Nursing Home Resident Assessment

Resource Utilization Groups
OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's New York regional office prepared this report under the direction of John I. Molnar, Regional Inspector General, and Renee C. Dunn, Deputy Regional Inspector General. Principal OEI staff included:

**REGION**
- Danielle Fletcher, *Lead Analyst*
- Lucille Cop
- Vince Greiber
- Steve Shaw

**HEADQUARTERS**
- Susan Burbach, *Program Specialist*
- Barbara Tedesco, *Mathematical Statistician*
- Linda Moscoe
- Brian Ritchie

* All staff in the New York Regional Office participated in this inspection.

To obtain copies of this report, please call the New York Regional Office at 212 264-2000. Reports are also available on the World Wide Web at our home page address:

http://www.hhs.gov/oig/oei
EXECUTIVE SUMMARY

PURPOSE

To provide an initial review of the integration of the prospective payment system with the resident assessment.

BACKGROUND

The Office of Inspector General undertook a series of nursing home inspections examining the quality of care in nursing homes. This report is a part of that series. A companion report, “Nursing Home Resident Assessment, Quality of Care,” provides a more detailed analysis of the components of the minimum data set.

The Nursing Home Reform Act mandates that nursing facilities use a clinical assessment tool known as the Resident Assessment Instrument to identify residents’ strengths, weaknesses, preferences, and needs in key areas of functioning. The assessment is an integral part of the residents’ medical record. It is designed to help nursing facilities thoroughly evaluate residents and provides each resident with a standardized, comprehensive, and reproducible resident assessment. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident. The minimum data set (MDS) is a component of the resident assessment which contains a standardized set of essential clinical and functional status measures.

The prospective payment system for a Medicare Part A skilled nursing facility stay was phased into nursing homes between July of 1998 and January of 1999. This has raised a new dimension of issues and concerns and changed the significance of the resident assessment. Under the prospective payment system, skilled nursing facilities are required to classify residents into one of forty-four Resource Utilization Groups (RUGs-III) based on assessment data from the resident assessment.

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records for a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators.

FINDINGS

Coding differences exist: both upcoding and downcoding

The RUGs flow from the MDS and drive Medicare reimbursement to nursing homes under the prospective payment system. Residents are initially assigned to one of seven
major categories of RUGs and then are further classified into 1 of 44 minor RUG categories based on a MDS assessment. For 46 percent of the residents the nursing home coded the resident in a RUG that was higher than our reviewer. For the remaining 30 percent, the nursing home coded the residents in a RUG that was lower than our reviewer. We tested the potential effect on reimbursement; it was not statistically significant.

Therapy minutes and activities of daily living are keys to RUG differences

There are 108 MDS elements that are used in developing the RUG category for each Medicare resident. The minutes of therapy given to the residents is a key driver of the RUG reimbursement. The nursing home completes the MDS by recording the time the beneficiary spent receiving therapy. The therapy log includes both the time the beneficiary spent receiving therapy and other related activities. Our reviewers compared the number of minutes on the MDS to the time in the therapy logs and determined a difference to exist when the therapy time did not match. Thus, some difference is anticipated between the log and the MDS. One would expect the log to be higher than the MDS. However, we found that in most cases the MDS is higher. The nursing home more often coded the resident with more therapy minutes on their copy of the MDS than the therapy logs indicate. More specifically, we found that minutes of both occupational and physical therapy given in the last seven days show rates of difference between 39 and 46 percent respectively. Thirty-one percent of the occupational therapy records and 34 percent of the physical therapy records were coded in the MDS with more minutes.

Further, Section G of the MDS, “Physical Functioning and Structural Problems” has a higher total rate of difference (37 percent) than any other section used to develop RUGs. Each field in Section G used in the RUG computation has a difference rate of at least 28 percent.

Concerns were raised regarding PPS training and additional staff responsibility

Ninety-three percent of MDS coordinators and 98 percent of nursing home administrators report that the introduction of PPS has given additional responsibilities to existing staff. However, about 40 percent of administrators and MDS coordinators note that new staff has been hired to handle PPS.

Almost all MDS coordinators and nursing home administrators state that the staff received initial PPS training. However, 28 percent of MDS coordinators and administrators feel that their staff were inadequately trained about the Medicare PPS. Some cite that there was confusion and misunderstanding in the initial training sessions and express a need for additional training. Twenty-seven percent of MDS coordinators note that they receive ongoing training and 60 percent of administrators say they have plans for additional PPS training sessions.
RECOMMENDATIONS

This is an early alert raising concerns about the accuracy of the RUG codes. The fact that coding differences are both higher and lower indicates confusion or difficulties in implementing the MDS rather than an effort to “upcode” the RUGs to increase Medicare reimbursement. However, such a practice cannot be ruled out and our study demonstrates how vulnerable Medicare is to such a practice.

There are apparently differences in how people perceive the MDS. Some see it as a primary document that does not need to be validated by medical documentation. Others feel it must be consistent and validated with the medical record. Clearly, there are variations in interpretation in the way people are using the system. We believe any inability to validate the resident assessment through the medical record would expose the Medicare program to billing abuses. For these reasons, we recommend that HCFA:

- more clearly define MDS elements, especially section G;
- provide enhanced and coordinated training to nursing homes to be sure that similar and accurate MDS and RUG information is being disseminated; and
- require that nursing homes establish an audit trail to validate the 108 MDS elements that drive the RUG code from other parts of the medical record, paying particular attention to therapy minutes and activities of daily living.

The problems we describe in this report will require continuing attention. We plan to revisit the prospective payment system in nursing homes after it has been implemented for a while.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration. They concur with the first two recommendations and describe a number of important steps they are taking to improve understanding and implementation of resident assessment, particularly the MDS.

However, HCFA does not concur with our third recommendation to establish an audit trail to validate the 108 MDS elements. Instead, they plan to fund a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. They hope to combine data validation and program integrity approaches.

We are certainly open to approaches other than the one used in this study to validate the
RUG codes and are ready to work with HCFA in analyzing any such alternate methods. However, for the time being we see no alternative to relying on a medical record review, not just the MDS, to assure correct reimbursement for SNF services.

We appreciate HCFA’s thoughtful consideration of our report. We wish to emphasize again that our work was intended to be an early look to identify potential vulnerabilities and issues for further work.

The Health Care Financing Administration also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix G.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>i</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>FINDINGS</td>
<td></td>
</tr>
<tr>
<td>Coding differences</td>
<td>8</td>
</tr>
<tr>
<td>Therapy minutes and ADLs</td>
<td>10</td>
</tr>
<tr>
<td>Concerns with PPS training and staff responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>12</td>
</tr>
<tr>
<td>APPENDICES</td>
<td></td>
</tr>
<tr>
<td>A: RUG Classification</td>
<td>14</td>
</tr>
<tr>
<td>B: Confidence Intervals</td>
<td>15</td>
</tr>
<tr>
<td>C: RUG payment statistical test</td>
<td>16</td>
</tr>
<tr>
<td>D: Chi-square</td>
<td>17</td>
</tr>
<tr>
<td>E: RUG Rates</td>
<td>18</td>
</tr>
<tr>
<td>F: Minimum Data Set</td>
<td>20</td>
</tr>
<tr>
<td>G: Agency Comments</td>
<td>27</td>
</tr>
</tbody>
</table>
INTRODUCTION

PURPOSE

To provide an initial review of the integration of the prospective payment system with the resident assessment.

