FREE WEBINAR

PDPM Power Hour

Level up your reimbursement

TUE, APR 23 | 1:30 PM CT

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CONSULTING SERVICES

SKILLED NURSING

YOUR SPEAKER

JOLENE JOHNSON RAC-CT
President
Luminate Healthcare Consulting

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Today's Agenda

- PDPM Review
- Primary Diagnosis
- Nursing CMG

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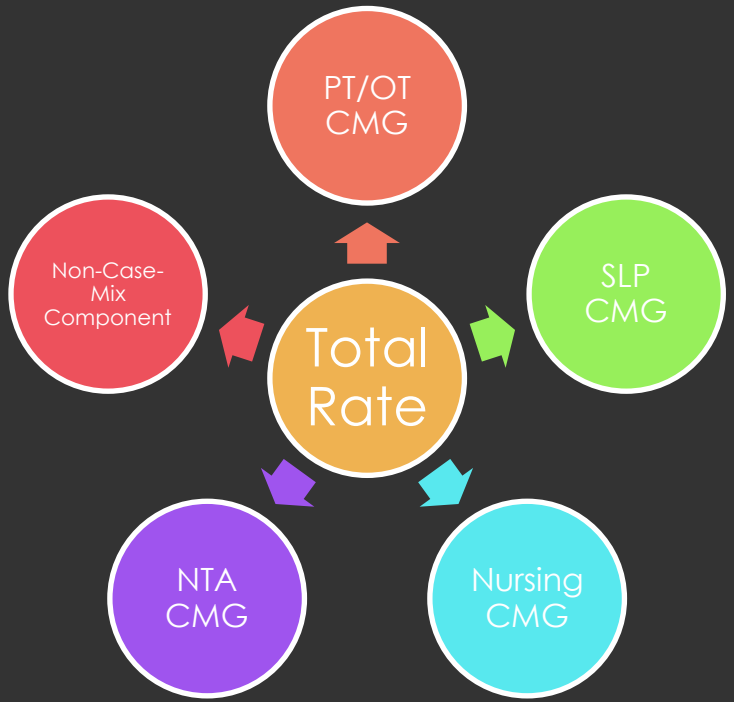
PDPM REVIEW

