Eating ADL: Accuracy Is Paramount

Caralyn Davis, staff writer

Throughout this series on teaching certified nursing assistants (CNAs) about the four late-loss activities of daily living (ADLs), AANAC’s master teachers have emphasized the important role that accurate ADL coding plays in skilled nursing facility prospective payment system (SNF PPS) reimbursement under the RUG-IV system. Changes in Skilled Nursing Facility billing in Fiscal Year 2011, a recent report from the Office of Inspector General (OIG), drives home the point even further: billing for therapy resource utilization groups (RUGs) with high ADL scores dropped to 30 percent in the first half of FY 2011 from 35 percent in the last half of FY 2010.

Quality Improvement Integrated into Health Information Technology: Why Nurses Should Care?

Sandra Hudak, RN, and Siobhan Sharkey, MBA

As a nurse leader, are you concerned that health information technology (HIT) is more of a hopeful promise than a practical reality for front-line caregivers?

Where and how can timely and meaningful information effectively support clinical decisions and care management to achieve better clinical outcomes?

At the center of the HIT value proposition is this challenge: Where and how can timely and meaningful information effectively support clinical decisions and care management to achieve better clinical outcomes? Implementing HIT for its own sake is not an appealing prospect. However, leveraging HIT to better manage resident care is a critical need. Are there any concrete examples of HIT used effectively to improve processes of care and resident clinical outcomes?

On-Time Quality Improvement (On-Time) is funded by the Agency for Healthcare Research and Quality, with support

How pleasant is the day when we give up striving to be young—or slender.

— WILLIAM JAMES
CMS Announces Final Rule Changes

The AANAC staff and board of directors recently visited several members of Congress to discuss the SNF PPS proposed rule changes and advocate for a more moderate approach to the proposed cuts. CMS has opted to move forward with most of the original rule changes, in spite of our best efforts. Please read the following for an abridged version of CMS’s press release announcing the final rule:

CMS ANNOUNCES MORE ACCURATE FY 2012 PAYMENTS FOR MEDICARE SKILLED NURSING FACILITIES CASE-MIX INDEXES RECALIBRATED TO BETTER ALIGN PAYMENTS WITH COSTS

Also requires a new assessment to capture changes in therapy services, and allocation of group therapy time to ensure payment accuracy

The Centers for Medicare & Medicaid Services (CMS) announced on Friday, July 29, 2011, a final rule reducing Medicare skilled nursing facility (SNF) Prospective Payment System (PPS) payments in FY 2012 by $3.87 billion, or 11.1 percent lower than payments for FY 2011 to correct for an unintended spike in payment levels and better align Medicare payments with costs.

CMS is now recalibrating the case-mix indexes (CMIs) for FY 2012 to restore overall payments to their intended levels on a prospective basis. The SNF PPS uses a resource classification system known as Resource Utilization Groups Version 4 (RUG-IV), which assigns a patient to a RUG group to determine a daily payment rate. Each RUG group consists of CMIs that reflects a patient’s severity of illness and the services that a patient requires in the skilled nursing facility (SNF). In transitioning from the previous classification system to the new RUG-IV on October 1, 2010, CMS adjusted the CMIs for FY 2011 based on forecasted utilization under this new classification system to establish parity in overall payments.

CMS found that the parity adjustment made in FY 2011, which was intended to ensure that the new RUG-IV system would not change overall spending levels from the prior year, instead resulted in a significant increase in Medicare expenditures during FY 2011. This increase in spending was primarily due to shifts in the utilization of therapy modes under the new classification system differing significantly from the projections on which the original parity adjustment was based.

“Additional data analyzed by CMS since publication of the proposed rule confirmed the extent of the overpayments that have occurred since implementation of the RUG-IV system,” said Jonathan Blum, deputy administrator and director of the Center for Medicare. “We are also making several improvements to our payment system to strengthen its integrity.”