BACKGROUND

The Senate Special Committee on Aging held hearings in the summer of 1998 following reports by the Health Care Financing Administration (HCFA) and the General Accounting Office (GAO) of serious concerns about nursing home residents' care and well-being. Subsequently, the Office of Inspector General (OIG) undertook a series of nursing home inspections examining the quality of care in nursing homes. They include trends in reported abuse among residents, the role of the ombudsman in protecting residents, the capacity of the State survey and certification program, the trends in the Online Survey Certification and Reporting System (OSCAR) data, the access of nursing home survey results, and access to nursing homes. This report is a part of that series. A companion report, “Nursing Home Resident Assessment Quality of Care,” has a more detailed analysis of the components of the minimum data set (MDS).

Generally a nursing home is a residential facility which offers daily living assistance to people who are either physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, and, in most cases, some medical treatment for those residents who require it.

Medicare Part A can help pay for skilled nursing facility (SNF) care for up to 100 days in a benefit period when a beneficiary meets certain conditions. These conditions include a requirement of daily skilled nursing or rehabilitation services, a prior three consecutive day stay in a hospital, admission to the SNF within a short period of time after leaving the hospital, treatment for the same condition that was treated in the hospital, and a medical professional certifying the need for daily skilled nursing or rehabilitation care. In 1990 Medicare paid $1.7 billion to nursing homes. In 1998 this amount had increased to $10.4 billion. Medicare pays only a small portion of the nation’s nursing home bills. Most bills are paid by personal funds, purchased long-term care insurance, and Medicaid.

Medicaid coverage varies among States. Medicaid eligible beneficiaries who require custodial care such as help with eating, bathing, taking medicine and toileting, as well as

---

those who require skilled care may have a nursing home stay paid by Medicaid. Medicaid payments to nursing homes in 1996 totaled $40.6 billion. Despite the increase in Medicare and Medicaid payments, concern remains about the quality of care in nursing homes.

In 1986 the Institute of Medicine conducted a study on nursing home regulation and reported prevalent problems regarding the quality of care for nursing home residents and the need for stronger Federal regulations. In 1987, the GAO reported that over one-third of nursing homes were operating under the Federal minimum standards. This report, along with widespread concern regarding nursing home conditions, led Congress to pass the Omnibus Budget Reconciliation Act (OBRA 1987). As a part of OBRA 1987, Congress passed the comprehensive Nursing Home Reform Act (P.L. 100-203), expanding requirements that nursing homes have to comply with prior to Medicare or Medicaid certification.

The Resident Assessment

The Nursing Home Reform Act mandates that nursing homes use a clinical assessment tool known as the Resident Assessment Instrument (RAI) to identify residents’ strengths, weaknesses, preferences, and needs in key areas of functioning. The RAI is designed to help nursing homes thoroughly evaluate residents and to provide each resident with a standardized, comprehensive, and reproducible assessment. “With consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities. Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.”

The RAI was developed by a research consortium under contract with the HCFA and consists of three key components: the Minimum Data Set (MDS), Triggers and Resident Assessment Protocols (RAPs), and Utilization Guidelines. Most States required nursing homes to begin implementing the RAI in 1991. It was intended that the RAI be a dynamic tool, and HCFA began developing version 2.0 of the RAI in early 1993 which is now in use. The HCFA is committed to continuous reviews and updates.

The RAI is intended to be completed by an interdisciplinary team of nursing home staff who gather facts about the residents’ strengths and needs. The interdisciplinary team should ideally include dieticians, speech, physical and occupational therapists, social workers, pharmacists, and nurses. The attending physician is also an important participant in the RAI process providing valuable input on sections of the MDS and RAPs. Federal regulations require each individual who completes a portion of the RAI to sign, date, and certify its accuracy. Regulations also require that a registered nurse sign and certify that

\[ U.S. \text{ Department of Health and Human Services, Health Care Financing Administration, } \textit{Long Term Care Resident Assessment Instrument User’s Manual Version 2.0} \text{ October, 1995.} \]
the assessment is complete. Upon completion of the assessment, the information guides the team to prepare individualized care plans for each resident.

The Minimum Data Set

The MDS 2.0, a component of the RAI, contains a standardized set of essential clinical and functional status measures. It must be collected on every resident in the nursing home at regular intervals during their nursing home stay regardless of the method of payment. Nursing homes are required to “conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.” All residents must be completely assessed in the first 14 days after admission, promptly after a significant change in their physical or mental condition, and at least once every 12 months. Additionally, all MDS assessments must be reviewed at least every 3 months to assure continued accuracy. Since the implementation of the prospective payment system there is a more frequent MDS schedule for those residents reimbursed by Medicare Part A.

Resource Utilization Groups and the Prospective Payment System

A new dimension of issues and concerns was layered upon the resident assessment with the advent of the prospective payment system. Effective June 23, 1998, nursing homes participating in the Medicare and Medicaid programs are required to electronically submit, at least monthly, MDS data to the State for all assessments conducted during the previous month. Under the prospective payment system for a Medicare Part A skilled nursing facility (SNF) stay, SNFs are required to classify residents into one of 44 Resource Utilization Groups (RUGs-III) based on assessment data from the MDS. Each SNF must complete the assessments according to a schedule designed for Medicare payment. This schedule requires residents, upon admission to a SNF, be assessed on the 5th, 14th, 30th, 60th, and 90th days of the resident’s stay.

Under the new prospective payment system, SNFs will know in advance how much HCFA will pay for each Medicare patient. The prospective payment system was phased into nursing homes in July of 1998, and all nursing homes were expected to comply with the new system in January of 1999. Some States are currently using a PPS system for Medicaid reimbursement, while others are considering adopting it in lieu of their existing systems.

The RUG-III classification is based on residents’ resource needs and is divided into seven major categories: rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior problems, and reduced physical function. Payment rates are

---

further differentiated between and within the seven major categories. Facility differences in case-mix and for geographic variations in wages are also incorporated into the payment rates. The HCFA conducted a demonstration project to determine the appropriate payment rates.

In a memorandum released in May 1999, HCFA gives instructions to the fiscal intermediaries which outlines the process to be used for medical record review for PPS claims. All fiscal intermediaries are to review Medicare SNF PPS claims. The goal is to identify inappropriate payments. It states that the Medicare bill must be supported by the appropriate provider documentation including “the MDS, the medical record including physician, nursing, and therapy documentation, and the beneficiary’s billing history.”

This requirement is reinforced by another memorandum released in March 2000 which refers to proper documentation including “hospital discharge summaries and transfer forms; physician orders and progress notes; patient care plans; patient assessment instrument (MDS); nursing and rehabilitation therapy notes; and treatment and flow charts and vital sign records; weight charts and medication records.”

