TABLE OF CONTENTS

PART		PAGE
	Introduction	2
II	Schedule for Requests for Classification	3-4
III	Key Definitions	5
IV	Instructions for Completing CMR Form	
	A. General Information	6-7
	B. Facility and Resident Identifying Information	8-9
	C. Assessment Information	10-23
V	Resident Classification System - Decision Tree	25
VI	How to Arrive at Case Mix Classification	27-30
VII	Resident Notification	31
VIII	Reconsideration Procedures and Worksheet	33-36

ATTACHMENTS

I CMR Assessment form

III Classification notice

IV Medical Plan of Care

V Commonly used Psychotropic Drugs and Sedatives/Hypnotics

VI Request for Reconsideration of Resident Classification (Transmittal)

I. INTRODUCTION

Minnesota Laws of 1985 established a reimbursement system for residents in nursing homes and boarding care homes certified to participate in the Medicaid Program. This system is commonly referred to as a "Case Mix" system. The case mix system establishes eleven payment classifications based on resident's care needs. Those needs are identified by assessments conducted at various intervals by the facility, the Department of Health's Case Mix Review Program (CMR) or by the county pre-admission screening team.

This instruction manual outlines procedures for completing the assessments. Additional instructions regarding the case mix reimbursement system are found in Minnesota Rules Parts 9549.0050 to 9549.0059 and Parts 4656.0010 to 4656.0090.

All assessments must be based on the Case Mix Review procedures established by the Department of Health and must be recorded on the forms developed by the Case Mix Review Program (<u>See</u> Attachment I for sample form).

All assessment forms must be completed by Registered Nurses. All residents of certified nursing Facilities, both private paying and Medicaid, must be assessed. Assessments must reflect the resident's condition at the time of the assessment. The assessment process includes physical observation of the resident and review of the resident's medical record.

The MDH CMR program assigns the case mix classification for each assessment form completed. Each completed assessment form must be mailed to CMR as a Request for Classification (RFC). The facility must mail the original copy of the assessment form and the required documentation to CMR. A photo copy of the assessment form is retained by the facility. If the pre-admission screening team conducts the assessment, the screening team must mail the original assessment form to the facility. The facility is responsible for completing the identification information, retaining a photo copy and mailing the original to CMR. Facilities must not alter the assessment items completed by the pre-admission screening team.

Requests for Classification (RFC's) are to be mailed to:

Minnesota Department of Health
Case Mix Review
85 East Seventh Place
P.O. Box 64938
St. Paul, MN 55164-0938

Upon receipt of the RFC, the MDH CMR program will review the assessment form and the accompanying documentation, when applied (see page 3). The assessment information will be processed electronically and the classification assigned. CMR will provide the facility with a classification printout and letter for the resident, notifying them of the assigned classification. (See Attachment III for sample notification letter)

II. SCHEDULE FOR REQUESTS FOR CLASSIFICATIONS

TYPE OF RFC	REQUIRED COMPONENTS	TIME FRAME	EFFECTIVE DATE
New Admission (Assessed by Pre-admission Screening)	PAS submits assessment form (#HE01313 Red) to facility. Facility completes items needed for resident identification, records medical diagnoses and attaches Medical Plan of Care or Interagency Transfer Form	Assessment must be done within 10 working days prior to admission or 10 working days after admission. Forms mailed to CMR within 5 working days of completion	Date of admission
New Admission (assessed by facility) not screened/assessed by PAS - or screening was not done within time frame above	Blank assessment form (#HE01313 Red) is requested from County Pre-admission screening team, completed and submitted to CMR with Medical Plan of Care or Interagency Transfer Form	Same as above	Date of admission
Transfer From Another Facility (assessed by facility)	Assessment form (#HE1201 Blue), Medical Plan of Care or Interagency Transfer Form	Same as above	Date of admission
Move Between Licensure Levels Within Facility (assessed by facility)	Assessment form (#HE1201 Blue), Medical Plan of Care or Interagency Transfer Form	Same as above	Date of admission
Return From Hospital (assessed by facility)	Assessment form (#HE1201 Blue), Medical Plan of Care or Interagency Transfer Form	Assessment completed and mailed to CMR within 5 working days	Date of admission
30 Day Post Return From Hospital (assessed by facility <u>unless annual or semi-annual assessment occurs during the specified time period)</u>	Assessment form (#HE1201 Blue), Documentation to reflect the resident's current condition	No earlier than 30 days and no later than 35 days after return from hospital. Mail within 5 working days	First day of the month following the date of assessment
Annual Review (CMR Team). *** See next page**	Assessment form (#HE1201 Blue)	Annually as scheduled by MDH	First day of the month following the date of the team exit
Semi-Annual Assessment (assessed by facility) **** See next page**	Assessment form (#HE1201 Blue), Transmittal Sheet with census on the day assessments were completed. (Include explanation of any discrepancy between the daily census and number of assessments submitted)	No earlier than 162 days and no later than 182 days after the most recent CMR review. Mail within 5 working days of completion of assessments	First day of the month following the date of completion of the facility semi-annual assessments