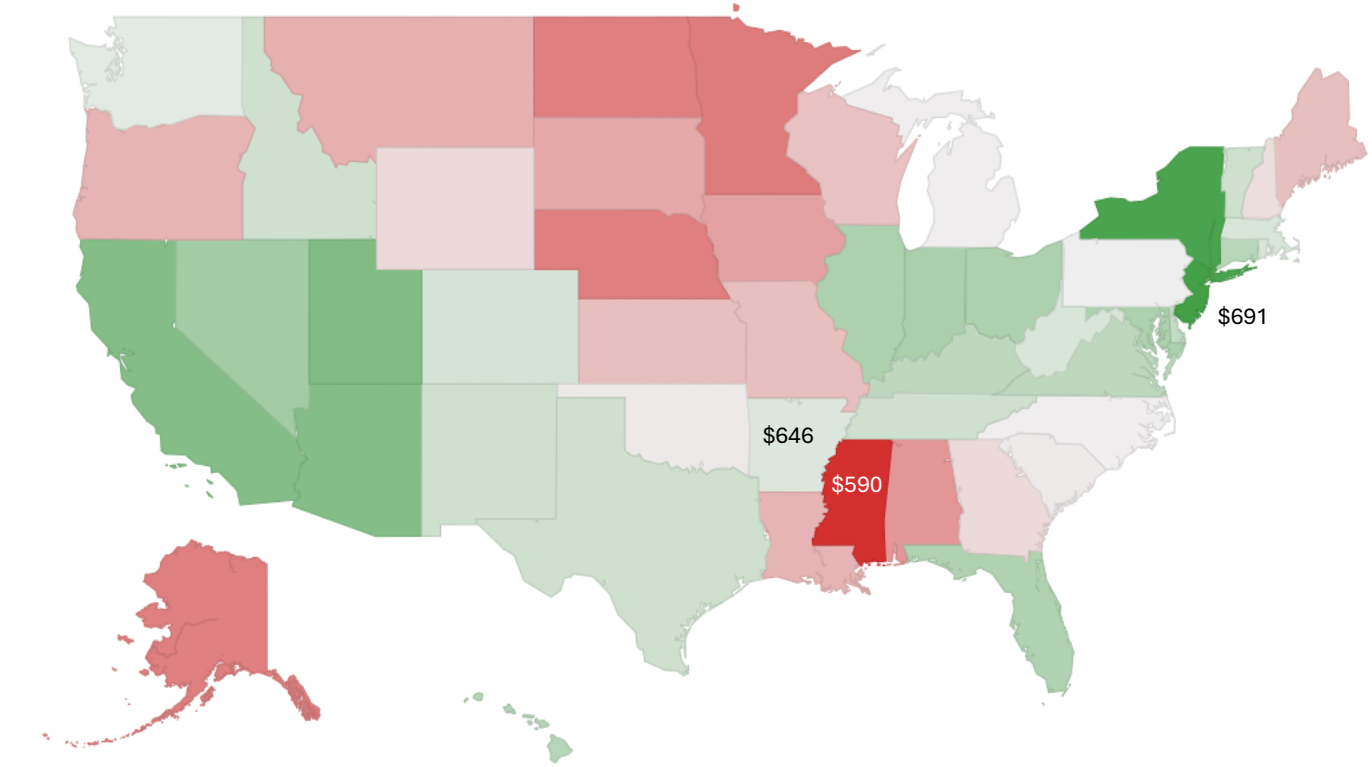
PDPM Model


PT/OT CMG
SLP CMG
Nursing CMG
NTA CMG
Non-Case-Mix Component
Total Rate

PDPM ASSESSMENT SCHEDULE

Medicare MDS Assessment Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Five-Day Scheduled PPS Assessment	Day 1-8	All covered Part A stays until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of IPA through Part A discharge (unless another IPA is completed)
PPS Discharge Assessment	PPS End of Medicare date	N/A

PPD



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POLL #1

How confident do you feel in your understanding and implementation of the Patient-Driven Payment Model (PDPM)?

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PRIMARY DIAGNOSIS

ICD-10 Coding is Key

Reimbursement is weighted by both primary diagnosis and active diagnosis sequencing.

ICD-10 must be aligned across all disciplines for proper billing

Primary diagnosis influence 3 out of the 5 CMG : PT/OT/ST

ICD-10 should reflect the main reasons for SNF stay and skilled care services

Review documentation pre-admission or very early in stay.

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Active Diagnosis

The RAI MDS 3.0 Manual steps for assessment to determine active diagnoses.

- **Step 1 Diagnosis identification:** 60-days look-back to identify all physician or physician extender documented disease/diagnosis.
- **Step 2 Diagnosis status:** 7-day look-back period to determine if the diagnosis is active

What makes a diagnosis considered active?

- "Active diagnosis are diagnoses that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period"-RAI manual Chapter 3.
- Records to review for "active" diagnosis: transfer documents, physician progress notes, H&P, discharge summaries, nursing assessments, nursing care plans, Medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Active Diagnosis: RAI Coding Tips

(CHAPTER 3, PAGE I-11 & I-12)

****In the absence of specific documentation that a disease is active, the following indications may be used to confirm active disease:*

Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

SNF Primary Diagnosis

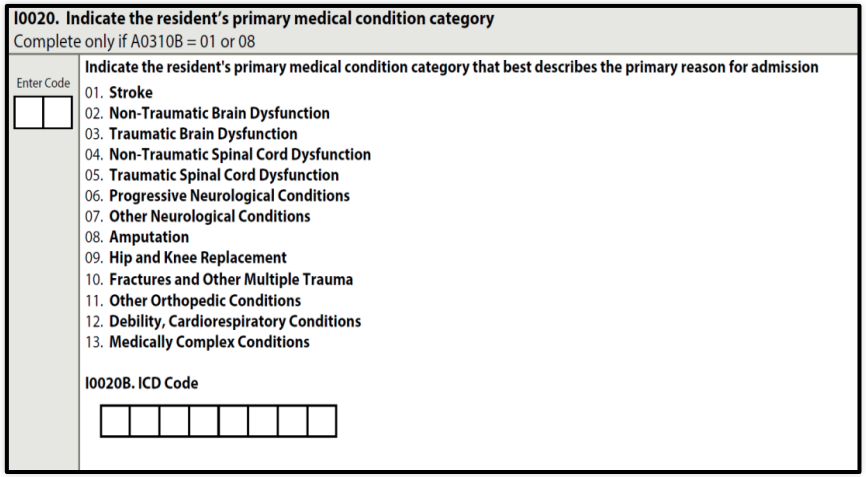
I0020/I0020B:

- Classifies the resident into a PDPM clinical category.
- Code the resident's primary medical condition, then proceed to I0020B for the primary SNF diagnosis.

Primary Diagnosis Facts:

- Primary diagnosis for SNF "is chiefly responsible for continued residence in the nursing facility"
- Primary diagnosis may change over the course of the stay.
- Primary diagnosis " may or may not be the same reason that the patient was admitted to the qualifying hospital stay"