**MDS Coordination**

When Medicare reimbursement became linked to resident assessments, the role of the MDS coordinator became more vital to nursing homes. MDS coordinators are generally registered nurses who oversee the assessments and paperwork in order to guarantee proper completion. The MDS coordinators are able to mesh a combined effort of an interdisciplinary staff to produce the written and electronic documents necessary for Medicare reimbursement. The MDS coordinator is also responsible for ensuring that each resident’s MDS is coded accurately so that the nursing home is financially able to provide all necessary services.

In addition, MDS coordinators affect the quality of care of the residents. Completing a thorough and accurate comprehensive assessment enables the nursing home to provide appropriate plans of care for each resident. The MDS coordinators can provide a global picture of each resident and can spot weaknesses in their plans of care.

**Prior Studies**

The Research Triangle Institute completed a study in 1995 entitled “Evaluation of the Nursing Home Resident Assessment Instrument” that examined the effect of the resident assessment instrument on quality of care in nursing homes. One finding suggested that

---


5 Program Memorandum Intermediaries, transmittal No. A-00-08. Department of Health and Human Services, Health Care Financing Administration, March 2000.
administrators and directors of nursing positively accepted the RAI and believed it helped individualize the plans of care. Another key finding suggested that overall quality of care and care planning improved in nursing homes when the RAI was implemented. In addition, the study indicated that the RAI significantly reduced hospitalization rates and improved resident outcomes in certain areas.

However, recent reports by the Office of Inspector General and another researcher found that the failure to provide comprehensive assessments was among the 10 most frequently cited deficiencies in nursing homes. A 1996 study for HCFA reported that between 25 and 30 percent of nursing homes were deficient in their development of comprehensive assessments and/or comprehensive care plans.

METHODOLOGY

This inspection is based on information gathered from three different sources: a medical review of nursing home medical records from a sample of 640 nursing home residents, a self-administered survey of 64 nursing home MDS coordinators, and a telephone survey of 64 nursing home administrators. We conducted our field work between June and August 1999.

Sample Selection

We selected Medicare, Medicaid, and private pay nursing home residents using a three-stage stratified, cluster sample. First, we selected a stratified sample of eight States to include the four States with the most certified nursing home beds (California, New York, Texas, and Illinois), two States randomly selected from the four currently using a prospective payment system for Medicaid reimbursement in a HCFA demonstration project (Mississippi and Maine), and two States randomly selected from the remaining 40 States (Connecticut and Virginia).

Skilled nursing facilities refers to nursing homes that participate in Medicare. Nursing facilities refers to nursing homes certified to participate in Medicaid. For the purposes of this study, we will refer to Medicare, Medicaid, and private pay facilities as nursing homes because we included all payor types for the sample selection.

Next, we randomly chose eight nursing homes in each of the eight sample States, excluding nursing homes with a bed count of less than 60 to ensure a sufficient number of residents who fit the selection criteria. Finally, we randomly selected 10 residents in each


nursing home for a total of 640 residents. This selection was made from all nursing home residents who were in the 64 sample nursing homes in December 1998, regardless of payment source. These residents were admitted to the nursing home between July 1998 and December 1998. We selected the 14 day admission assessment completed for the resident from July to December 1998 and reviewed all the medical records prior to this assessment. Data for all samples were weighted and projected to the universe.

Medical Review and Analysis

Comparison with the medical record. We obtained the services of a medical review contractor who employed nurses with experience in completing the MDS in nursing homes and in consulting and training on the MDS process to conduct the review. These nurses visited each nursing home and completed a 14 day assessment based on the resident’s medical record for the same 14 day time period. In doing so, our reviewers did not refer to the original MDS during their review nor did they contact the residents or the staff to complete their assessments. They were instructed to complete each field of the assessment only if there was sufficient and reliable information in the medical record to warrant a determination. Subsequently, we made a comparison of the results for each field. In this way, we were able to determine if the nursing homes’ resident assessment was consistent with the rest of the medical record.

Nine residents did not fit our selection criteria, thus leaving a sample of 631 residents. All but three completed copies of the MDS were forwarded to us by the nursing home. The nurses were unable to complete some fields in the MDS due to lack of information in the medical record\(^8\). Most of these fields required information that was inappropriate for a 14 day assessment. All other fields had sufficient information for our reviewers to complete the MDS.

The methodology is useful to identify differences between what our reviewers would have entered in the MDS based on a review of the other medical records, versus what the facility nurses observed in the actual physical assessment of the patient. Our method does not permit a specific determination of why the differences occurred -- e.g., an error in the MDS review by the observing nurse, an error or omission in the medical record, or simply an honest difference of opinion given a similar set of facts. However, overall such differences might highlight the need to take steps to ensure greater consistency.

Generation of RUGs. In addition, the reviewers generated a RUG based on their prepared MDS to compare to the RUG generated by the facility. Because we included all payer sources in our sample, we were able to compare RUGs for 228 beneficiaries. The remaining 403 beneficiaries had no RUG information on the copy of the MDS forwarded to us. Medicaid and private pay residents are not required to be grouped in a RUG. In

---

\(^8\) These fields include B6, C7, E3, E5, G3a, G9, H4, I3, K3, N5a, R1a, R1b, and R1c.
addition, some nursing homes had yet to begin using PPS for reimbursement. In order to compare differences in reimbursement rates between our reviewers and the nursing home, we calculated RUG rates of our reviewers and the nursing homes based on case-mix adjusted Federal rates for northeast, urban nursing homes.

Surveys

We sent a self-administered questionnaire to each MDS coordinator in the 64 nursing homes in our sample and asked questions regarding the implementation of the resident assessment and plans of care. We had a 100 percent response rate from the MDS coordinators. We obtained information regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. In addition, we looked at the structures and processes the staff use to perform the resident assessment and their satisfaction with the process.

Interviews

We conducted structured telephone interviews in July 1999 with nursing home administrators in each of the 64 sample nursing homes. We had a 100 percent response rate. We asked them questions regarding the implementation of the resident assessment and plans of care. During these interviews, we also obtained information from them regarding the characteristics, training, and coordination of the staff who complete the assessments and plans of care. We also looked at the structures and processes the staff used to fulfill the resident assessment instrument requirements and their satisfaction with the process.

Limitations

The results of this analysis are limited by the information available in the medical record. In some cases, the nursing home completes the MDS based on observation of or discussion with the resident about which there may not be any other information in the medical record.

For Section P: Special Treatment and Procedures, which includes minutes of occupational and physical therapy given in the last 7 days, the reviewer compared the therapy logs to the MDS. In some cases, the logs were kept in units of 15 minutes. The reviewers converted the units to minutes.

This inspection was conducted in accordance with the Quality Standards for Inspections issued by the President’s Council on Integrity and Efficiency.
FINDINGS

Coding differences exist: both upcoding and downcoding

Resource Utilization Groups, or RUGs, flow from the Minimum Data Set (MDS) and drive Medicare reimbursement to nursing homes under the Prospective Payment System (PPS). A resident is initially assigned to one of the seven major categories of RUGs based on their clinical characteristics and functional abilities. Upon completion of the MDS, Medicare residents are further classified into 1 of 44 minor RUGs categories. See Appendix A for a complete listing of RUGs.

