.
08	Off-cycle Other Medicare-required assessment (OMRA).
11	5-Day (or readmission/return) Medicare-required assessment AND Admission assessment.
17	14-Day Medicare-required assessment AND Admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-Day Medicare assessments, regardless of whether it is also an OBRA Admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18	OMRA (Other Medicare Required Assessment) replacing 5-Day Medicare-required assessment

19	Special payment situation – 5-Day assessment
28	OMRA replacing 30-Day Medicare-required assessment
29	Special payment situation – 30-Day assessment
30	Off-cycle Significant Change assessment (outside assessment window).
31	Significant Change assessment REPLACES 5-Day Medicare-required assessment.
32	Significant Change assessment (SCSA) REPLACES 30-Day Medicare-required assessment
33	Significant Change assessment REPLACES 60-Day Medicare-required assessment
34	Significant Change assessment REPLACES 90-Day Medicare-required assessment
35	Significant Change assessment REPLACES a readmission/return Medicare-required assessment.
37	Significant Change assessment REPLACES 14-Day Medicare-required assessment
38	OMRA replacing 60-Day Medicare-required assessment.
39	Special payment situation – 60-Day assessment.
40	Off-cycle Significant Correction assessment of a prior assessment (outside assessment window)
41	Significant Correction of a Prior assessment (SCPA) REPLACES a 5-Day Medicare-required assessment
42	Significant Correction of a Prior assessment REPLACES 30-Day Medicare-required assessment
43	Significant Correction of a Prior assessment REPLACES 60-Day Medicare-required assessment
44	Significant Correction of a Prior assessment REPLACES 90-Day Medicare-required assessment
45	Significant Correction of a Prior assessment REPLACES a readmission/return assessment.
47	Significant Correction of a Prior assessment REPLACES 14-Day Medicare-required assessment
48	OMRA replacing 90-Day Medicare required assessment.
49	Special payment situation – 90-Day assessment.
54	90-Day Medicare assessment that is also a Quarterly assessment
78	OMRA replacing 14-Day Medicare-required assessment.
79	Special payment situation – 14-Day assessment
00	Default code

6.5 SNF PPS Eligibility Criteria for SNFs

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized below.

TECHNICAL ELIGIBILITY REQUIREMENTS

Technical eligibility remains the same, as outlined below, per the Medicare Intermediary Manual, Claims Process, Part 3 (HCFA Pub. 13-3) and the Skilled Nursing Facility Manual (HCFA Pub. 12). The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay.
- Admission for SNF-level services is within thirty days of discharge from an acute care stay.

NOTE: See CMS Pub 13-3 Section 3131.3B for an exception to the 30-day transfer requirement; i.e., Medical Appropriateness Exception.

CLINICAL ELIGIBILITY REQUIREMENTS

A beneficiary is eligible for SNF extended care if all the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition for which the resident:
 - was treated during the qualifying hospital stay, or
 - arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

PHYSICIAN CERTIFICATION

A physician, or a clinical nurse specialist, or nurse practitioner employed by a physician (and not employed by the SNF) must certify and then periodically re-certify the need for extended care services in the nursing facility.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable. (42 CFR 424.20)
 - The initial certification certifies, per the existing context found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, **or**
 - Validates that the beneficiary's assignment to one of the upper RUG-III (Top 26) groups is correct through a statement indicating the assignment is correct.
- **Re-certifications** are used to document the continued need for skilled extended care services.
 - The first re-certification is required no later than the **14th** day.
 - Subsequent re-certifications are required no later than **30 days** after the first re-certification.

NOTE: These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.

6.6 RUG-III 44 Group Model Calculation Worksheet for SNFs

This RUG-III Version 5.12 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III Classification based on the information from an MDS assessment. The worksheet takes the computer programming and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 44-group RUG-III Version 5.12 model. In the 44-group model, there are 14 different Rehabilitation groups representing 5 different levels of rehabilitation services. The 44-group model is therefore well suited for use with restorative programs that classify residents on the basis of both nursing care needs and rehabilitation needs. The Medicare PPS program is a good example of such a program. RUG-III models order the groups from high to low resource need. In the 44-group model, the residents in the Rehabilitation groups have the highest level of combined nursing and rehabilitation need, while residents in the Extensive Services groups have the next highest level of need. Therefore, the 44-group model has the Rehabilitation groups first followed by the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Functions groups.