- *While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.*



I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or 08

Enter Code

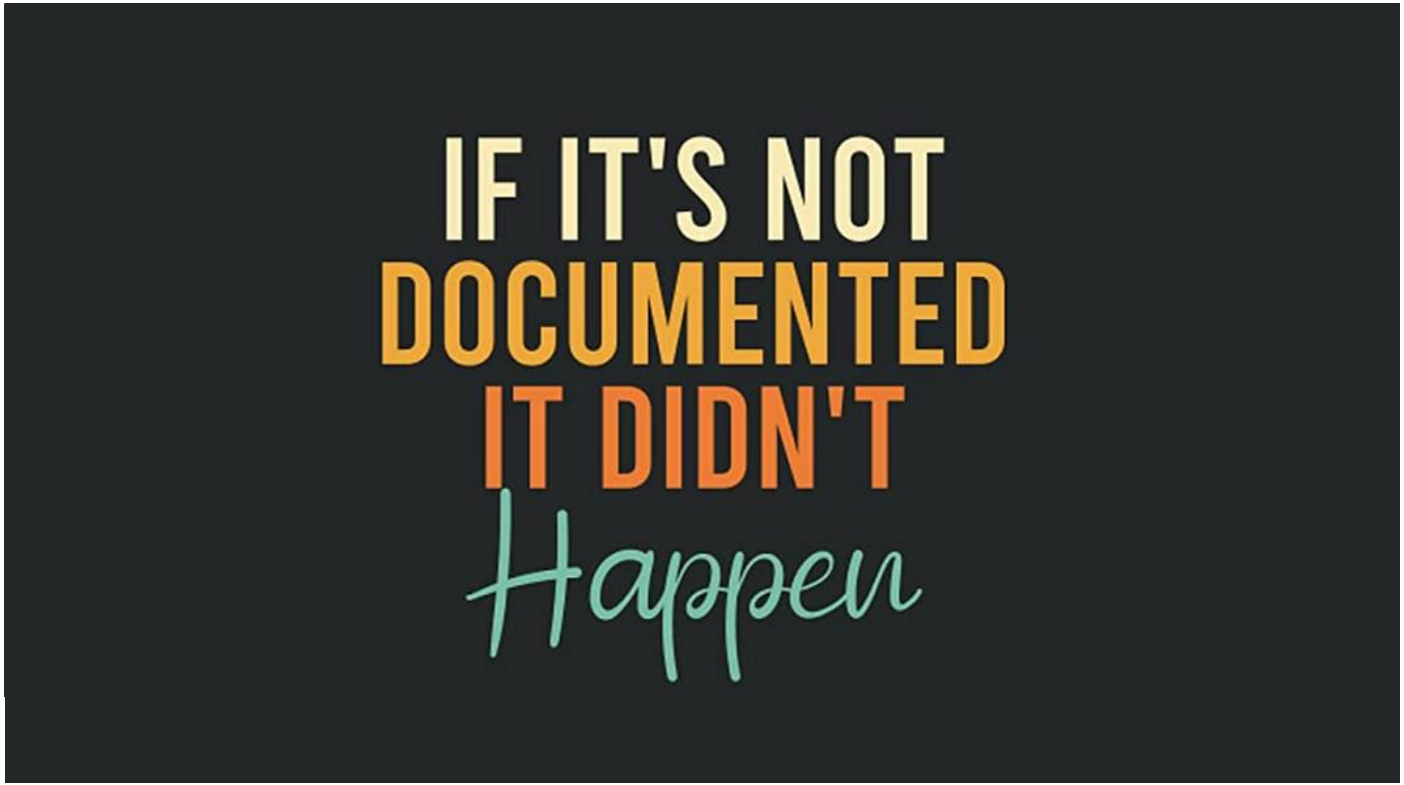
Indicate the resident's primary medical condition category that best describes the primary reason for admission

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

I0020B. ICD Code

Diagnosis at Risk

- Asthma, COPD, or Chronic Lung Disease
- Morbid Obesity
- Foot Infections & Open Lesions on the Foot
- Orthopedic issues
- Swallowing problems & mechanically altered diets
- Malnutrition/Risk for Malnutrition
- Isolation


IF IT'S NOT
DOCUMENTED
IT DIDN'T
Happen

NURSING

POLL #2

How many years of experience do you have as an MDS Coordinator?