For 46 percent of the residents, the nursing home coded the resident in a RUG that was higher than our reviewer. For the remaining 30 percent, the nursing home coded the residents in a RUG that was lower than our reviewer. See Chart 1. See Appendix B for confidence intervals.

Chart 1

RUG Coding

![Chart showing RUG Coding]

Source: Medical Record Review
In order to determine the potential effect of these differences on reimbursement, we created a model based on assumptions. We assumed that the prospective payment system was fully implemented and all nursing homes in the sample were in the urban northeast. Using the case-mix adjusted Federal rates for the northeast, we found no statistically significant effect. See Appendix C.

We looked at some characteristics that might explain the variation in coding. Nursing homes that are not a member of a chain organization are more likely than those that are a part of a chain organization to have RUG determinations different from our reviewers. Eighty-two percent of non-chain nursing homes, compared to 72 percent of chain nursing homes had differences between the nursing homes and our reviewers in the RUG codes. There was not a significant difference between rural or urban nursing homes. See Appendix D. Seven of the eight states in our sample had at least one nursing home that coded all of their residents in a different RUG than our reviewer.

Special rehabilitation, the largest of the 7 major RUG categories, is composed of 14 of the 44 RUGs. Physical, speech, or occupational therapy are clinical indicators that identify residents in the Special Rehabilitation category. Each RUG is given a number value that corresponds to the complexity of the diagnosis, symptoms, and treatment. Nursing homes are more likely than our reviewers to code the residents in the Special Rehabilitation RUGs. Thirty-seven percent of all residents coded in a higher reimbursement level were assigned to the Special Rehabilitation RUG category. While the remaining 9 percent of all other residents who were coded higher by the nursing home fell into the remaining 6 major RUG categories: Extensive Care, Special Care, Clinically Complex, Cognitively Impaired, Behavior Problems, and Reduced Physical Functions.

In addition to this RUG group being the largest and generating the highest payments, “Special Rehabilitation” is notable because a previous OIG study found that nursing homes prefer special rehabilitation patients. Discharge planners who were interviewed said that patients who require rehabilitation therapy are easier to place. They explained that these patients generally have short stays and become independent in activities of daily living quickly. In another report, 46 percent of nursing home administrators report that special rehabilitation patients such as physical, occupational, or speech therapy recipients are more likely to be admitted for care.

---

9 Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities (OEI-02-99-00400), August 1999

10 Department of Health and Human Services, Office of Inspector General, Office of Evaluations and Inspections, Early Effects of the Prospective Payment System on Access to Skilled Nursing Facilities: Administrators’ Perspective (OEI-02-99-00401), October 1999
Therapy minutes and activities of daily living are keys to RUG differences

Minutes of therapy given to the residents is a key driver of the rehabilitation RUG reimbursement. Minutes of both occupational and physical therapy given in the last 7 days are two fields that are included in Section P: Special Treatment and Procedures. The nursing home completes the MDS by recording the time the beneficiary spent receiving therapy. The therapy log includes both the time the beneficiary spent receiving therapy and other related activities. Our reviewers compared the number of minutes on the MDS to the time in the therapy logs and determined a difference to exist when the therapy time did not match. Thus, some difference is anticipated between the log and the MDS. One would expect the log to be higher than the MDS. However, we found that in most cases the MDS is higher. The nursing home more often coded the resident with more therapy minutes on their copy of the MDS than the therapy logs indicate.

More specifically, of the 39 percent difference rate in occupational therapy, 31 percent of the records were coded with higher rates than the therapy logs while only 9 percent were coded lower. Of the 46 percent difference rate in physical therapy, 34 percent were coded higher with only 12 percent coded lower. The overall difference rates of occupational and physical therapy are well above the 15 percent difference rate average of all 108 elements. See Appendix B for confidence intervals.

A resident’s functional status is measured by an index of activities of daily living (ADLs) and the number and types of services used. The ADL index is based on scores in MDS Section G, Physical Functioning and Structural Problems. This includes bed mobility, transfer, eating, and toilet use.

Section G has a 37 percent difference rate making it the highest difference rate of all sections used to develop the RUGs. All seven fields in Section G used in the RUG computation have a difference rate of at least 28 percent. Section G includes assessments for both self-performance and support. The self-performance section assess the degree to which a resident can perform an activity independently. The support assessment describes the nature and extent of the support provided. Some specific examples include the self-performance assessment of bed mobility which has a 36 percent difference rate and the support assessment of bed mobility which has a 33 percent difference rate. The self-performance difference rate for transfers is 40 percent, and the support difference rate is 36 percent.

Forty percent of the nursing home MDS coordinators report Section G is the most difficult to complete. When asked to indicate which section they would change, 20 percent report they would change Section G. Some explained that the “staff views capabilities differently [and the capabilities] remain subjective” and they “would like
Concerns were raised regarding PPS training and additional staff responsibility

Ninety-three percent of MDS coordinators and 98 percent of nursing home administrators report that the introduction of PPS has given additional responsibilities to existing staff. Further, about 40 percent of administrators and MDS coordinators note that new staff has been hired to handle PPS.

Twenty-eight percent of MDS coordinators and administrators feel that the staff was inadequately trained about the Medicare PPS. Some cite that there was confusion and misunderstanding in the initial training sessions and express a need for additional training. Twenty-seven percent of MDS coordinators note that they receive on-going training and 60 percent of administrators say they have plans for additional PPS training sessions. Almost all MDS coordinators and administrators state that the staff received initial PPS training. Most MDS coordinators include formal workshops outside the nursing homes as part of their initial training. Other initial training includes informal on-the-job training, reading and referring to the manual, and formal training provided in the nursing home.

Administrators and MDS coordinators state that they receive training from private consultants, corporate offices, HCFA, and the fiscal intermediary. Eighty-seven percent of administrators feel that they have adequate resources available about PPS. They cite corporate offices, consultants, the fiscal intermediary, and magazines and books as resources used when they have questions.
RECOMMENDATIONS

This is an early alert raising concerns about the accuracy of the RUG codes. The fact that coding differences are both higher and lower indicates confusion or difficulties in implementing the MDS rather than an effort to “upcode” the RUGs to increase Medicare reimbursement. However, such a practice cannot be ruled out and our study demonstrates how vulnerable Medicare is to such a practice.

There are apparently differences in how people perceive the MDS. Some see it as a primary document that does not need to be validated by medical documentation. Others feel it must be consistent and validated with the medical record. Clearly, there are variations in interpretation in the way people are using the system. We believe any inability to validate the resident assessment through the medical record would expose the Medicare program to billing abuses. For these reasons, we recommend that HCFA:

- more clearly define MDS elements, especially section G;
- provide enhanced and coordinated training to nursing homes to be sure that similar and accurate MDS and RUG information is being disseminated; and
- require that nursing homes establish an audit trail to validate the 108 MDS elements that drive the RUG code from other parts of the medical record, paying particular attention to therapy minutes and activities of daily living.