There are two basic approaches to RUG-III Classification: (1) hierarchical classification and (2) index maximizing classification. CMS has not developed an index maximization worksheet. The worksheet included at the end of this chapter was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below.

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, you start at the top and work down through the RUG-III model, and the classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation groups at the top of the RUG-III model. Then you work your way down through the groups in hierarchical order: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. When you find the first of the 44 individual RUG-III groups for which the resident qualifies, then assign that group as the RUG-III Classification and you are finished.

If the resident would qualify in one of the Rehabilitation groups and also in a Extensive Services group, always choose the Rehabilitation classification, since it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearer the top of the model.

Index Maximizing Classification. Index maximizing classification is used in Medicare PPS and most Medicaid payment systems. For a specific payment system, there will be a designated set of Case Mix Indices (CMI) for each RUG-III group. The first step in index maximizing is to determine all of the RUG-III groups for which the resident qualifies. Then from the qualifying groups you choose the RUG-III group that has the highest case mix index. Index maximizing classification is simply choosing the group with the highest index. The index maximizing method uses the case mix indices prior established in July 1998 when the SNF PPS was introduced. It does not reflect payment rate changes resulting from Congressionally mandated “add-on” payments.

While the present worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. To index maximize, you would evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, you again start at the beginning of the worksheet. You then work down through all of the 44 RUG-III Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When you finish, 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.

CALCULATION OF TOTAL "ADL" SCORE ***RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION***

The ADL score is used in all determinations of a resident's placement in a RUG-III category. It is a very important component of the classification process.

► ***STEP # 1***

To calculate the ADL score use the following chart for G1a (bed mobility), G1b (transfer), and G1i (toilet use). **Enter the ADL scores to the right.**

<u>Column A =</u>	and	<u>Column B =</u>	<u>ADL score =</u>	<u>SCORE</u>
-, 0 or 1	and	(any number)	= 1	G1a= _____
2	and	(any number)	= 3	G1b= _____
3, 4, or 8	and	-, 0, 1 or 2	= 4	G1i= _____
3, 4, or 8	and	3 or 8	= 5	

► ***STEP # 2***

If K5a (parenteral/IV) is checked, the eating ADL score is 3. If K5b (feeding tube) is checked and EITHER (1) K6a is 51% or more calories OR (2) K6a is 26% to 50% calories and K6b is 501cc or more per day fluid enteral intake, then the eating ADL score is 3. **Enter the ADL eating score (G1h) below and total the ADL score. If not, go to Step #3.**

► ***STEP # 3***

If neither K5a nor K5b (with appropriate intake) are checked, evaluate the chart below for G1hA (eating self-performance). *Enter the score to the right* and total the ADL score. This is the RUG-III **TOTAL ADL SCORE**. (The total ADL score range possibilities are 4 through 18.)

<u>Column A (G1h) =</u>	<u>ADL score =</u>	<u>EATING SCORE</u>
-, 0 or 1	= 1	G1h = _____
2	= 2	
3, 4, or 8	= 3	

TOTAL RUG-III ADL SCORE _____

Other ADLs are also very important, but the researchers have determined that the late loss ADLs were more predictive of resource use. They determined that allowing for the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.

CATEGORY I: REHABILITATION

RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

After determining a resident's total ADL score, you start the classification process beginning at the Rehabilitation level. Rehabilitation therapy is any combination of the disciplines of physical, occupational, or speech therapy. This information is found in Section P1b. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in Section P3 and H3a,b of the MDS Version 2.0.

► ***STEP # 1***

Determine if the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the resident does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. Ultra High Intensity Criteria

In the last 7 days (section P1b [a,b,c]):

- 720 minutes or more (total) of therapy per week **AND**
- At least two disciplines, 1 for at least 5 days, **AND**
- 2nd for at least 3 days

<u>RUG-III ADL Score</u>	<u>RUG-III Class</u>
16 - 18	RUC
9 - 15	RUB
4 - 8	RUA

B. Very High Intensity Criteria

In the last 7 days (section P1b [a, b, c,]):

- 500 minutes or more (total) of therapy per week **AND**
- At least 1 discipline for at least 5 days

<u>RUG-III ADL Score</u>	<u>RUG-III Class</u>
16 - 18	RVC
9 - 15	RVB
4 - 8	RVA

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

- (1) In the last 7 days (section P1b [a, b, c]):
 - 325 minutes or more (total) of therapy per week **AND**
 - At least 1 discipline for at least 5 days

- (2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section T1b, T1c, T1d and section P1b [a, b, c]):
 - Ordered Therapies, T1b is checked **AND**
 - In the last 7 days:
 - Received 65 or more minutes, P1b [a,b,c] **AND**
 - In the first 15 days from admission:
 - 520 or more minutes expected, T1d **AND**
 - rehabilitation services expected on 8 or more days, T1c.