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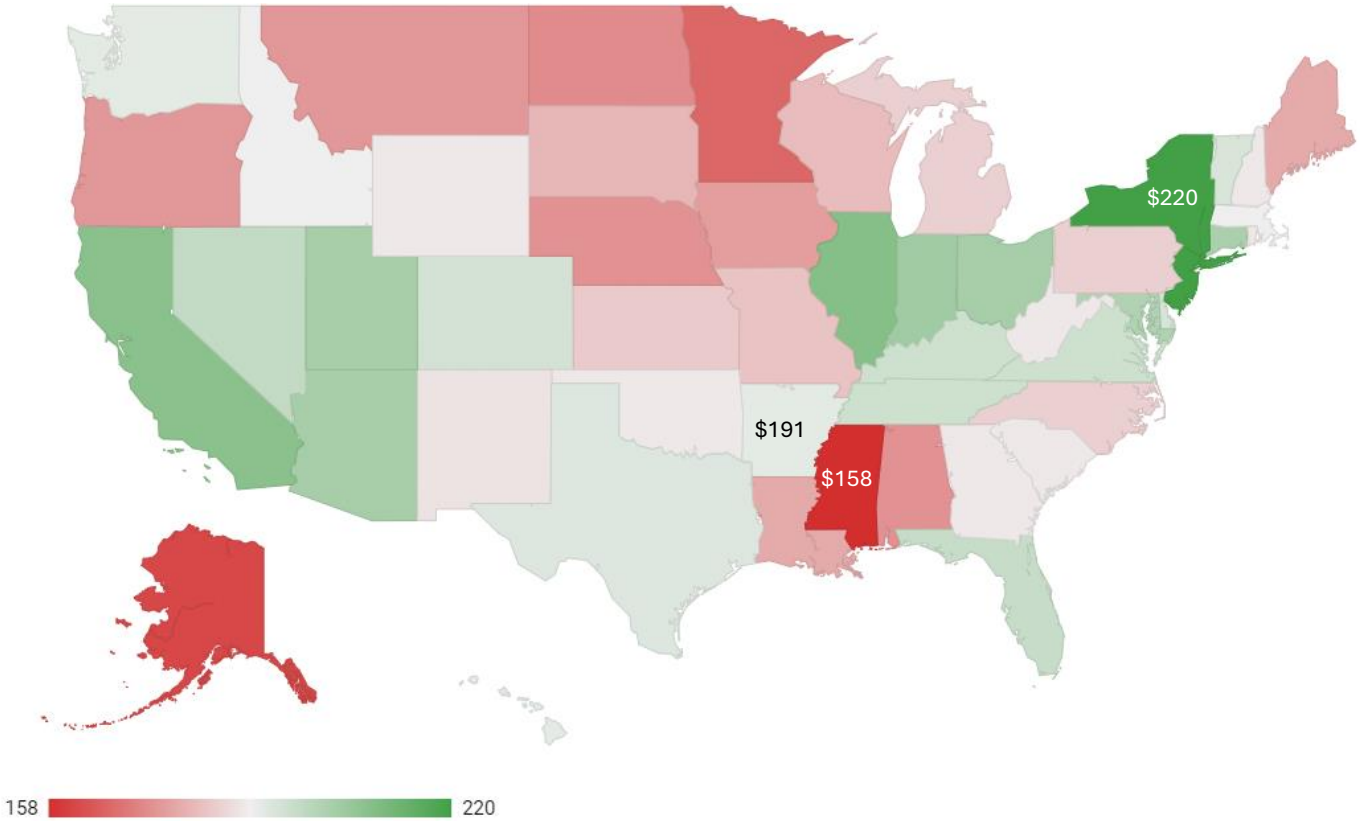
Nursing



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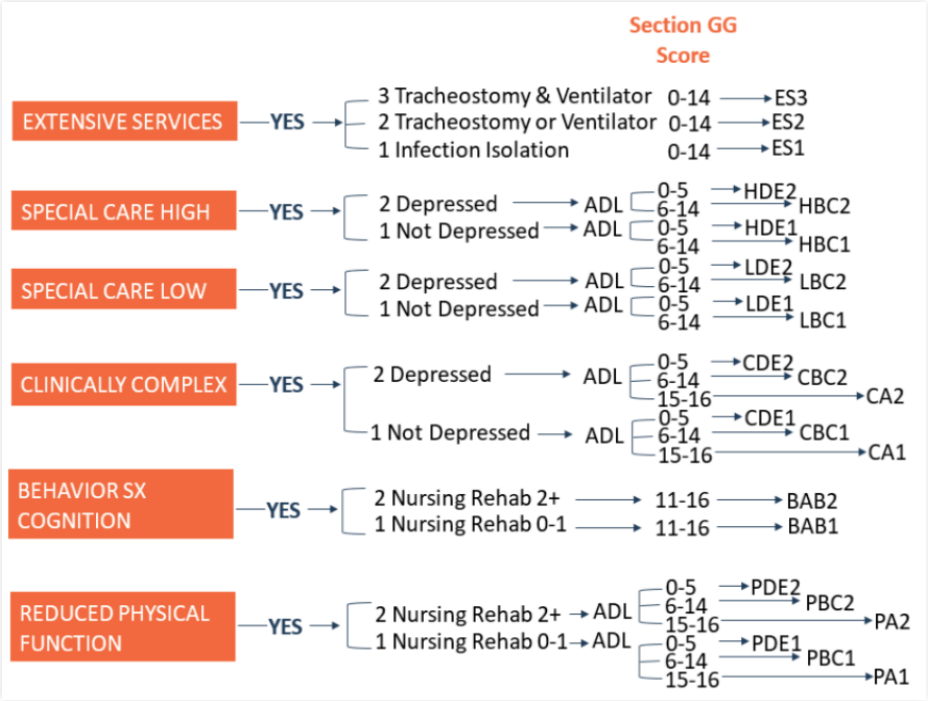
NURSING CMG

6 Categories

25 CMG

Hierarchy System:

- The highest category will be used to calculate reimbursement even if resident qualify for multiple categories
- Example: Resident receives hemodialysis and has diagnosis of sepsis



Nursing CMG: Good to know

- No adjustment factors = payment stays the same regardless of LOS
- 18% increase for HIV/ AIDS on claim
- If GG score =15 or 16, the highest CMG we can get is Clinically Complex (CA, CBC, CDE)

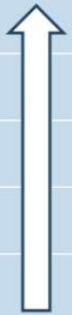
MDS Section GG Items		Score
GG0130A1	Self Care: Eating	0-4
GG0130C1	Self care: Toilet Hygiene	0-4
GG0170B1 GG0170C1	Mobility: Sit to Lying; Lying to sitting on Side of Bed	0-4 (avg of 2 items)
GG0170D1 GG0170E1 GG0170F1	Mobility: Sit to Stand; Chair/bed-to-chair transfer; Toilet Transfer	0-4 (avg of 3 items)

Nursing Function Score

Source: table 24 -25 final rule Federal Register Vol. 83 No. 158 8/8/18

- Uses 7 items
- Total score 0-16

Scoring Response for GG		Score
05 06	Set up assistance Independent	4
04	Supervision or Touching Assist	3
03	Partial/Moderate Assist	2
02	Substantial/Maximal Assist	1
01,07,09,10,88,(-)	Dependent, refused, not attempted	0



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EXTENSIVE SERVICES

TOTAL FUNCTIONAL SCORE OF 14 OR LESS.