The problems we describe in this report will require continuing attention. We plan to revisit the prospective payment system in nursing homes after it has been implemented for a while.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration. They concur with the first two recommendations and describe a number of important steps they are taking to improve understanding and implementation of resident assessment, particularly the MDS.

However, HCFA does not concur with our third recommendation to establish an audit trail to validate the 108 MDS elements. Instead, they plan to fund a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. They hope
to combine data validation and program integrity approaches.

We are certainly open to approaches other than the one used in this study to validate the RUG codes and are ready to work with HCFA in analyzing any such alternate methods. However, for the time being we see no alternative to relying on a medical record review, not just the MDS, to assure correct reimbursement for SNF services.

We appreciate HCFA’s thoughtful consideration of our report. We wish to emphasize again that our work was intended to be an early look to identify potential vulnerabilities and issues for further work.

The Health Care Financing Administration also provided technical comments which we have incorporated in the report. The full text of the comments is provided in Appendix G.
Confidence Intervals for Key Findings

We calculated confidence intervals for the key findings. The point estimate and 95 percent confidence interval are given for each of the following findings. The point estimates and confidence intervals for the findings vary based on the standard error for each individual finding.

<table>
<thead>
<tr>
<th>KEY FINDINGS</th>
<th>POINT ESTIMATE</th>
<th>CONFIDENCE INTERVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of matched RUGs</td>
<td>24%</td>
<td>+/-9%</td>
</tr>
<tr>
<td>Percent of mismatched RUGs</td>
<td>76%</td>
<td>+/-9%</td>
</tr>
<tr>
<td>NH coded higher and coded Special Rehabilitation</td>
<td>37%</td>
<td>+/-14%</td>
</tr>
<tr>
<td>Difference rate of physical therapy</td>
<td>46%</td>
<td>+/-5%</td>
</tr>
<tr>
<td>Difference rate of occupational therapy</td>
<td>39%</td>
<td>+/-11%</td>
</tr>
<tr>
<td>Difference rate of 108 MDS elements</td>
<td>15%</td>
<td>+/-4%</td>
</tr>
</tbody>
</table>
Statistical Tests for RUG Payment

It is not possible to make a precise dollar projection without using a model based on assumptions. The prospective payment system for nursing homes is in transition until 2002. Currently, nursing homes are reimbursed using a mixed rate composed of part federal rates and part rates based on individual nursing homes’ previous cost base. In addition, at the time we pulled our sample, December 1998, not all nursing homes had converted to PPS, and billing information was not widely available.

In order to determine the potential difference in reimbursement, we constructed a payment model based on assumptions. We used urban, northeast case-mix adjusted federal rates for residents in all nursing homes and assumed that PPS was fully implemented for all of our nursing homes. We then projected reimbursement based on the RUG and payment associated with that RUG. See Appendix E for payment rates. At the 95 percent confidence level, the difference is not statistically significant.

<table>
<thead>
<tr>
<th>Dollar Projections of Coding</th>
<th>Dollar Projection</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>$27,388,798</td>
<td>$17,902,544 - $36,875,052</td>
</tr>
<tr>
<td>Our Reviewer</td>
<td>$25,005,872</td>
<td>$18,142,667 - $31,869,077</td>
</tr>
</tbody>
</table>
APPENDIX D

Statistical Tests for Key Findings

We computed Chi-square values for differences in urban and rural nursing homes and the
differences in RUG determinations different from our reviewers. We also looked at the
differences between chain and non-chain nursing homes and the differences in RUG
determinations. As shown in the table below, some variables are statistically significant
and some variables are not.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Degrees of Freedom</th>
<th>Chi-Square</th>
<th>Significant Difference in RUG coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban vs. Rural</td>
<td>1</td>
<td>.57</td>
<td>No</td>
</tr>
<tr>
<td>Chain vs. Non-chain</td>
<td>1</td>
<td>8.50</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### RUG Rates: Case-Mix Adjusted Rates for Northeast Urban Nursing Homes

<table>
<thead>
<tr>
<th>RUG Category</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUC</td>
<td>$384.21</td>
</tr>
<tr>
<td>RUB</td>
<td>$345.90</td>
</tr>
<tr>
<td>RUA</td>
<td>$327.28</td>
</tr>
<tr>
<td>RVC</td>
<td>$296.15</td>
</tr>
<tr>
<td>RVB</td>
<td>$286.30</td>
</tr>
<tr>
<td>RHC</td>
<td>$271.53</td>
</tr>
<tr>
<td>RMC</td>
<td>$267.34</td>
</tr>
<tr>
<td>RVA</td>
<td>$261.12</td>
</tr>
<tr>
<td>SE3</td>
<td>$252.91</td>
</tr>
<tr>
<td>RHB</td>
<td>$249.64</td>
</tr>
<tr>
<td>RMB</td>
<td>$238.87</td>
</tr>
<tr>
<td>RHA</td>
<td>$228.84</td>
</tr>
<tr>
<td>RMA</td>
<td>$224.64</td>
</tr>
<tr>
<td>SE2</td>
<td>$218.97</td>
</tr>
<tr>
<td>RLB</td>
<td>$212.95</td>
</tr>
<tr>
<td>SE1</td>
<td>$194.88</td>
</tr>
<tr>
<td>SSC</td>
<td>$190.50</td>
</tr>
<tr>
<td>CC2</td>
<td>$189.41</td>
</tr>
<tr>
<td>SSB</td>
<td>$181.74</td>
</tr>
<tr>
<td>RLA</td>
<td>$179.01</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>SSA</td>
<td>$177.36</td>
</tr>
<tr>
<td>CC1</td>
<td>$175.18</td>
</tr>
<tr>
<td>CB2</td>
<td>$166.42</td>
</tr>
<tr>
<td>CB1</td>
<td>$158.75</td>
</tr>
<tr>
<td>CA2</td>
<td>$157.66</td>
</tr>
<tr>
<td>PE2</td>
<td>$153.28</td>
</tr>
<tr>
<td>PE1</td>
<td>$151.09</td>
</tr>
<tr>
<td>CA1</td>
<td>$148.90</td>
</tr>
<tr>
<td>PD2</td>
<td>$145.62</td>
</tr>
<tr>
<td>PD1</td>
<td>$143.43</td>
</tr>
<tr>
<td>IB2</td>
<td>$142.33</td>
</tr>
<tr>
<td>BB2</td>
<td>$141.24</td>
</tr>
<tr>
<td>IB1</td>
<td>$140.14</td>
</tr>
<tr>
<td>BB1</td>
<td>$137.95</td>
</tr>
<tr>
<td>PC2</td>
<td>$137.95</td>
</tr>
<tr>
<td>PC1</td>
<td>$136.86</td>
</tr>
<tr>
<td>IA2</td>
<td>$129.19</td>
</tr>
<tr>
<td>BA2</td>
<td>$128.10</td>
</tr>
<tr>
<td>IA1</td>
<td>$124.81</td>
</tr>
<tr>
<td>PB2</td>
<td>$122.62</td>
</tr>
<tr>
<td>PB1</td>
<td>$121.53</td>
</tr>
<tr>
<td>PA2</td>
<td>$120.44</td>
</tr>
<tr>
<td>BA1</td>
<td>$119.34</td>
</tr>
<tr>
<td>PA1</td>
<td>$117.15</td>
</tr>
</tbody>
</table>
Minimum Data Set