The FY 2012 recalibration of the CMIs will result in a reduction to skilled nursing facility payments of $4.47 billion or 12.6 percent. However, this reduction would be partially offset by the FY 2012 update to Medicare payments to skilled nursing facilities. The update—an increase of 1.7 percent or $600 million for FY 2012—reflects a 2.7 percent increase in the prices of a “market basket” of goods and services reduced by a 1.0 percent multi-factor productivity (MFP) adjustment mandated by the Affordable Care Act. The combined MFP-adjusted market basket increase and the FY 2012 recalibration will yield a net reduction

continued on page 7
“At the same time, beneficiaries’ need for assistance with ADLs did not change, on average. The average ADL score was 13 during the last half of FY 2010 and, applying the FY 2010 rules, remained 13 during the first half of FY 2011,” said the OIG. “In FY 2011, CMS changed how the ADL score was calculated and the range of ADL scores associated with each RUG; these changes likely contributed to SNFs’ decreased use of RUGs with high ADL scores.”

On a practical level, the OIG findings demonstrate that SNFs now have less room for error with their ADLs. Under the MDS 3.0 and the RUG-IV system, obtaining an eating ADL score is more complex—and consequently more dependent on coding accuracy. For example, the eating ADL score now is generated from specific combinations of codes in column 1 (ADL self-performance) and column 2 (ADL support provided) of item G0110H (eating). (See chart, at right.) To learn how to determine the eating ADL score under RUG-IV, see page 6 – 19 of the RAI User’s Manual for the MDS 3.0.

“MDS nurses should incorporate ADL training of the four late-loss ADLs, including eating, into the new-hire orientation program for direct-care workers,” says Amy Franklin, RN, CDON, RAC-MT, senior nurse consultant for Pathway Health Services in Grand Rapids, MI. “Do the initial training right then and there to show aides how to code in MDS language and how to utilize either the electronic or paper tools that the facility has in place.” MDS nurses also should provide educational inservices on the late-loss ADLs a minimum of every three months, she advises.

However, orientation, training and quarterly inservices only provide a strong educational foundation. To ensure that CNAs are documenting the actual eating assistance they provide to residents, MDS nurses have to visit

### Eating ADL score in RUG-IV vs. RUG-III

<table>
<thead>
<tr>
<th>ADL SELF-PERFORMANCE (G0110H)</th>
<th>ADL SUPPORT PROVIDED</th>
<th>ADL SCORE</th>
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<td>4</td>
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**Under RUG-III, to calculate the ADL score for eating (G1h):**

If K5a (parenteral/IV) is checked, the eating ADL score is 3. If K5b (feeding tube) is checked and EITHER (1) K6a is 51% or more calories OR (2) K6a is 26% to 50% calories and K6b is 501cc or more per day fluid enteral intake, then the eating ADL score is 3.

If neither K5a nor K5b (with appropriate intake) are checked, evaluate the chart below for G1hA (eating self-performance).

### G1H ADL SCORE

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<th>ADL SCORE</th>
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<td>3 or 4</td>
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<td>3</td>
<td>2 or 3</td>
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<td>4</td>
<td>2 or 3</td>
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</table>

**Source:** Chapter 6 of the MDS 3.0 RAI User’s Manual and Chapter 6 of the MDS 2.0 RAI User’s Manual.
the dining room at least weekly, says Franklin. “During a meal time, they need to come in and point out by example what limited assist, extensive assist, and the other codes mean. With limited assist, for instance, aides need to understand what guided maneuvering is. But that’s very difficult for a nurse aide to visualize in lecture compared to practical application by the MDS coordinator. Giving aides examples using their own residents will give them a direct connection to the definitions. The way I explain it is: If I describe an apple to you, but all you see is a banana, you are always going to think it is a banana. So it’s important to let people see the apple with their own eyes.”

The HIPAA privacy rule has made many providers wary of running afoul of the law. However, talking about specific residents during inservices and other facility educational activities is not a HIPAA violation, she adds. “These are your residents, so you aren’t violating HIPAA when you give an example that shows Frank is dependent when you are training your staff.” (To learn more about what is allowed under HIPAA, visit here.)