<u>* and **, page 3:</u>

* **Annual Review by the CMR Team:**

CMR will not establish classifications for residents who experience:

- admission
- transfer
- re-admission from hospital, OR
- discharge

during the time period of the CMR team visit

** **The following items on the CMR Assessment Form do not require completion at the Semi-annual Assessment by the Facility:**

- **The Physician's Statement of General Condition (item 10),**
- **Medication (items 31 to 34)**

The form is to be signed by a Registered Nurse on the day the asessment is completed.

DO NOT
FOLD, STAPLE, HOLE PUNCH OR TAPE ASSESSMENT FORMS.

USE ONLY PAPER CLIPS TO ATTACH ACCOMPANYING DOCUMENTATION

III. KEY DEFINITIONS

The following definitions are from Minnesota Rules, parts 4656.0010 to 4656.0090 and 9549.0050 to 9549.0059.

Medical plan of care. "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnosis, secondary diagnoses, orders for treatments and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures and discharge potential. (See Attachment IV for sample form)

Resident plan of care. "Resident plan of care" for residents of nursing facilities means the comprehensive care plan as set forth in the Code of Federal Regulations, title 42, section 483.20, paragraph (d), as amended through October 1, 1992.

Resident record. "Resident record" means the entire record of a resident compiled by the nursing facility or boarding care home. The resident's record must include the following:

a. The admission record
b. The medical plan of care
c. The resident plan of care
d. Documentation from services providing care to the resident
e. Reports of any diagnostic testing and consultation
f. A copy of any transfer data provided to another health care facility, AND
g. A discharge summary

Guideline for Isolation Precautions in Hospitals. "Guideline for Isolation Precautions in Hospitals" means the guideline written by Julia S. Garner, RN, MS and Bryan P. Simmons, MD, reprinted by the U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, from Infection Control July/August 1983 (Special Supplement); 4 (suppl): pp. 245-325. They are available at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Ave., St. Paul, MN 55155, (Phone 612 296-2775) and through the minitex interlibrary loan system.

IV. INSTRUCTIONS FOR COMPLETING THE CASE MIX REVIEW FORM

A. GENERAL INFORMATION

1. ASSESSMENT FORM

The Case Mix Review Form is to be completed for each (RFC) Request for Classification.

Form #HE-1201 is to be completed for the following RFCs:

a. CMR Annual Review
b. Facility Semi-Annual Review
c. Return from hospital and 30 day post hospitalization review
d. Internal transfer
e. External transfer

PLEASE NOTE:

For assessments a. & b. above, the resident identification will be pre-printed, and forms will be provided as necessary.

For assessments c. - e. above, use the blank forms (blue) #HE-1201 and follow the instructions below.

For New Admissions screened by P.A.S. (or assessed by the facility if not screened by P.A.S.) use CMR Assessment Form #HE-01313 (red). This form must be requested from the county Pre-Admission Screening department each time a resident is admitted or re-admitted from home or from a non Case Mix facility.
This includes residents who are transferred from nursing facilities in other states.
For re-admissions from home the previously assigned CMR case number must be indicated in the comments section of the assessment form.