In this appendix we have included a complete copy of the Minimum Data Set.
MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless otherwise indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME
   - First name
   - Middle name
   - Last name
   - Date of birth

2. ROOM NUMBER
   - Room number

3. ASSESSMENT REFERENCE DATE
   - Day
   - Month
   - Year

4a. DATE OF RENITENCY
   - Day
   - Month
   - Year

5. MARITAL STATUS
   - Married
   - Widowed
   - Divorced
   - Never married

6. MEDICAL RECORD NO.
   - Medical record number

7. CURRENT PAYMENT SOURCES FOR NUL STAY
   - Medicare per diem
   - Medicaid per diem
   - Medicare/LC per diem
   - Medicaid/LC per diem
   - Supplementary per diem
   - Other per diem

8. REASONS FOR ASSESSMENT
   - Admission assessment
   - Annual assessment
   - Significant change in status assessment
   - Significant correlation of prior full assessment
   - Reassessment
   - Reassessment due to change in health status
   - Reassessment due to change in status

9. RESPONSIBILITY LEGAL GUARDIAN
   - Check all that apply
   - Durable power of attorney/financial
   - Legal guardian
   - Other legal guardian
   - Patient's representative
   - Patient's proxy

10. ADVANCED DIRECTIVES
    - Living will
    - Do not resuscitate
    - Do not hospitalize
    - Organ donation
    - Authority: none

SECTION B. COGNITIVE PATTERNS

1. COMATOSE
   - Yes
   - No

2. MEMORY
   - Short term memory OK
   - Long term memory OK
   - Memory problem

3. MEMORY RECALL ABILITY
   - Cannot recall
   - Cannot recall, but can repeat
   - Can recall

4. COGNITIVE SKILLS FOR DECISION-MAKING
   - Grossly impaired
   - Moderately impaired
   - Slightly impaired
   - Untimely impaired

5. INDICATORS OF DELIRIUM
   - Confusion
   - Disorientation
   - Hallucinations
   - Haphazard thinking

6. CHANGE IN COGNITIVE STATUS
   - Improved
   - Unchanged
   - Declined

SECTION C. COMMUNICATION/Hearing patterns

1. HEARING
   - Normal
   - Partial hearing
   - Deaf

2. COMMUNICATION DEVICES AND TECHNIQUES
   - Check all that apply
   - Hearing aid
   - Cochlear implant
   - Other

3. MODES OF EXPRESSION
   - Speech
   - Nonverbal
   - Sign language
   - Other

4. MAKING SELF UNDERSTOOD
   - Expresses needs directly
   - Expresses needs with gestures
   - Requires written communication
   - Requires sign language

5. SPEECH CLARITY
   - Normal
   - Mildly impaired
   - Severely impaired

6. ABILITY TO UNDERSTAND OTHERS
   - Understands
   - Learns
   - Learns with assistance

7. CHARGE IN COMMUNICATION/Hearing
   - Improvement
   - Decline
   - Unchanged
Nursing Home Resident Assessment: RUGs

SECTION D. VISION PATTERNS

1. VISION
   - Ability to see in an adequate light and without physical obstacles
   - AWARENESS views large print, but not regular print in newspaper comic
   - 2. ADJUSTMENT views large print, but not regular print in newspaper comic
   - 3. COOUR VISION – patient views objects
   - 4. HABIT VISION – patient views only light, colors, or shapes, does not appear to follow objects

2. VISUAL DIFFICULTIES
   - Visual problems – decreased peripheral vision (e.g., leaves, food
   - Food and eating, activities, dressing, grooming, bathing
   - Activities of daily living
   - Sleep patterns
   - Activities of daily living
   - Activities of daily living

3. VITAL AND APPEARANCES
   - No
   - No
   - No
   - No

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, AND UPSET
   - Mood and behavior changes
   - Sleep disturbance
   - Appetite changes
   - Weight loss
   - Physical activity

2. MOOD PERSEVERANCE
   - Mood and behavior changes
   - Sleep disturbance
   - Appetite changes
   - Weight loss
   - Physical activity

3. CHANGE IN MOOD
   - Mood and behavior changes
   - Sleep disturbance
   - Appetite changes
   - Weight loss
   - Physical activity

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INDEPENDENCE
   - Independence
   - Independence
   - Independence
   - Independence
   - Independence

2. UNRESTRICTED RELATIONSHIPS
   - Unhappy with roommate
   - Unhappy with roommate
   - Unhappy with roommate
   - Unhappy with roommate
   - Unhappy with roommate

3. PAST RELATIONSHIPS
   - Past relationship
   - Past relationship
   - Past relationship
   - Past relationship
   - Past relationship

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PEERFORMANCE
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance

2. SELF-PERFORMANCE
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance
   - ADL self-peerformance

3. MOBILITY
   - Mobility
   - Mobility
   - Mobility
   - Mobility
   - Mobility

4. TRANSFER
   - Transfer
   - Transfer
   - Transfer
   - Transfer
   - Transfer

5. TOILET USE
   - Toileting
   - Toileting
   - Toileting
   - Toileting
   - Toileting

6. PERSONAL HYGIENE
   - Personal hygiene
   - Personal hygiene
   - Personal hygiene
   - Personal hygiene
   - Personal hygiene

MOS 19-31/3006

OEI-02-99-00041
Nursing Home Resident Assessment: RUGs

2. BATHING
   - From resident's last body skin/neuromuscle, senses/taste, and
     appetites input to lowest (B/C/D/E/F/G/H/I/K/L/M/N/O/P/Q/R/S/)
     score (see chart below).
     0. Independent — No assistance
     1. Supervised — Does it yourself only
     2. Physical help needed only
     3. Physical help in part of bathing activity
     4. Total supervision
     5. Active client; no need for any assistance

3. APPLIANCES AND PROGRAMS
   - How is the resident's mobility?
     0. None
     1. Bed mobility, not of the bed
     2. Chair mobility, not of the chair
     3. Walker mobility
     4. Wheelchair mobility
     5. Other mobility

4. FUNCTIONAL LIMITATION IN RATING OR MOBILITY
   - (see training manual)
     1. No limitation
     2. Limited to one site
     3. Limited to both sites

5. MODES OF LOCUS AND TRANSFER
   - (see training manual)
     1. Wheeled cart
     2. Transfer belt
     3. Lift manually

6. TASK SEGMENTATION
   - Some or all of the above activities were broken into subtasks during last 7 days
     0. No
     1. Yes

7. ADL FUNCTIONAL REHABILITATION POTENTIAL
   - Resistant able to perform self-activity but is very slow
     0. None
     1. Occasional
     2. Daily