The most common mistake that CNAs make is failing to understand the importance of each episode of eating assistance for coding column 1 (ADL self-performance), says Franklin. “They often think about the assistance they provide in the context of the whole meal, so they don’t think it’s important if they only helped the resident once or twice during the meal. For example, if an aide hands a resident her spoon or gives her a bite to get her started on her meal but doesn’t provide any other assistance throughout the course of the meal, the aide won’t document that single episode of care. A lot of aides don’t realize that we want to know about that one time they helped the resident. They don’t understand that those single episodes can add up over the look-back period to change how the resident is coded in G0110H.”

continued on page 10
On-Time is one example of a practical approach to embedding HIT into front-line practices to improve clinical outcomes in long-term care facilities. The On-Time program blends QI and IT by redesigning processes for earlier identification of high-risk residents (e.g., pressure ulcer, falls, transfer to hospital) and integrating user-friendly clinical decision support (CDS) tools into those processes (Sharkey, Hudak, Horn, & Spector, 2011; Sharkey, Hudak, & Horn, 2011; Horn et al., 2010).

Why take notice? On-Time QI has close to 10 years of implementation experience to share. Over 80 nursing homes have implemented On-Time for Pressure Ulcer (PrU) Prevention since 2003. To date, specific results based on facilities that have fully implemented On-Time process improvements are promising:

- Reduced in-house incidence of PrUs: 42 – 55%
- Reduced CMS quality measure—high-risk residents with PrUs: 30 – 33%
- Reduced CMS quality measure—unintentional weight loss: 12 – 18%

What are the nuts and bolts of On-Time Pressure Ulcer Prevention? For an initial introduction, consider two examples of what the On-Time Pressure Ulcer Prevention module looks like in actual clinical practice:

continued on page 6
Example #1: Identify residents earlier who are at risk for decreased meal intake and weight loss. Nutritional status is critical for PrU prevention, and CNA documentation of meal intake and weight information is important to the entire team to understand resident risk. The On-Time Nutrition Report is used to identify and monitor residents with decreased meal intake and/or weight loss, both of which are indicators for high risk of PrU development. The report, like all On-Time CDS reports, was designed by nursing home front-line teams to provide trended information and calculations that are not easy to do manually. For example, weekly meal intake for the past four weeks is trended for each resident.

Having timely information is necessary but not sufficient for achieving improvement. Process improvements were designed to help the clinical team use each On-Time report as part of its daily work in existing or new processes. For example, the On-Time Nutrition Report is used in a five-minute stand-up meeting held weekly with Dietary, Nursing, and CNAs. This “huddle” is an example of how a team integrates the use of the Nutrition Report into practice, improves communication across disciplines, and includes CNA staff in collaborative data-driven discussions with Nursing and Dietary.

Example #2: Identify residents at highest risk for pressure ulcer development. It is often difficult to view timely information of multiple risk factors for all residents. The On-Time Trigger Summary Report is used to identify residents at potential risk for PrU development based on several factors in CNA documentation: meal intake, weight, urinary incontinence, bowel incontinence, and Foley catheter use. Process improvements using the Trigger Summary Report include identifying and communicating about high-risk residents on a weekly basis, enhancing rehabilitation team focus on high-risk residents, and monitoring unit-level trends of high-risk triggers.

The entire On-Time QI Pressure Ulcer Prevention Program consists of five CDS tools and associated process improvements that are implemented with front-line teams working with a facilitator. Requirements for the five standard On-Time CDS reports have been incorporated into the software of ten vendors (Electronic Medical Record (EMR) vendors for long-term care), including Resource Systems—Care Tracker, Optimus EMR, LINTECH, Melyx Corporation, Reliable Systems, SigmaCare, American Data, Healthcare Systems Connection, Point-Click-Care, and HealthMEDX. For specific details on the entire On-Time program consider these resources: http://www.ahrq.gov/RESEARCH/ontime.htm and http://www.ahrq.gov/research/ltc/ontimeqimanual/.