Subsequently, the CMR case number assigned by the CMR computer will be in effect. This number will be listed on classification notices and resident lists generated by the CMR office.

Special instructions for completion of the I.D. information for form #HE-01313 (red) are provided on the first page of that form.

2. HOW TO COMPLETE THE ASSESSMENT FORM:

a. Use a number 2 lead pencil in all areas EXCEPT RN Signature

b. Fill in bubbles completely

c. In column areas, e.g. LOCATION NUMBER, MARK ONLY ONE BUBBLE IN EACH COLUMN. Write the number in the white area and fill in the bubble below

d. When making corrections, erase completely and re-mark

e. Comments Box: When used for comments/corrections, mark bubble

f. Block marked FOR TRANSFER OR HOSPITAL ONLY: The effective date, which is the date of the present admission, and the birthdate must be marked for all transfers, both internal and external, re-admissions from hospital, and the 30 day post hospitalization assessment

g. Date and sign form. Use BLACK INK for the RN signature. Include work phone # in signature box

h. Diagnoses (back of form): Follow instructions on page 23

i. Retain a photo copy, and submit the original form to CMR with the attachments specified on page 4

DO NOT
FOLD, STAPLE, HOLE PUNCH OR TAPE
ASSESSMENT FORMS.

USE ONLY PAPER CLIPS TO ATTACH
ACCOMPANYING DOCUMENTATION

B. FACILITY AND RESIDENT IDENTIFYING INFORMATION
See Specific Block Areas on the CMR Form (blue #HE-1201)

#1. CMR CASE NUMBER: Use the 6-digit number provided by the department. If a case number is unavailable for a recently admitted resident, please submit the form with this field blank

#2. LOCATION NUMBER: Use the 7-digit number provided by the department

#3. FACILITY NAME: Enter the facility name as listed on current license.
E.g., Nursing Home (NH) or Health Care Center (HCC) may be abbreviated

#4. SEX: Enter F for female, M for male. (Mark bubbles)

#5. RECIPIENT'S NAME: Enter last name, first name, middle initial

#6. PMI NUMBER: Enter the 8 digit PMI Number in the columns (red form)/spaces (blue form) of the PMI number block

#7. BIRTHDATE: Enter two digits for the month, two digits for the day, three digits for the century and year

Example: Code April 14, 1920 as 04 14 920 (seven digits)

#8. LEVEL OF CARE: Enter codes for current living arrangement for all residents as follows:

NF I

NF II

#9. ADMITTED FROM:

0 = No record

1 = Home

2 = Hospital

3 = State MI-MR Facility

4 = Other Long Term Care Facility

#29. CURRENT LEVEL OF CARE: Enter the resident's level of care at the time of assessment (NF1 or NF2). It may be different from the information on the pre-printed form block #8.

#30. SOURCE: Enter reason for assessment.

CMR	=	CMR Annual Review
FACILITY	=	Facility Semi-Annual Assessment
EX TRSF.	=	External transfer from one nursing home to another. Please provide the name and city of previous nursing home in the comments box
INT. TRSF.	=	Internal transfer between licensure levels at the present nursing home (to/from NFI to/from NFII)
HOSP.	=	Return from hospital
30-35 DAY REASSESSM.	=	30-35 day post hospitalization review. (For residents who have returned to the same facility after hospitalization, and are still in the facility after 30 days)

#s **10 - 28 and 31 - 40:** Follow instructions under ASSESSMENT INFORMATION for specific items

C. ASSESSMENT INFORMATION

See specific block areas on the CMR form

10. PHYSICIAN'S STATEMENT OF GENERAL CONDITION

Interpret the physician's current progress note and code as:

0 = No record

1 = Improving

2 = Stable

3 = Unstable

4 = Declining

5 = Terminal

11. SPECIAL TREATMENTS

For coding of Special Treatments, the medical record must establish that:

a) The physician has performed a medical evaluation of the resident's immediate and long-term needs, as related to the special treatments

b) A registered nurse has assessed the health needs of the resident as they relate to the need for special treatments, and has communicated these needs to a physician

c) A registered nurse has implemented the delegated medical functions and the nursing functions, which may be performed in collaboration with other health team members, or may be delegated by the registered nurse to other nursing personnel, AND

d) A registered nurse has periodically reassessed the health needs of the resident as they relate to the need for special treatments, and has regularly communicated these needs to a physician

Code as follows: (Continued next page)

SPECIAL TREATMENTS (Continued)

0 = **No Treatments**

1 = **Tube feedings (Nasogastric or gastrostomy feedings)**

2 = **Oxygen and Respiratory Therapy**

Special measures to improve respiratory function include postural drainage, blow bottles, IPPB, respirators, suctioning and oxygen. Stand by oxygen would not be coded unless actually administered.

3 = **Ostomies and Catheters**

Code if routine care is provided by licensed staff. Include tracheostomy, colostomy, ileostomy, ureterostomy, cystostomy, indwelling catheters, and intermittent catheterization (if done at least daily).

4 = **Wound Care/Decubiti**

Wound Care/Decubiti includes wound and decubitus dressings and care, ostomy dressings and warm moist packs ordered for inflamed areas.

The medical record must establish that:

a) The physician or a registered nurse has documented the presence of a wound

b) A written wound treatment plan has been developed

c) Progress notes indicating the resident's response to treatment have been recorded by licensed nurses, AND

d) The physician has documented periodic reassessment of the status and treatment of the wound and determined the need for continued wound care

(Continued next page)

SPECIAL TREATMENTS (Continued)

5 = Skin Care

Skin care is defined as recognized therapeutic and preventive measures in response to an identified medical condition or an identified high risk factor(s) which is related to a medical condition or a functional disability.

The resident's medical record must establish that:

a) The physician has identified the medical condition or a registered nurse has identified the high risk factor(s) for which skin care is needed

b) A written plan for skin care has been developed

c) Progress notes indicating the resident's response to treatment have been recorded by licensed nurses, AND

d) The physician has documented periodic reassessment of the status of the resident's medical condition

6 = Rehabilitation Procedures-ROM/Exercise, Ambulation, ADL, Transfers

Nursing has the responsibility to plan and implement restorative nursing measures to help the residents reach and/or maintain their best level of functioning. These include nursing orders for passive range of motion, ambulation, transfer and Activities of Daily Living teaching.

These procedures may also be carried out as follow-up to a specific physical therapy program or as the physician orders.

Use code 6 for application of prosthetics, splints or braces.

7 = Toileting (Bladder)

Include documented routine program of taking to toilet or individualized program. Include external catheters.

8 = Toileting (Bowel)

Include documented routine or individualized programs. Plan may include bran, laxatives, or suppositories administered at stated intervals.

9 = Hyperalimentation/Hickman catheter

10 = Intravenous fluids

(Continued next page)

SPECIAL TREATMENTS (Continued)

11 = Intravenous medications

12 = Blood transfusions

13 = Drainage tubes

14 = Symptom Control for the Terminally Ill

Symptom control for the terminally ill means a program designed by a physician, registered nurse and the resident, for ongoing management of pain, nausea or other disabling symptoms.

The medical record must establish that:

a) A physician has diagnosed a terminal illness

b) A written symptom control program has been developed

c) Progress notes indicating the resident's response to treatment have been recorded by licensed nurses, AND

d) The physician has documented periodic reassessment of the status of the resident's medical condition as it relates to the symptom control plan

15 = Isolation Precautions

Isolation precautions means procedures in accordance with the "Guideline for Isolation Precautions in Hospitals", written by Julie S. Garner, RN, MS and Bryan P. Simmons, MD, reprinted by the U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, from Infection Control July/August 1983 (Special Supplement); 4 (suppl): p.p. 245-325.