8. CHANCE IN ADL FUNCTION
   - Since last assessment was changed
     0. No change
     1. Improved
     2. Deteriorated

SECTION H. CONTINUITY IN LAST 14 DAYS

1. CONTINUITY SELF PERFORMANCE CATEGORY
   - (Code for resident's performance over all 14 days)

2. CONTINUITY: Complete care plan (see chart above)
   - 0. No change
   1. Bed mobility, not of the bed
   2. Chair mobility, not of the chair
   3. Walker mobility
   4. Wheelchair mobility
   5. Other mobility

3. BLADDER FUNCTION
   - (Control of urinary bladder function: 0 = bladder, volume insufficient to
     flow through unaffected; 1 = bladder, continent to 3 ml.
     Treatment programs: 0 = intermittent

4. BOWEL FUNCTION
   - Bowel elimination pattern
     0. Constipated
     1. Daily

SECTION J. HEALTH CONDITIONS

1. PROBLEM CONDITIONS
   - Check all problems present in last 7 days unless the chart frame is
     indicated
     0. None
     1. Nausea, vomiting
     2. Diarrhea
     3. Fever
     4. Hallucinations
     5. Prolonged aspiration
     6. Incontinence
     7. Unmatched dates
     8. Deterioration

2. OTHER CURRENT OR DISEASES
   - Detailed diagnosis and ICD-9 codes
     0. None
     1.

3. OEI-02-99-00041
**Nursing Home Resident Assessment: RUGs**

**SECTION M. SKIN CONDITION**

<table>
<thead>
<tr>
<th>Coded Areas</th>
<th>Possible Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1:</td>
<td>Pressure ulcer—injury caused by pressure resulting in damage of underlying tissue</td>
</tr>
<tr>
<td>Stage 2:</td>
<td>Skin trauma or open lesion caused by improper circulation in the lower extremities</td>
</tr>
</tbody>
</table>

**SECTION L. ORAL/ENTAL STATUS**

<table>
<thead>
<tr>
<th>Oral Status and Care/Prevention</th>
<th>Codes that meet criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Hygiene:</td>
<td>Clean teeth and gums regularly</td>
</tr>
<tr>
<td>Dentures:</td>
<td>Wear dentures as directed</td>
</tr>
<tr>
<td><strong>COMMON ISSUES</strong></td>
<td></td>
</tr>
</tbody>
</table>
Nursing Home Resident Assessment: RUGs

SECTION A. MEDICATIONS
1. NUMBER OF MEDICATIONS
   a. Record the number of different medications used in the last 7 days.
   b. Record the number of different medications used in the last 30 days.
2. NEW MEDICATIONS
   a. Record any new medications that were initiated during the
      last 30 days.
3. INJECTIONS
   a. Record the number of injections or any type received during
      the last 30 days.
   b. Record any new injections that were initiated during the
      last 30 days.
4. DAYS RECEIVED THE FOLLOWING TREATMENT:
   a. Antihypertensives
   b. Antidepressants
   c. Antiepileptics
   d. Antianxiety
   e. Other psychiatric

SECTION B. SPECIAL TREATMENTS AND PROCEDURES
1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS
   a. Ventilator or nebulizer
   b. Oxygen therapy
   c. Nasal cannula
   d. Chemotherapy
   e. Physical therapy
   f. Occupational therapy
   g. Speech-language pathology and audiology services
   h. Respiratory therapy
   i. Psychological therapy (by a licensed mental health professional)

2. INTERVENTIONS FOR WOUND CARE, BEHAVIORAL, COGNITIVE, AND DEMENTIA ISSUES
   a. Check all interventions or strategies used in the last 7 days—no
      matter whose received
   b. Record the number of days in the last 7 days in which
      behavioral symptom evaluation was performed
   c. Record the number of days in the last 7 days in which
      psychological evaluation was performed
   d. Depression
   e. Anxiety

3. NURSING INTERVENTIONS, TREATMENT, AND CARE
   a. Range of motion (passive)
   b. Range of motion (active)
   c. Skin care
   d. Stoma care
   e. Ambulation assistance
   f. Communication

SECTION C. DISCHARGE POTENTIAL AND OVERALL STATUS
1. DISCHARGE POTENTIAL
   a. Resident was discharged to another facility
   b. Resident was discharged to home
   c. Resident died
   d. Resident declined discharge

2. OVERALL CHANGE IN RESIDENT STATUS
   a. Improvement/reduction
   b. Stable
   c. Decline

SECTION D. ASSESSMENT INFORMATION
1. PARTICIPATION AND ASSESSMENT
   a. Resident
   b. Family
   c. Significant other

2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT
   a. Nursing Home Administrator
   b. M.D.
   c. Other

MOS2 © 2004 OEO-02-99-00041
## Section I: Therapy Supplement for Medicare PPS

### 1. Special Treatments and Procedures

a. **Recreation Therapy** — Enter number of days and total minutes of recreation therapy administered for at least 15 minutes a day in the last 7 days (Enter 0 if none)

<table>
<thead>
<tr>
<th>(A) # of days administered to 15 minutes or more</th>
<th>(B) Total # of minutes provided in last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Skip unless a Medicare 5 day or Medicare readmission occurs assessment.

b. **Ordered Therapies** — Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?

- **No**
- **Yes**

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.

### 2. Walking When Most Self-Sufficient

Complete item 2 if ADL self-performance score for TRANSFER is 6, 7, or 8 AND at least one of the following is present:

- Resident received physical therapy involving gait training (P1.b,c)
- Physical therapy was ordered for the resident nursing gait training (P1.b)
- Resident received nursing rehabilitation for walking (P3.f)
- Physical therapy involving walking has been discontinued within the past 100 days

Skip to item 3 if resident did not walk in last 7 days

**Note:** For following five items, base coding on the episode when the resident walked the fastest without sitting down (include walking during rehabilitation sessions)

- **Furthest distance walked without sitting down during the episode**
  - 0: 100-499 feet
  - 1: 500-949 feet
  - 2: 950-1999 feet
  - 3: 2000-2999 feet
  - 4: 3000 feet and above

- **Time walked without sitting down during the episode**
  - 0: 1-2 minutes
  - 1: 3-4 minutes
  - 2: 5-10 minutes
  - 3: 10-30 minutes
  - 4: 31+ minutes

- **Self-Performance in walking during this episode**
  - 0: INDEPENDENT—No help or oversight
  - 1: LIMITED ASSISTANCE—Overnight, encouragement or cueing provided
  - 2: LIMITED ASSISTANCE—Resident highly involved in walking, received physical therapy guidance, or other non-weight bearing assistance
  - 3: LIMITED ASSISTANCE—Resident received weight bearing assistance while walking

- **Walking support provided associated with this episode (pick one regardless of resident’s self-performance classification)**
  - 0: No walking physical therapist
  - 1: Setup, two staff
  - 2: One person physical therapist
  - 3: Two persons physical assistant

- **Parallel bars used by resident in association with this episode**

<table>
<thead>
<tr>
<th>(A) No.</th>
<th>(B) Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Case Mix Group

<table>
<thead>
<tr>
<th>Medicare</th>
<th>State</th>
</tr>
</thead>
</table>
Comments on the Draft Report

In this appendix, we present in full the comments from the Health Care Financing Administration.
Thank you for the opportunity to review and comment on the above-referenced draft reports. Nursing home residents deserve and expect access to safe, quality care. In 1998, the Health Care Financing Administration (HCFA) began an aggressive initiative to promote quality care and to strengthen the enforcement process for the 1.6 million beneficiaries who reside in nursing homes. HCFA now requires States to crack down on nursing homes that repeatedly violate health and safety standards and has strengthened the inspection process to increase its focus on preventing bedsores, malnutrition, and resident abuse. In addition, HCFA has created Nursing Home Compare, a searchable database available at www.medicare.gov, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents. HCFA is taking these actions to make sure that residents get the quality care and safe environment that they deserve.