Conclusion
We summarize some “words of wisdom” from facilities that have implemented On-Time, to help nursing home leaders devise their own strategies for leveraging HIT in a meaningful way for staff and effective resident care.

- HIT by itself does not lead to QI.
- Incorporation of HIT into the workflow is not a one-time event but rather a commitment to improved process.
- Effective HIT implementation involves an explicit plan for how information will be used by the clinical team. Often
of $3.87 billion, or 11.1 percent. It is designed to ensure that payments more accurately reflect the resources required to provide care for the range of SNF patients, including those requiring more medically complex care.

This recalibration removes an unintended spike in payments that occurred in FY 2011 rather than decreasing an otherwise appropriate payment amount. Even with the recalibration, the FY 2012 payment rates will be 3.4 percent higher than the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels.

Along with recalibrating and updating the SNF PPS payment rates for FY 2012, this final rule makes a number of additional revisions aimed at enhancing SNF PPS accuracy and integrity. The rule modifies the patient assessment windows and grace days to minimize duplication and overlap in observation periods between assessments. The final rule also:

- Clarifies circumstances when SNFs must report breaks of three or more days of therapy.
- Eliminates the distinction between facilities regularly furnishing therapy services on a 5- or 7-day basis for purposes of setting the date for the End of Therapy (EOT) Other Medicare Required Assessment (OMRA).
- Streamlines procedures for documenting situations involving a brief interruption in therapy, where therapy resumes without any change in the patient’s RUG-IV classification level.
- Introduces a new Change of Therapy (COT) OMRA to capture those changes in a patient’s therapy status that would be sufficient to affect the patient’s RUG-IV classification and payment, even though they may not increase to the level of a significant change in clinical status.
- Provides for the allocation of a therapist’s time for group therapy (defined in the rule as a single therapist leading four patients in a common activity) to ensure that Medicare payments better reflect resource utilization and cost for these services, and specifically that the therapist’s time is being appropriately counted and reimbursed.
- Discusses the impact of certain provisions of the Affordable Care Act, and announces that proposed provisions regarding ownership disclosure requirements set forth in the Affordable Care Act will be finalized at a later date.

More information on this SNF PPS final rule and other health care related news can be found at www.healthcare.gov, a new web portal made available by the U.S. Department of Health and Human Services.

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Dear Betty,

My peers and I are frustrated with some of our newer employees who don’t seem to have the same dedication as those of us who have been around for a while. Is there a key to connecting?

Baby Boomers

Dear Boomers,

For the first time in American history, four different generations are working together. The key to connecting them is in knowing what divides these distinct groups and what is important to each of them. Greg Hammill in his article, “Mixing and Managing Four Generations of Employees,” shares characteristics for the generations you are attempting to mesh into a team:

- **The Silent Generation** includes birth years 1925 – 1945. Most are retired; many live in our settings, but those born on the later end of the spectrum are still part of our workforce. Silent Generation members are disciplined, loyal team players who work best within a system, want approval from their employers, and embody a traditional work ethic. They are the most disciplined generational group and often have a lifetime career with one employer, or at least one field of work.

- **Baby Boomers** are those born from 1946 – 1964. Their characteristics include optimism, competitiveness, and a focus on personal accomplishment. They work hard, are often stressed, like to achieve, seek self-improvement, and complain but accept problems as part of the job. They often are at odds with younger generations who do not share their values. Their primary focus is on work, making them the generation most susceptible to burnout and stress-related illness.

- **Generation X** includes years 1965 – 1980. Gen Xers were raised when divorce turned many of them into “latch-key” children, thus giving them a sense of independence that causes resentment when others look over their shoulder. They question authority, expect immediate results, and are committed to their team and their boss. Their loyalty is less to the company, and more to their peers and supervisor.