<u>RUG-III ADL Score</u>	<u>RUG-III Class</u>
13 - 18	RHC
8 - 12	RHB
4 - 7	RHA

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

- (1) In the last 7 days: (section P1b [a,b,c])
 - 150 minutes or more (total) of therapy per week **AND**
 - At least 5 days of any combination of the 3 disciplines

- (2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply:** (section T1b, T1c, T1d):
 - Ordered Therapies, T1b is checked **AND**
 - In the first 15 days from admission:
 - 240 or more minutes are expected, T1d **AND**
 - rehabilitation services expected on 8 or more days, T1c.

<u>RUG-III ADL Score</u>	<u>RUG-III Class</u>
15 - 18	RMC
8 - 14	RMB
4 - 7	RMA

- E. **Low Intensity Criteria** (either (1) or (2) below may qualify):
- (1) In the last 7 days (section P1b [a,b,c] and P3):
 - 45 minutes or more (total) of therapy per week **AND**
 - At least 3 days of any combination of the 3 disciplines **AND**
 - 2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

 - (2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section P3 and section T1b, T1c, T1d):
 - Ordered therapies T1B is checked **AND**
 - In the first 15 days from admission:
 - 75 or more minutes are expected, T1d **AND**
 - rehabilitation services expected on 5 or more days, T1c **AND**
 - 2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, P3.

**Nursing Rehabilitation Services*

<i>H3a,b**</i>	<i>Any scheduled toileting program and/or bladder retraining program</i>
<i>P3a,b**</i>	<i>Passive and/or active ROM</i>
<i>P3c</i>	<i>Splint or brace assistance</i>
<i>P3d,f**</i>	<i>Bed mobility and/or walking training</i>
<i>P3e</i>	<i>Transfer training</i>
<i>P3g</i>	<i>Dressing or grooming training</i>
<i>P3h</i>	<i>Eating or swallowing training</i>
<i>P3i</i>	<i>Amputation/Prosthesis care</i>
<i>P3j</i>	<i>Communication training</i>
<i>**Count as one service even if both provided</i>	

<u><i>RUG-III ADL Score</i></u>	<u><i>RUG-III Class</i></u>
14-18	RLB
4-13	RLA

RUG-III Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category II.

CATEGORY II: EXTENSIVE SERVICES ***RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION***

The classification groups in this hierarchy are based on various services provided. Use the following instructions to begin the calculation:

▶ ***STEP # 1***

Is the resident coded for receiving **one** or more of the following extensive services?

K5a	Parenteral / IV
P1ac	IV Medication
P1ai	Suctioning
P1aj	Tracheostomy care
P1al	Ventilator or respirator

If the resident does not receive one of the above, skip to Category III now.

▶ ***STEP # 2***

If at least **one** of the above treatments is coded and the resident has a total RUG-III ADL score of 7 or more, he/she classifies as Extensive Services. ***Move to Step #3. If the resident's ADL score is 6 or less, he/she classifies as Special Care (SSA). Skip to Category III, Step #5 now and record the classification as SSA.***

▶ ***STEP # 3***

The resident classifies in the Extensive Services category. To complete the scoring, however, an extensive count will need to be determined. If K5a (Parenteral IV) is checked, add 1 to the extensive count below. If P1ac (IV Medication) is checked, add 1 to the extensive count below. To complete the extensive count, determine if the resident also meets the criteria for Special Care, Clinically Complex, and Impaired Cognition. The final split into either SE1, SE2, or SE3 will be completed after these criteria have been scored. ***Go to Category III, Step #1 now.***

K5a	Parenteral / IV
P1ac	IV Medication

Extensive Count _____
(Enter this count in Step #4 on Page 6-23.)