FUNCTIONAL SCORE OF 15-16 → SKIP TO CLINICALLY COMPLEX. *(About $200 loss, dropping from ES1 to CA1)*

RAI Guideline:

- O0100E, Tracheostomy:
  - This item may be coded if the resident performs his/her own tracheostomy care
- O0100F, Invasive Mechanical Ventilator
  - Resident unable to support his/her own respiration.
  - Has to be a closed system. No cpap or bipap.
  - Not associated with a surgery procedure or diagnostic procedure
  - Code if resident has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off. (RAI, Chapter 3, Page O-3)

Function Score	Qualifying Criteria for Extensive Services	Group	Services Count	CMG	CMI	HIPPS Code
0–14	• Tracheostomy • Ventilator or respirator • Infectious Iisolation	Extensive Services	Tracheostomy **and** ventilator/respirator	ES3	4.06	**A**
			Tracheostomy **or** ventilator/respirator	ES2	3.07	**B**
			Infectious isolation only	ES1	2.93	**C**

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110M1, Isolation *or quarantine* for active infectious disease (does not include standard *body/fluid* precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "single room isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in *their* room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

O0110M1: Isolation post Admit

"If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.)which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease and **may still code O0110M for single room isolation since it is still being maintained while the resident is in the facility**.*" (RAI Manual page O-8)*

Special Care High

- Total functional score of 14 or less
- Functional score of 15-16 → Skip to clinically complex *(About $95 loss, dropping from HBC1 to CA1)*
- Depression end-split applies

Qualifying Criteria for Special Care High	CMG Group	Function Score	Depression Severity = or > 10	CMG	CMI	HIPPS Code
Received one of the following with a function score of at least 14: • Comatose and completely ADL dependent or ADL did not occur • Septicemia • Diabetes with ***both*** o Insulin injections all seven days and o Two or more days of insulin order changes • Quadriplegia with ADL score < 11 • COPD and SOB when lying flat • Parenteral/IV feedings • Respiratory therapy for all seven days • Fever and one of the following: o Pneumonia, o Vomiting, o Weight loss or o Feeding tube*	Special Care High	0–5	Yes	HDE2	2.40	**D**
		0–5	No	HDE1	1.99	**E**
		6–14	Yes	HBC2	2.24	**F**
		6–14	No	HBC1	1.86	**G**

SPECIAL CARE HIGH: I6200 + J1100C

I6200, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)

J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
☐	A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	B. **Shortness of breath** or trouble breathing **when sitting at rest**
☐	C. **Shortness of breath** or trouble breathing **when lying flat**
☐	Z. **None of the above**

- **Check J1100C:** if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath.

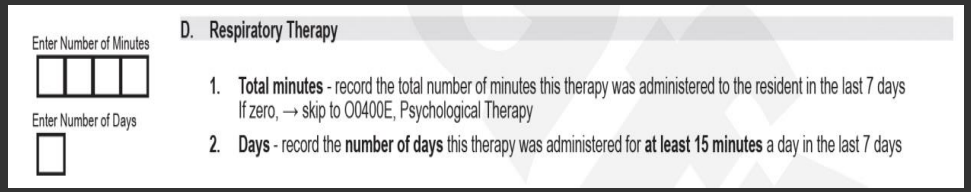
Steps for Assessment (per RAI)

- Interview resident about SOB
- If the resident is not experiencing SOB or trouble breathing during interview, ask if SOB occurs at other times
- Review medical records. Interview staff on all shifts, and family member regarding resident history of SOB, allergies or other environmental triggers of SOB
- Observe the resident for SOB. Signs of SOB include: increased respiratory rate, pursed lip breathing… interrupted speech pattern.
- If SOB is observed, note whether it occurs with certain positions or activities

Special Care High:
Respiratory Therapy x 7 Days

Summary:

- Respiratory treatment (nebs) x 7 consecutive days with at least 15 minutes of treatment per day.
- Order set must include a spot for charge nurse to document minutes of treatment.
- Nurse must be respiratory certified.