- **Generation Y** is the Millennials. These individuals are team-oriented, work well in groups, multitask, are willing to work hard, expect structure in the workplace, respect positions and titles, seek learning and career development, and want a satisfying relationship with their boss. They like being part of the team and prefer to work in groups. They learned to multitask by playing sports, taking music lessons, achieving in school, and engaging in social interests. A desire to connect with their boss may cause conflict with Gen Xers who want hands-off management.

So how can you bring this mixed group of employees together to work toward common goals and a unified vision? First, you as Baby Boomer nurse leaders must understand your own generational characteristics. Next, seek to relate to each group by identifying their traits and strengths. To facilitate understanding, share basics about each group’s characteristics with the entire team, and encourage blending of efforts in caring for residents and solving departmental issues. Guide staff to acknowledge the diverse characteristics and to respect the views of others. Assist team members to recognize that what one generation sees as strength may be seen as weakness by another. As they gain insight about themselves and the other groups, facilitate joint goal setting that is built on individual strengths and designed to reduce conflict. By learning about each generation’s natural characteristics, your team can strive to visualize things from each other’s perspective. This mutual focus will connect them as they care for their residents who are most likely members of varied generations as well.

—Betty

Betty Frandsen, RN, NHA, MHA, C-NE, has worked in long term care for over 30 years, including 14 years as a Director of Nursing, and as an Administrator in both Pennsylvania and New York. She served as Vice President of Education and Regulatory Affairs for AANAC, and is a past president of NADONA/LTC.

If you have a nursing management or leadership question that Betty could help with, send your problem to iserio@aanac.org.
At the 2011 AANAC Fall Forum, we're focused on making sure you're prepared to face the challenges of the coming months. Amidst regulation and rule changes, updates to the RAI manual and a looming budget crunch in the government, you must have a clear vision of the requirements necessary to succeed. To that end, we have hand-selected a group of keynote speakers to help you see your future in LTC clearly.

**Wednesday, Oct. 12:**
Harnessing the Energy of Perpetual Change

Keynote Speaker: Best-selling author Donna Wright is known for her irreverent wit—she's sometimes called “the humorist in healthcare.” Through her background as an oncology nurse and her extensive experience working with healthcare executives, Donna understands how healthcare organizations and the caregivers at every level within them work.

Let her show you how to interact with people going through difficult changes while using humor therapeutically in this hilarious presentation guaranteed to make you a better leader, manager, educator and, most importantly, caregiver.

**Thursday, Oct. 13:**
CMS Updates

Keynote Speakers: CMS’s Director for the Division of Nursing Homes, Dr. Alice Bonner and Thomas Dudley, technical advisor for the Office of Clinical Standards and Policy will join us on Thursday to share the most current news straight from CMS.

They’ll touch on survey and certification, the new quality measurements (including Five-Star) and the MDS instrument along with what changes they might predict for professional involved in long-term care. You can’t get more up-to-the-minute information than this. And you couldn’t hope for a more reliable source.
What You Need to Know

Check out these latest updates from the “Need to Know” section of the AANAC homepage and find the information you need to get the job done right.

SNF PPS Final Rule for FY 2012—Display Copy Released
Draft RUG-IV Grouper for FY 2012 Released—Includes Draft CMIs
CMS Accepts Quality Measures

Reimbursement Tip
If the Medicare stay is less than 8 days you can bill default without an MDS in the system. See page 6 – 46 of RAI Manual.

Judy Wilhide Brandt, RN, RAC-MT, C-NE

Treatment of Members Policy
AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

FAQ referral
Do you have a question you need answered NOW? Members of AANAC can go directly to the experts! Go to the FAQ section of the website. The answer may be right in front of you!

Eating ADL, continued from page 4

Another common mistake involves the definition of supervision (1) in G0110H1. On the undercoding side, many CNAs don’t realize that “conversation with the resident to engage him or her in a meal is supervision,” says Franklin. “Talking to the resident and coaching him or her by providing encouragement or cueing during the meal is supervision.” On the overcoding side, some CNAs mistakenly believe that general supervision of the dining room meets the definition of supervision for MDS coding purposes. “However, sitting in the dining room because someone has to be in the dining room isn’t supervision,” she explains. “Supervision requires direct, one-on-one coaching with the resident.”