CATEGORY III: SPECIAL CARE

RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this hierarchy are based on certain resident conditions. Use the following instructions:

► ***STEP # 1***

Determine if the resident is coded for **one** of the following conditions:

I1s	Cerebral palsy, with ADL sum ≥ 10
I1w	Multiple sclerosis, with ADL sum ≥ 10
I1z	Quadriplegia, with ADL sum ≥ 10
J1h	Fever and <u>one</u> of the following;
	I2e Pneumonia
	J1c Dehydration
	J1o Vomiting
	K3a Weight loss
	K5b Tube feeding*
K5b, I1r	Tube feeding* and aphasia
M1a,b,c,d	Ulcers 2+ sites over all stages with 2 or more skin treatments**
M2a	Any stage 3 or 4 pressure ulcer with 2 or more skin treatments**
M4g,M4c	Surgical wounds or open lesions with 1 or more skin treatments***
P1ah	Radiation treatment
P1bdA	Respiratory therapy =7 days

**Tube feeding classification requirements:*

- (1) *K6a is 51% or more calories OR*
- (2) *K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake in the last 7 days.*

***Skin treatments:*

<i>M5a, b[#]</i>	<i>Pressure relieving chair and/or bed</i>
<i>M5c</i>	<i>Turning/repositioning</i>
<i>M5d</i>	<i>Nutrition or hydration intervention</i>
<i>M5e</i>	<i>Ulcer care</i>
<i>M5g</i>	<i>Application of dressings (not to feet)</i>
<i>M5h</i>	<i>Application of ointments (not to feet)</i>
<i>[#]Count as one treatment even if both provided</i>	

****Skin Treatments*

<i>M5f</i>	<i>Surgical wound care</i>
<i>M5g</i>	<i>Application of dressing (not to feet)</i>
<i>M5h</i>	<i>Application of ointments (not to feet)</i>

If the resident does not have one of the above conditions, skip to Category IV now.

► **STEP # 2**

If at least one of the special care conditions above is met:

- a. If the resident previously qualified for Extensive Services, proceed to Extensive Count Determination. **Go to Step #3. OR**
- b. If the RUG-III ADL score is 7 or more, the resident classifies as Special Care. **Go to Step #4. OR**
- c. If the RUG-III ADL score is 6 or less, the resident classifies as Clinically Complex. **Skip to Category IV, Step #4.**

► **STEP # 3 (Extensive Count Determination)**

If the resident previously met the criteria for the Extensive Services category and the evaluation of the Special Care category is done only to determine if the resident is an SE1, SE2, or SE3, **enter 1 for the extensive count below and skip to Category IV, Step #1.**

Extensive Count _____
(Enter this count in Step #4 on Page 6-23.)

► **STEP # 4**

If at least one of the special care conditions above is coded and the RUG-III ADL score is 7 or more, **the resident classifies in the Special Care category. Select the Special Care classification below based on the ADL score and record this classification in Step #5:**

<u>RUG-III ADL Score</u>	<u>RUG-III Class</u>
17 - 18	SSC
15 - 16	SSB
7 - 14	SSA

► **STEP #5**

Record the appropriate Special Care classification:

RUG-III CLASSIFICATION _____

CATEGORY IV: CLINICALLY COMPLEX RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions. Use the following instructions:

► ***STEP # 1***

Determine if the resident is coded for **one** of the following conditions:

B1	Coma and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA= 4 or 8)
I1a,O3, P8	Diabetes mellitus and injection 7 days and Physician order changes \geq 2 days
I1v	Hemiplegia with ADL sum \geq 10
I2e	Pneumonia
I2g	Septicemia
J1c	Dehydration
J1j	Internal bleeding
K5b	Tube feeding*
M4b	Burns
M6b,c,f	Infection of foot (M6b or M6c) with treatment in M6f
P1aa	Chemotherapy
P1ab	Dialysis
P1ag	Oxygen therapy
P1ak	Transfusions
P7, P8	Number of Days in last 14, Physician Visit/order changes: Visits \geq 1 day and changes \geq 4 days <u>OR</u> Visits \geq 2 days and changes \geq 2 days

****Tube feeding classification requirements***

- (1) ***K6a is 51% or more calories OR***
- (2) ***K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake in the last 7 days.***

If the resident does not have one of the above conditions, skip to Category V now.

► ***STEP # 2***

If at least one of the clinically complex conditions above is met:

- a. Extensive Count Determination. ***Go to Step #3 OR***
- b. Clinically Complex classification. The resident classifies as Clinically Complex. ***Go to Step #4.***

► **STEP # 3 (Extensive Count Determination)**

If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Clinically Complex category is done only to determine if the resident is an SE1, SE2, or SE3, **enter 1 for the extensive count below and skip to Category V Step #1.**

Extensive Count _____
(Enter this count in Step #4 on Page 6-23.)