Enter Number of Minutes

Enter Number of Days

D. Respiratory Therapy

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

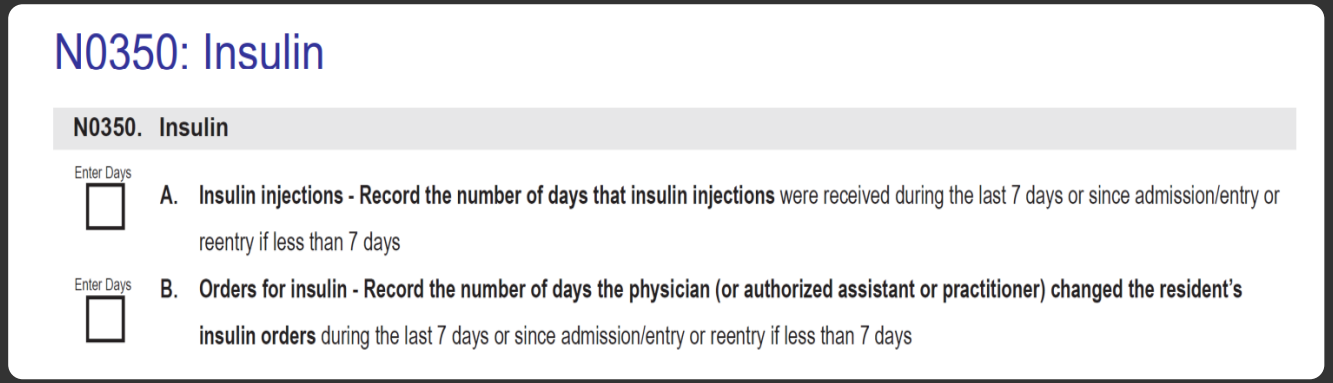
Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

Special Care High:
Diabetes with insulin injections

Summary:

Special care high nursing CMG is triggered when resident has Diabetes with both:

- 7 days of insulin injections during the look back period &
- 2 or more days of insulin order changes



N0350: Insulin

N0350. Insulin

Enter Days ☐ A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

Special Care High:
Parenteral/ IV Feedings

K0520: Nutritional Approaches

K0520. Nutritional Approaches
Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

Check all that apply

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

K0520A: PARENTERAL/IV FEEDING

WHEN THERE IS SUPPORTING DOCUMENTATION THAT REFLECTS THE NEED FOR ADDITIONAL FLUID INTAKE SPECIFICALLY ADDRESSING A NUTRITION OR HYDRATION NEED.

RAI's Definition of Dehydration

Two or more of the following indicators:
**Intake of < 1500 ml fluids daily.*
**Clinical signs of dehydration: Dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, fever, or abnormal lab values (e.g., elevated hemoglobin, hematocrit, potassium, sodium, albumin, BUN, or urine specific gravity)*
**fluid loss exceeds fluid intake (e.g., loss from vomiting, fever, diarrhea)*

DO CODE

IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently

IV fluids running at KVO (Keep Vein Open)

IV fluids contained in IV Piggybacks

Hypodermoclysis and subcutaneous ports in hydration therapy

IV fluids can be coded KO520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

DO NOT CODE

IV Medications—**Code these when appropriate in O0100H, IV Medications.**

IV fluids used to reconstitute and/or dilute medications for IV administration.

IV fluids administered as a routine part of an operative or diagnostic procedure o recovery room stay.

IV fluids administered solely as flushes.

Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

Special Care Low

- Total functional score of 14 or less
- Functional Score of 15-16 → skip to Clinically Complex *(About $50 loss, dropping from LBC1 to CA1)*
- Depression end-split applies

Qualifying Criteria for Special Care Low	CMG Group	Function Score	Depression Severity = or > 10	CMG	CMI	HIPPS Code
Received one of the following with a function score of at least 14: • Cerebral palsy with ADL score < 11 • Multiple sclerosis with ADL score < 11 • Parkinson's with ADL score < 11 • Respiratory failure and oxygen therapy while a resident • Feeding tube* • Two or more stage 2 pressure ulcers with o Two or more selected skin tx • Any stage 3 or 4 pressure ulcers with o Two or more selected skin tx • Two or more venous/arterial ulcers with o Two or more selected skin tx • One stage 2 and one venous/arterial ulcer with o Two or more selected skin tx • Foot infection, diabetic foot ulcer or other open lesion of the foot o With application of dressings to the foot • Radiation treatment while a resident • Dialysis treatment while a resident	Special Care Low	0–5	Yes	LDE2	2.08	**H**
		0–5	No	LDE1	1.73	**I**
		6–14	Yes	LBC2	1.72	**J**
		6–14	No	LBC1	1.43	**K**

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Special Care Low:
Section M

Two+ **stage 2 pressure ulcers** with two+ skin treatments**	M0300B1
Any stage **3 or 4 pressure ulcer** with two+ skin txs**	M0300C1, D1, F1
Two or more **venous/arterial ulcers** with two+ skin treatments**	M1030
1 **stage 2 pressure ulcer** & 1 **venous/arterial ulcer** with 2+ skin txs**	M0300B1, M1030
Foot infection, diabetic foot ulcer or other open foot lesion with dressings to feet	M1040A,B,C; M1200I
Unstageable-Slough and/or eschar	M0300F1

M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

*Documentation may vary, so it is important to review all documentations, interview the treatment nurse, charge nurse and query MD on any conflicting wound documentation

M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

Section M: RAI Tips

General Tips

- Oral mucosal ulcers are captured in L0200C- abnormal mouth tissue
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as surgical wound.
- Resident with dx of DM and has an ulcer on the plantar (bottom) surface of the foot and the ulcer is present in the 7 days look back→ code M1040B for Dm foot ulcer
- If a pressure ulcer healed during the look back period→ do NOT code on the assessment.
- M1200: skin treatments can be coded on the MDS if the ointment or dressing is in place for the purpose of preventing a skin condition.