Editor’s note: To find out when Franklin is teaching, see the AANAC 2011 Workshop Schedule, page 14.

Quality Improvement, continued from page 6

HIT implementation starts with plans for data entry and the transition from paper to an electronic system but fails to focus on how the data will be turned into information to support improved clinical decision making and resident outcomes. As you plan HIT implementation, focus first on how and what information the clinical team will use.

• Involve front-line staff. Include front-line staff in early HIT implementation activities. This involvement promotes buy-in of project activities and reduced resistance to change in daily practices.

• CNA documentation is valuable to include early in HIT implementation plans. There are several considerations: First, all members of the clinical team use the information from CNA documentation in care planning and monitoring the status of residents. To the extent that CNA daily documentation is automated, it becomes more accessible to the entire team and easily summarized. Second, CNAs spend the most time with residents and their observations and understanding of resident needs are critical to effective care planning and interventions.

References

About the Authors
Sandy Hudak, MS, RN, and Siobhan Sharkey, MBA, are principals at Health Management Strategies, Inc., established in 1996, a health care research and consulting group focused on quality improvement (QI) and health IT implementation (QI-IT), CDS design and translation to health IT for implementing clinical best practices, and clinical workflow re-engineering to embed improvements into daily work. http://www.hmstrat.com
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- Medicare Documentation in a Skilled Nursing Facility
- Medicare in a Skilled Nursing Facility
- The Beneficiary Notice Initiative in a Skilled Nursing Facility

Upcoming courses:

- The Prospective Payment System in a Skilled Nursing Facility*
- Medical Review in a Skilled Nursing Facility*
- Part B Therapy in a Skilled Nursing Facility*

* These courses will be made available as they are completed. We expect all courses to be online by September 1st, 2011.

Medicare University training provides the global understanding necessary for interdisciplinary team members to drive better resident care through accurate Medicare reimbursement.

Register today at AANAClassroom and start making sense of Medicare.
HHS Announces $71.3 million in Nursing Education Grants

The Department of Health and Human Services announced last week that they will be reauthorizing up to $71.3 million in funds to support nursing education. AANAC recently visited several members of Congress and explicitly requested the reauthorization of nursing education grant funding. Please see the following link for more information. http://www.aanac.org/pages/doc_lib/detail.aspx?id=3211
Q + A

A resident was scheduled for Discharge assessment—return anticipated, but then after two days, the resident died in the hospital. Should we complete the Discharge assessment or change it to Death in Facility record? You would need to complete a Discharge assessment, since the resident was either A) admitted to the hospital or B) in a hospital observation stay more than 24 hours before expiring.

Ronald A. Orth, RN, NHA, CPC, RAC-MT
(raorth@clinicalreimbursement.com)

Here’s the scenario:
• Admission was 4/28/11
• Admission/5-day done with ARD 5/4/11
• 14-day was done with ARD 5/11/11
• Last day of skilled therapy was 5/19/11
• End of Therapy OMRA done with ARD 5/22/11
This resident continued on Part A for a G-tube feeding. Should we have done a 30-day assessment after the End of therapy OMRA? Her 30-day would have been due approximately 5/27/11.

Your End of therapy OMRA ARD was in the allowable window for the 30-day ARD. You could have combined the two assessments. It is always important to remember to complete the scheduled assessments (5-day, 14-day, 30-day, 60-day, 90-day). We get caught up in the OMRA sometimes and forget to code the scheduled assessments, which are required. Today is July 11. Since the window for the 30-day assessment has long been closed, it is not possible to go back and set an ARD into that window. You are also past the window for the 60-day in case you missed that one.