► **STEP # 4**

Evaluate for Depression. Signs and symptoms of a depressed or sad mood are used as a third level split for the Clinically Complex category. Residents with a depressed or sad mood are identified by the presence of a combination of symptoms, as follows:

Count the number of indicators of depression. The resident is considered depressed if he/she has at least 3 of the following:

(Indicator exhibited in last 30 days and coded "1" or "2")

- E1a Negative statements
- E1b Repetitive questions
- E1c Repetitive verbalization
- E1d Persistent anger with self and others
- E1e Self deprecation
- E1f Expressions of what appear to be unrealistic fears
- E1g Recurrent statements that something terrible is going to happen
- E1h Repetitive health complaints
- E1i Repetitive anxious complaints/concerns (Non-health related)
- E1j Unpleasant mood in morning
- E1k Insomnia/changes in usual sleep pattern
- E1l Sad, pained, worried facial expression
- E1m Crying, tearfulness
- E1n Repetitive physical movements
- E1o Withdrawal from activities of interest
- E1p Reduced social interaction

Does the resident have 3 or more indicators of depression? YES _____ NO _____

► **STEP # 5**

Assign the Clinically Complex category based on both the ADL score and the presence or absence of depression.

<u><i>RUG-III ADL Score</i></u>	<u><i>Depressed</i></u>	<u><i>RUG-III Class</i></u>
17 - 18	YES	CC2
17 - 18	NO	CC1
12 - 16	YES	CB2
12 - 16	NO	CB1
4 - 11	YES	CA2
4 - 11	NO	CA1

RUG-III CLASSIFICATION _____

CATEGORY V: IMPAIRED COGNITION

RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

► ***STEP # 1***

Determine if the resident is cognitively impaired according to the RUG-III Cognitive Performance Scale (CPS). The resident is cognitively impaired if **one** of the three following conditions exists:

- (1) B1 Coma and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA = 4 or 8) and B4 is blank or unknown (value “-”)
- (2) B4 Severely impaired cognitive skills (B4 = 3)
- (3) B2a, B4, C4 These three items (B2a, B4, and C4) are all assessed with none being blank or unknown (N/A)

AND

Two or more of the following impairment indicators are present

- | | |
|---------|---------------------------|
| B2a = 1 | Short-term memory problem |
| B4 > 0 | Cognitive skills problem |
| C4 > 0 | Problem being understood |

AND

One or more of the following severe impairment indicators are present:

- | | |
|---------|---------------------------------|
| B4 >= 2 | Severe cognitive skills problem |
| C4 >= 2 | Severe problem being understood |

If the resident does not meet the criteria for cognitively impaired:

- a. and the evaluation is being done to determine if the resident is in SE1, SE2, or SE3, ***skip to Step #4 on Page 6-23 “Category II: Extensive Services (cont.)”***

OR

- b. ***Skip to Category VI now.***

► ***STEP # 2***

If the resident meets the criteria for cognitive impairment:

- a. Extensive Count Determination. ***Go to Step #3. OR***
- b. Impaired Cognition classification. The resident may classify as Impaired Cognition. ***Go to Step #4.***

► **STEP # 3 (Extensive Count Determination)**

If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Impaired Cognition category is done to determine if the resident is in SE1, SE2, or SE3, **enter 1 for the extensive count below and skip to Step #4 on Page 17, "Category II: Extensive Services (cont.)."**

Extensive Count _____
 (Enter this count in Step #4 on Page 6-23.)

► **STEP # 4**

The resident's total RUG-III ADL score must be 10 or less to be classified in the RUG-III Impaired Cognition category. **If the ADL score is greater than 10, skip to Category VII now. If the ADL score is 10 or less and one of the impaired cognition conditions above is present, then the resident classifies as Impaired Cognition. Proceed with Step #5.**

► **STEP # 5**

Determine Nursing Rehabilitation 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:

Enter the nursing rehabilitation count to the right.

- H3a,b** Any scheduled toileting program and/or bladder retraining program
 - P3a,b** Passive and/or active ROM
 - P3c* Splint or brace assistance
 - P3d,f** Bed mobility and/or walking training
 - P3e* Transfer training
 - P3g* Dressing or grooming training
 - P3h* Eating or swallowing training
 - P3i* Amputation/Prosthesis care
 - P3j* Communication training
- *Count as one service even if both provided*

Nursing Rehabilitation Count _____

► **STEP # 6**

Select the final RUG-III Classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

<u>RUG-III ADL Score</u>	<u>Nursing Rehabilitation</u>	<u>RUG-III Class</u>
6 - 10	2 or more	IB2
6 - 10	0 or 1	IB1
4 - 5	2 or more	IA2
4 - 5	0 or 1	IA1

RUG-III CLASSIFICATION _____

CATEGORY II: EXTENSIVE SERVICES (cont.)
RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

If the resident previously met the criteria for the Extensive Services category with an ADL score of 7 or more, complete the Extensive Services classification here.