The medical record must establish that:

a) A physician has diagnosed the disease or infectious agent

b) Progress notes indicating that the isolation precautions are being followed have been recorded by licensed nurses, AND

c) The physician has documented periodic reassessment of the resident's medical condition as it relates to the need for isolation precautions

12. CLINICAL MONITORING

Clinical monitoring includes nursing procedures emanating from the resident's diagnosis and medically unstable condition and high risk condition(s).

The medical record must establish that:

a) The physician has identified the medically unstable condition for which the clinical monitoring is needed

b) A registered nurse has completed an assessment identifying the high risk condition(s)

c) A written plan for clinical monitoring has been developed

d) Systematically recorded measurements (such measurements may be collected by licensed or unlicensed nursing personnel) have been made

e) The clinical monitoring data has been interpreted by a registered nurse and communicated to the physician, AND

f) The physician has documented periodic reassessment of the resident's medical status and documented the need for continued clinical monitoring

Scale:

0 = Less than once a day

1 = One or two shifts a day

2 = Monitoring on every shift

13. SPECIAL PROGRAMS

A special program is a service provided by a qualified professional. There is a written treatment program designed specifically for the individual including goals for achievement and specific time limitations. Progress notes are written by the professional providing the service and coordinated with the medical plan of care. Record appropriate program only if the resident is receiving the service at the time of the review.

0 = No program ordered

1 = Speech therapy

Evaluation and treatment by a speech therapist or speech pathologist of a specific communication disorder.

2 = Physical Therapy

Specialized treatment by a licensed physical therapist to restore function, relieve pain, and prevent disability following disease, injury, or loss of body part. "Maintenance" programs are included.

3 = Occupational Therapy

Specialized restorative treatment by a registered occupational therapist involving use of sensory integration exercises, perceptual-motor techniques, skill practice, and training for independence in activities of daily living and in social skills.

4 = Social Service

Counseling, providing information, making referrals, acting as intermediary, advocate, or coordinator for a client in his relationship with family, community, and fellow residents.

5 = Psychological/Behavioral Services

Program directed by a licensed psychologist or behavior analyst. Program designed to change behavior and/or explore feelings and attitudes.

6 = Psychotherapy

Face-to-face encounter with psychiatrist for evaluation, treatment, or monitoring. Do not code if service is limited to medication review.

7 = Activity Program

This program has a written assessment of individual needs and interests with programming to meet those needs.

INDIVIDUAL DEPENDENCIES

For a coding under Individual Dependencies, the medical record must establish that:

a) The physician has performed a medical evaluation of the resident that includes a review of the resident's physical and cognitive impairments as they relate to the individual's dependency

b) A registered nurse has assessed the functional status of the resident

c) In coordination with the other resident care disciplines providing care, a written plan of care is developed and maintained by the nursing service consonant with the medical plan of care, AND

d) The physician has approved the plan of care and has documented periodic reassessment of the resident's status

14. DRESSING

0 = Dresses without help of any kind

1 = Needs and receives supervision or programming. Record for resident who receives assistance to lay out clothes, fasten clothing, or whose performance is being monitored

2 = Needs and receives help from another person to put on clothing (resident participates)

3 = Is dressed (unable to participate)

4 = Never dressed

15. GROOMING

0 = Grooms self without help of any kind

1 = Needs and receives supervision or programming

2 = Needs and receives daily help from another person

3 = Is groomed (unable to participate)

16. BATHING

0 = Bathes without help of any kind

1 = Needs and receives minimal supervision or programming in bathing

2 = Needs and receives supervision only

3 = Needs and receives help in and out of tub

4 = Needs and receives personal help washing and/or drying body

5 = Is bathed (unable to participate)

17. EATING

0 = Feeds self without help of any kind

1 = Needs and receives minimal supervision (reminders) or programming in eating

2 = Needs and receives personal assistance from direct care staff to cut meat, arrange food, butter bread, etc. at the time the meal is delivered to the resident

3 = Needs and receives partial feeding from another person. Includes observation for choking or inappropriate behavior (taking food from others, throwing food)