Since you did set an ARD in the window for the 30-day, you could correct the reason for assessment to include the 30-day. This would require an inactivation of that OMRA and sending the assessment again as an OMRA/30-day. Do not change the ARD; use the same assessment. If you have not yet set an ARD for the 60-day, then today is the first date that you can choose—the date the omission was identified.

Carol Maher, RN-BC, RAC-CT
(cmahero121@earthlink.net)

Scenario:
• Admitted May 23, received OT 35 minutes, PT 30 minutes that day
• Discharged May 24, would have received therapy this day except for unexpected discharge
• ARD May 24 for combined 5-day/SOT OMRA/Discharge Assessment
• Medicare start date for A2400 May 23;
• end date May 24
• Dashes entered for therapy end dates

Problem: The software is not calculating a RUG in Z0100A—it gives me AAA even though we calculate RMA. The error message is -3804, Inconsistent HIPPS code: If A0310C equals 1 or 3, then the first character of Z0100A calculated by the QIES.

ASAP system must equal R. I don’t know what else to do. You asked me to find out what the RUG would be if it was a 5-day not combined with a SOT OMRA—I got HBr with the ADL score of 3.

If you are an urban facility, the RMA you are expecting from the Short Stay assessment has a casemix index (CMI) of 24; HBr is 27. Your software is correctly calculating that you should be billing the HBr. Here’s how it works:

By following the CMS specifications, the software identifies every one of the 66 RUG categories your resident classifies into based on the ARD you set, and it selects the one with the highest casemix index, which is the one that pays the most. It is this index maximizing function that results in the default HIPPS appearing in the situation you have there—default because the index maximized RUG (HBr) isn’t a rehab RUG (doesn’t start with an R). So you just don’t use the Short Stay assessment.

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(RRS2000@aol.com)

Dial Tone Puzzle Answer: identifying deficient practices
### AANAC 2011 WORKSHOP SCHEDULE

#### TRAINING PARTNER

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<tr>
<th>RAC-CT CERTIFICATION WORKSHOPS</th>
<th>MASTER TEACHER</th>
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<td>Idaho Health Care Association</td>
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<td>Aug 30 – Sept 1</td>
<td>Boise, ID</td>
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<td>Maine Health Care Association</td>
<td>Andrea Otis-Higgins</td>
<td>Aug 31 – Sept 2</td>
<td>Augusta, ME</td>
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<td>Pathway Health Services, Inc.</td>
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<td>Sept 13 – 15</td>
<td>Green Bay, WI</td>
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<td>Jennifer Pettis</td>
<td>Sept 13 – 15</td>
<td>New Orleans, LA</td>
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<td>RRS Healthcare Consulting Services</td>
<td>Rena R. Shephard</td>
<td>Sept 13 – 15</td>
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<td>Judy Wilhide Brandt</td>
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<td>Sept 20 – 22</td>
<td>White Bear Lake, MN</td>
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<td>TAHS (Iowa)</td>
<td>Ronald Orth</td>
<td>Sept 20 – 22</td>
<td>Ft. Worth, TX</td>
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<td>NYAHSA</td>
<td>Sandy Biggi</td>
<td>Sept 21 – 23</td>
<td>Albany, NY</td>
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<td>Sept 27 – 29</td>
<td>Louisville, KY</td>
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<td>Ft. Myers, FL</td>
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<td>Oct 4 – 6</td>
<td>Portland, OR</td>
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<td>Pathway Health Services, Inc.</td>
<td></td>
<td>Oct 4 – 6</td>
<td>Fort Smith, AR</td>
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#### MEDICARE UNIVERSITY

| KGHC—Kansas Health Care Association                                          | Judy Wilhide Brandt     | Oct 25 – 27  | Topeka, KS         |

#### AANAC FALL FORUM

| RAC-CT Certification                                                        | Rena R. Shephard        | Oct 9 – 11   | San Diego, CA      |
| Medicare University                                                         | Jennifer Pettis         | Oct 9 – 11   | San Diego, CA      |
| Conquering Chaos                                                            | Sandy Biggi             | Oct 9 – 11   | San Diego, CA      |

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