M1040: Other Ulcers, Wounds and Skin Problems

- **M1040A**: infection of the foot
  - e.g., cellulitis, purulent drainage
- **M1040B:** DM foot ulcers
- **M1040C**: Other open lesion on the foot
  - e.g., cuts, fissures
- **M1040D**: Open lesions
  - wounds, boils, cysts, and vesicles…etc
- **M1040E**: Surgical wound
  - Surgical debridement of PU doesn't create surgical wounds
  - Graft or flap to close a PU = surgical wound
- **M1040F**: Burns
  - Do NOT include 1st degree burns.

Clinically Complex

Depression end-split applies

Qualifying Criteria for Clinically Complex	CMG Group	Function Score	Depression Severity = or > 10	CMG	CMI	HIPPS Code
Received one of the following with a function score of at least 14: • Pneumonia • Hemiplegia/hemiparesis with ADL score < 11 • Surgical wounds or open lesions with any selected skin tx: o Surgical wound care o Application of dressing or ointment (not to feet) • Burns – 2nd or 3rd degree • Chemotherapy while a resident • Oxygen therapy while a resident • IV medications while a resident • Transfusions while a resident	Clinically Complex	0–5	Yes	CDE2	1.87	**L**
		0–5	No	CDE1	1.62	**M**
		6–14	Yes	CBC2	1.55	**N**
		15–16	Yes	CA2	1.09	**O**
		6–14	No	CBC1	1.34	**P**
		15–16	No	CA1	0.94	**Q**
NOTE: resident with function score of 15–16 and meeting criteria for extensive services, special care high and low will qualify in clinically complex CMG.						

Clinically Complex: Section M

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

Section M Tips (Reminder)

- **M1040D**: Open lesions
  - wounds, boils, cysts, and vesicles…etc
- **M1040E**: Surgical wound
  - Surgical debridement of PU isn't surgical wounds
  - Graft or flap to close a PU = surgical wound
- **M1040F**: Burns
  - Do NOT include 1st degree burns.

M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

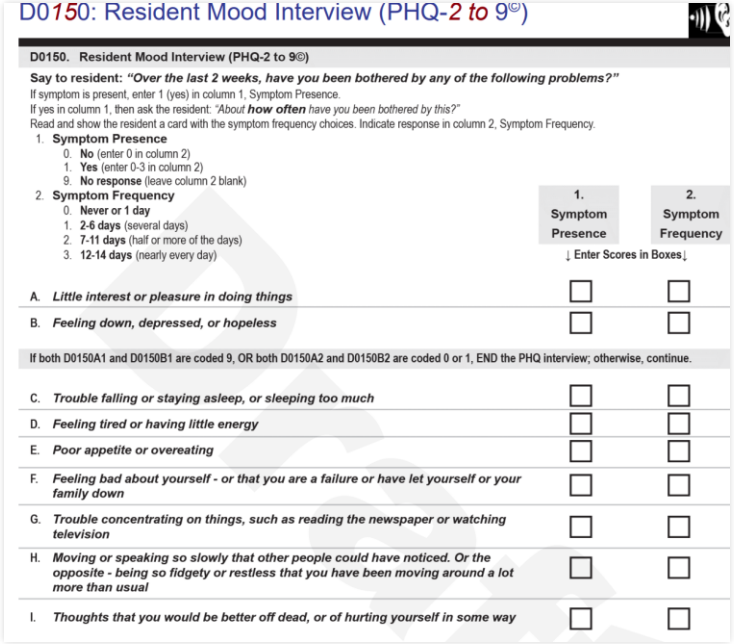
Depression End Split

End-split determination

- PHQ-2-9 score = or higher than 10 → End-split = “2”
- PHQ-2-9 score <10 → End-split = “1” or “0”

Depression end-splits applies to these nursing CMG:

- Special care high
- Special care low
- Clinically complex



D0150: Resident Mood Interview (PHQ-2 to 9©)

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: ***“Over the last 2 weeks, have you been bothered by any of the following problems?”***

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *“About* ***how often*** *have you been bothered by this?”*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   - 0. **No** (enter 0 in column 2)
   - 1. **Yes** (enter 0-3 in column 2)
   - 9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   - 0. **Never or 1 day**
   - 1. **2-6 days** (several days)
   - 2. **7-11 days** (half or more of the days)
   - 3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

1-4:	minimal depression
5-9:	mild depression
10-14:	moderate depression
15-19:	moderately severe depression
20-27:	severe depression

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Restorative End Split

End-split determination

- 2 or more programs
  - At least 15 mins/day and
  - At least 6 days during the 7-day look-back period

Restorative end-splits applies to these nursing CMG:

- Behavior/ Cognitive Impairment
- Reduced Physical Function

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	**Training and Skill Practice In:**
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

Nursing CMG: Additional Thoughts

MDS Coordinator and IDT members should have understanding of what clinical items are considered higher acuity.