► ***STEP # 4 (Extensive Count Determination)***

Complete the scoring of the Extensive Services by summing the extensive count items:

Page 6-15	Extensive Count - Extensive Services	_____
Page 6-17	Extensive Count - Special Care	_____
Page 6-19	Extensive Count - Clinically Complex	_____
Page 6-22	Extensive Count - Impaired Cognition	_____

Total Extensive Count _____

Select the final Extensive Service classification using the Total Extensive Count.

<u>Extensive Count</u>	<u>RUG-III Class</u>
4 or 5	SE3
2 or 3	SE2
0 or 1	SE1

RUG-III CLASSIFICATION _____

CATEGORY VI: BEHAVIOR PROBLEMS

RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION

▶ ***STEP # 1***

The resident's total RUG-III ADL score must be 10 or less. **If the score is greater than 10, skip to Category VII now.**

▶ ***STEP # 2***

One of the following must be met:

- E4aA Wandering (2 or 3)
- E4bA Verbal abuse (2 or 3)
- E4cA Physical abuse (2 or 3)
- E4dA Inappropriate behavior (2 or 3)
- E4eA Resisted care (2 or 3)
- J1e Delusions
- J1i Hallucinations

If the resident does not meet one of the above, skip to Category VII now.

▶ ***STEP # 3***

Determine Nursing Rehabilitation

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

- H3a,b**** ***Any scheduled toileting program and/or bladder retraining program***
 - P3a,b**** ***Passive and/or active ROM***
 - P3c*** ***Splint or brace assistance***
 - P3d,f**** ***Bed mobility and/or walking training***
 - P3e*** ***Transfer training***
 - P3g*** ***Dressing or grooming training***
 - P3h*** ***Eating or swallowing training***
 - P3i*** ***Amputation/Prosthesis care***
 - P3j*** ***Communication training***
- *Count as one service even if both provided.***

Nursing Rehabilitation Count _____

► **STEP # 4**

Select the final RUG-III Classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

<u><i>RUG-III ADL Score</i></u>	<u><i>Nursing Rehabilitation</i></u>	<u><i>RUG-III Class</i></u>
6 - 10	2 or more	BB2
6 - 10	0 or 1	BB1
4 - 5	2 or more	BA2
4 - 5	0 or 1	BA1

RUG-III CLASSIFICATION _____

CATEGORY VII: REDUCED PHYSICAL FUNCTIONS

RUG-III, 44 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 Impaired Cognition or Behavior Problems categories but have a RUG-III ADL score greater than 10, are placed in this category.

▶ ***STEP # 2***

Determine Nursing Rehabilitation

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

- | | |
|---------------|--|
| <i>H3a,b*</i> | <i>Any scheduled toileting program and/or bladder retraining program</i> |
| <i>P3a,b*</i> | <i>Passive and/or active ROM</i> |
| <i>P3c</i> | <i>Splint or brace assistance</i> |
| <i>P3d,f*</i> | <i>Bed mobility and/or walking training</i> |
| <i>P3e</i> | <i>Transfer training</i> |
| <i>P3g</i> | <i>Dressing or grooming training</i> |
| <i>P3h</i> | <i>Eating or swallowing training</i> |
| <i>P3i</i> | <i>Amputation/Prosthesis care</i> |
| <i>P3j</i> | <i>Communication training</i> |
- *Count as one service even if both provided*

Nursing Rehabilitation Count _____

► **STEP # 3**

Select the RUG-III Classification by using the RUG-III ADL score and the Nursing Rehabilitation Count.

<u><i>RUG-III ADL Score</i></u>	<u><i>Nursing Rehabilitation</i></u>	<u><i>RUG-III Class</i></u>
16 - 18	2 or more	PE2
16 - 18	0 or 1	PE1
11 - 15	2 or more	PD2
11 - 15	0 or 1	PD1
9 - 10	2 or more	PC2
9 - 10	0 or 1	PC1
6 - 8	2 or more	PB2
6 - 8	0 or 1	PB1
4 - 5	2 or more	PA2
4 - 5	0 or 1	PA1

RUG-III CLASSIFICATION _____