4 = Needs and receives total feeding from another person, tube feeding, or intravenous feeding

18. BED MOBILITY

0 = Moves self in bed without help

1 = Needs and receives occasional help from another person to sit up

2 = Always needs and receives help from another person to sit up

3 = Needs and receives turning and positioning

19. TRANSFERRING

0 = Transfers without help of any kind

1 = Needs and receives guidance only. Requires physical presence of another person during transfer

2 = Needs and receives physical aid of one person

3 = Needs and receives aid of two persons or mechanical device (unable to participate)

4 = Remains bedfast

20. WALKING

<u>Guidance to a destination does not constitute a dependency in walking.</u>

0 = Walks without help of any kind

1 = Needs and receives the help of a device (cane, walker, crutch)

2 = Needs and receives the personal help of one person

3 = Needs and receives the personal help of two persons

4 = Unable to walk

21. WHEELING

0 = Does not use wheelchair, or receives no personal help with wheeling

1 = Needs and receives help negotiating doorways, elevators, ramps, locking or unlocking brakes or uses power driven wheelchair

2 = Needs and receives total help with wheeling

22. COMMUNICATION

0 = Communicates needs

1 = Communicates needs with difficulty but can be understood

2 = Communicates needs with sign language, symbol board, written messages, gestures or an interpreter

3 = Communicates inappropriate content, makes garbled sounds, or displays echolalia

4 = Does not communicate needs

23. HEARING

Code the resident's ability to hear, with hearing aid if customarily worn.

0 = No hearing impairment

1 = Hearing difficulty at level of conversation

2 = Hears only very loud sounds

3 = No useful hearing

4 = Not determined

24. VISION

Code the resident's ability to see, with corrective lenses if customarily worn.

0 = Has no impairment of vision

1 = Has difficulty seeing at level of print

2 = Has difficulty seeing obstacles in environment

3 = Has no useful vision

4 = Not determined

25. ORIENTATION

Orientation is defined as the awareness of an individual to his/her present environment in relation to time, place and person.

For the nursing home resident, use this scale:

0 = Oriented

1 = Minor forgetfulness

2 = Partial or intermittent periods of disorientation

3 = Totally disoriented; does not know time, place, identity

4 = Comatose

5 = Not determined

26. BEHAVIOR

The medical record must establish that:

a) The behavior problem(s) have been identified

b) The resident's behavior has been assessed by a registered nurse and these findings communicated to a physician

c) A written plan of intervention has been developed

d) Progress notes indicating the resident's response to treatment have been recorded by licensed nurses, AND

e) The physician has documented periodic reassessment of the resident's behavior

Use the code that best describes the person's present behavior:

0 = Behavior requires no intervention

1 = Needs and receives occasional staff intervention in the form of cues because the resident is anxious, irritable, lethargic or demanding. Resident responds to cues

2 = Needs and receives regular staff intervention in the form of re-direction because the resident has episodes of disorientation, hallucinates, wanders within the facility, is withdrawn or exhibits similar behaviors. Resident is resistive, but responds to re-direction

3 = Needs and receives behavior management and staff intervention because resident exhibits disruptive behavior such as verbally abusing others, wandering into private areas of the facility, removing or destroying property, or acting in a sexually aggressive manner. Resident is resistant to re-direction

4 = Needs and receives behavior management and staff intervention because resident is physically abusive to self and others. Resident physically resists re-direction

27. TOILETING

Code the appropriate number except if resident has a catheter and is continent of bowel, code 0. If resident has an ostomy and is continent of urine, code 0. <u>If a continent resident with a catheter or ostomy needs and receives help to toilet, code 1.</u>

0 = Independent. (Include the resident who manages the problem of dribbling)

1 = Needs and receives help to toilet, no incontinence

2 = Occasional incontinence, not more than once a week. (Include the resident who receives help with dribbling)

3 = Nocturnal incontinence only

4 = Incontinent bladder, more than once a week

5 = Incontinent bowel, more than once a week

6 = Incontinent bowel and bladder

28. SELF-PRESERVATION SKILLS

This item is included to determine whether the individual has the mental judgement and physical ability necessary to cope with a changing environment or a potentially harmful situation. Record the most appropriate number.