The key is to have supporting documentation.

Understand that GG score influences nursing CMG (e.g. if a resident GG score > 14, the highest nursing CMG we can obtain is Clinically Complex).

Understand timing ARD has a huge impact on reimbursement.

Consider services provided “while a resident” that may not be delivered in the facility.

Final Thoughts

- Pre-Admission documentation review
- PDPM Huddle Meetings Daily with IDT
- Pre-Transmission Review
- Compliance/Medicare Meeting
- Triple Check

LUMINATE

Physician: _____

Morbid Obesity

Facility: _____ MR #: _____
Patient Name: _____ Room Number: _____

The following information is documented in the medical record regarding this patient's nutritional status [check only those that apply]:

___ BMI =<35(include actual BMI) BMI _____

___ Comorbidities diagnosis: _____

(Dm, HTN, CAD, osteoarthritis, HLD, GERD, sleep apnea, CHF)

Based on your medical judgment, can you further clarify in the progress notes which, if any, of the following conditions may be causing these findings [Check appropriate category]:

___ Overweight

___ Morbid Obesity

___ Other condition (please specify)

___ None of the above / Not applicable

___ **Present on admission**

Thank you!

Physician Signature: _____

Date: ___/___/___

LUMINATE

Immunodeficiency Query

Facility: _____ MR #: _____
Patient Name: _____ Room Number: _____

The following information is documented in the medical record regarding this patient's immune status [check only those that apply]:

___ Immunosuppressed due to:
- __ Chemotherapy for cancer treatment
- __ Immunosuppressant therapy to avoid transplant rejection
- __ Medical condition (list the conditions):_____

___ Immunodeficiency as exhibited by:

___	Frequent and recurrent pneumonia	___	Skin infections
___	Bronchitis	___	Inflammation and infection of internal organs
___	Sinus infections	___	Blood disorders, such as low platelet counts or anemia
___	Ear infections	___	Recurrent or frequent infection(s)
___	Meningitis	___	Other: _____

Based on your medical judgment, can you further clarify in the progress notes which, if any, of the following conditions may be causing these findings [Check appropriate category]:

___	D61810	Antineoplastic chemotherapy-induced pancytopenia
___	D61811	Other drug-induced pancytopenia
___	D61818	Other **pancytopenia**
___	D708	Other neutropenia
___	D709	Neutropenia, unspecified
___	D829	Immunodeficiency associated with major defect, unspecified
___	D828	Immunodeficiency associated with other specified major defects
___	D8481	Immunodeficiency due to conditions classified elsewhere
___	**D84821**	**Immunodeficiency due to drugs**
___	D849	Immunodeficiency, unspecified
___	D84822	Immunodeficiency due to external causes
___	D899	Disorder involving the immune mechanism, unspecified.
___		**Present on admission**
___	_____	_____
___	_____	_____

Thank you,

Physician Signature: _____
Date: ___/___/___

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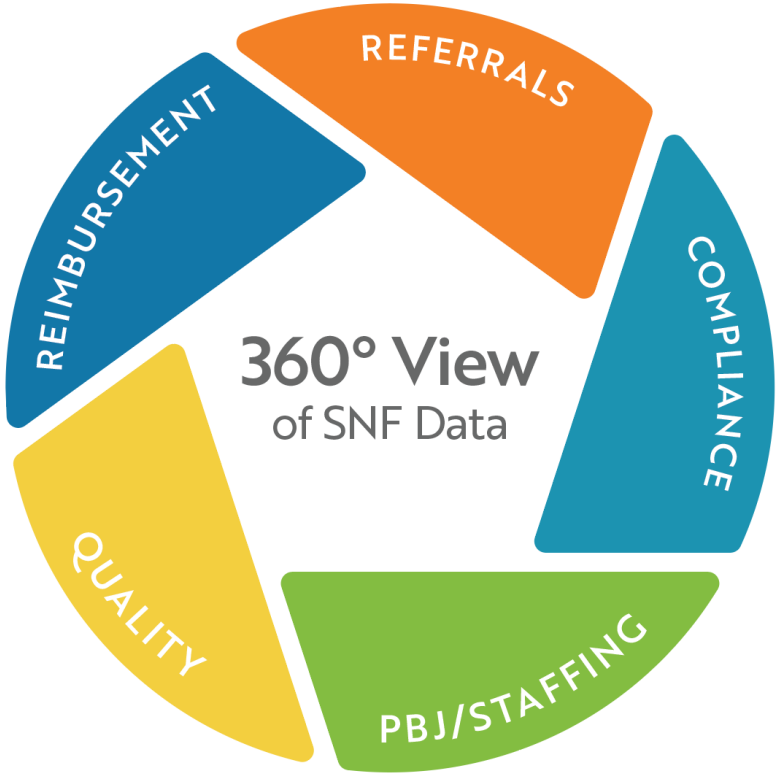

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