We have carefully reviewed your two reports on minimum data set (MDS) accuracy, and we agree that both highlight the need for HCFA to integrate the findings into our ongoing training and accuracy improvement efforts. HCFA has always been attentive to matters concerning the accuracy of MDS information, given its uses for the development of care plans, for quality monitoring, payment, consumer and provider feedback, policy development and research. We have dedicated significant resources and have sponsored a variety of projects aimed at monitoring and ensuring the accuracy of MDS information.

We are concerned, however, about the conclusions that might be drawn based on the OIG’s comparisons of RUG-III classification of cases between their reviewers and the skilled nursing facility (SNF) staff. We believe that too limited data were analyzed (very
few facilities were paid under the prospective payment system (PPS) at the time of the study and there were limitations associated with the methodology (recognized in both reports). As noted in our manuals and repeated in our training programs, the MDS is an integral part of the medical record; it is not an abstraction form. The OIG's methodology relies in part on an erroneous interpretation of certain language from HCFA's medical review Program Memoranda (cited on page 10 of the RUG report). While this language was intended to make clear that the MDS is an integral part of the medical record, there is no expectation that all information found in the MDS will be duplicated elsewhere in the medical record, as the OIG's report suggests. Rather the MDS, in conjunction with other clinical documentation, provides a full view of the beneficiary's clinical course in a given time period. Vital information must be obtained from a variety of sources. Therefore, an item-by-item validation of the MDS using other entries in the medical record cannot be assumed. The OIG's interpretation of the language in these Program Memoranda points to the need for HCFA to clarify the subject instructions.

HCFA believes that these are important areas for examination and looks forward to working closely with the OIG in designing a methodology for the next phase of its study of the RUG-III system and MDS accuracy. We appreciate the effort that went into these reports. Our detailed comments on the OIG's recommendations follow.

OIG Recommendation
We recommend that HCFA more clearly define MDS elements, especially Section G.

HCFA Response
We concur. Since the MDS was first implemented, we have made efforts on an as needed, ongoing basis to clarify item definitions and coding instructions. We recognize the need to make Section G, in particular, easier to understand and code. In addition, we are evaluating a new coding methodology for capturing activities of daily living (ADL) information, for possible implementation with version 3.0 of the MDS.

OIG Recommendation
We recommend that HCFA work with the nursing home industry to provide enhanced and coordinated training to nursing homes to be sure that similar and accurate information about the MDS and RUG is being disseminated.

HCFA Response
We concur. HCFA has an ongoing responsibility for the development and dissemination of educational programs and materials that will promote a uniform understanding of MDS requirements and improve the accuracy of MDS information. Some of our projects aimed at monitoring and ensuring the accuracy of MDS information have been carried
out since initial implementation of MDS requirements in 1991. Most recently for example, we provided training and clarification on items in the Activities sections of the MDS (Sections F and N) via a national Satellite Broadcast for Nursing Home Activities surveyors and providers on September 29. We also have additional short- and long-range plans for training that include the following:

- HCFA is planning further national SNF PPS training for early 2001 to update the fiscal intermediaries and providers on changes in the payment system and clarify existing policy and processes. The use of the MDS and RUG information by providers and medical reviewers will be a significant topic addressed during this training.

- By spring 2001, we plan to develop and release MDS policy and item coding clarifications for areas of the MDS that are considered most confusing and most in need of clarifications, such as Section G. The MDS items addressed will be prioritized based on feedback from a variety of MDS accuracy studies, including those completed by the OIG and Abt Associates, and feedback solicited from the industry via formal requests for comments and focus group meetings. These clarifications will be posted on HCFA’s MDS web site. Wide dissemination of these clarifications will provide updated MDS coding information to State agencies and others who train providers. We are also pursuing the possibility of disseminating this information directly to facilities via State MDS information “bulletin boards” that are part of a facility computer interface with States in the MDS submission process.

- We will review clarifications of policy and coding instructions and provide accompanying training materials at HCFA’s annual, national resident assessment instrument (RAI) conference in May of 2001. This conference is attended by State and regional office RAI and MDS Automation Coordinators, and representatives of national provider organizations.

- We plan to revise the Long Term Care Resident Assessment Instrument User’s Manual for the MDS version 2.0, to incorporate Questions & Answers and clarification information published since the last publication of the User’s Manual (October 1995). In addition, the revised manual will include new chapters relative to new policies implemented since 1995, including MDS Automation and Electronic Transmission, SNF PPS and MDS Correction Policy. We will develop and disseminate a draft, revised manual for comments and anticipate that a final manual will be published following a comment period, by the end of calendar year 2001.
We plan to develop a standard MDS training program, for use by State agencies, fiscal intermediaries, providers and others in MDS training programs to achieve uniformity and consistency in terms of MDS training across the country. We will begin by developing training programs for those areas of the MDS identified as high priorities for clarification, as mentioned above. We hope to be able to expand this training program to cover the entire RAI instrument and process.

In addition, HCFA maintains ongoing communication with State, regional, technical staff and contractors by hosting standing, monthly phone conferences with combined State and regional MDS and RAI Coordinators, and separately with regional office MDS and RAI Coordinators. We also host standing, bimonthly phone conferences with State MDS technical staff, and separately with HCFA’s MDS system contractors. Further, communication with providers through their trade organizations is an ongoing activity.

OIG Recommendation
We recommend that HCFA require that nursing homes establish an audit trail to validate the 109 MDS elements that drive the RUG code from other parts of the medical record paying particular attention to therapy minutes and the ADL.

HCFA Response
While we do not concur with this specific approach to validation, future HCFA plans for validating and ensuring the accuracy of the MDS data do include proposed funding of a Program Safeguard Contractor (PSC) to undertake the auditing and verification of MDS reports. Given the importance of MDS data accuracy to the assignment of Medicare SNF patients to appropriate RUG categories, we will begin approaching this verification function from both a data validation and a program integrity perspective. In addition, such an arrangement provides HCFA with a valuable external mechanism to evaluate individual State performance regarding the accuracy of data being reported. Accuracy protocols will be provided to the PSC for implementation in 2001.

Attachment