0 = Independent

1 = Minimal supervision

2 = Mentally unable

3 = Physically unable

4 = Both mentally and physically unable

<u>Items 29 and 30:</u> See page 9 under facility and resident identifying information.

MEDICATIONS

31. ORAL DOSES/DAY

Code "0" if the person does not receive oral medications

Code the number of doses administered per day

Include food supplements ordered by physician

Include an average number of oral p.r.n. medications given per day within the last week

32. INJECTIONS/WEEK

Code "0" if no injections are given

Code the number of injections administered within the last week

33. OTHER MEDICATIONS/DAY

Code "0" if person does not receive other medications

Code the number of medications administered per day

Include topicals, eye drops, irrigation fluids, medicated enemas or suppositories, etc. ordered by the physician. Include an average number of p.r.n. (other) medications administered per day

34. TOTAL MEDICATIONS/PRESCRIPTIONS/WEEK

Code total number of prescriptions, including oral medications, injections, and other medications given within the last week

35-37. PSYCHOTHERAPEUTIC DRUG USE

Code this section as follows:

0 = Not ordered

1 = Ordered by the physician but has not been administered in the past three months

2 = Drug is administered regularly

38. SEDATIVES/HYPNOTICS

Code 1 or 2 only if used in conjunction with psychotherapeutic drug. Otherwise code 0

(See Attachment V for listing of Commonly Used Psychotropic Drugs and Sedatives/Hypnotics)

39. LEVEL OF CARE
Leave blank

39 - 40: CMR teams see Addendum Pages I-VII

40. COMPONENT OF CARE

-

Leave blank

CURRENT/ACTIVE DIAGNOSES (Back of form)

Code the physician's current active medical diagnoses as recorded in the medical record.

Code up to six diagnoses only.

If a primary diagnosis is not listed, enter it in the top left corner. DO NOT CODE. Mark the bubble in the comments box on the bottom front of the form.

SIGNATURES/DATE

Signature of the registered nurse performing the assessment.

Code date of assessment.

Include WORK PHONE NUMBER in R.N. signature box.

DO NOT
FOLD, STAPLE, HOLE PUNCH OR TAPE
ASSESSMENT FORMS.

USE ONLY PAPER CLIPS TO ATTACH
ACCOMPANYING DOCUMENTATION

Decision Tree

VI. HOW TO ARRIVE AT A CASE MIX CLASSIFICATION

<u>Introduction</u>

The case mix classification is determined by applying criteria to each completed CMR assessment form. The Minnesota Department of Health will assign the final classification by computer to ensure consistency in classification. However, facility staff, Preadmission Screening teams, residents and families may wish to know how to apply the criteria themselves.

The completed assessment form includes many items of information about a resident's care, but only a few of these items are used in determining the case mix payment classification. All items on the form, as well as many other items, were taken into consideration in the case mix research project. However, the specific items used for the classification are those that the case mix research project identified as the best indicators of differences in costliness of care. The remaining items provide supporting documentation for the items used in the classification determination.

<table>
<tr>
<td>Step 1</td>
<td>Review scores on the eight key Activities of Daily Living (ADL's) to determine the total number of key ADL's in which the resident is considered dependent. Key ADL's and dependency scores are as follows:

<table>
<tr><th>CMR Form Item, ADL</th><th>Not Dependent</th><th>Dependent</th></tr>
<tr><td>Dressing</td><td>0-1</td><td>2-4</td></tr>
<tr><td>Grooming</td><td>0-1</td><td>2-3</td></tr>
<tr><td>Bathing</td><td>0-3</td><td>4-5</td></tr>
<tr><td>Eating</td><td>0-1</td><td>2-4</td></tr>
<tr><td>Bed Mobility</td><td>0-1</td><td>2-3</td></tr>
<tr><td>Transferring</td><td>0-1</td><td>2-4</td></tr>
<tr><td>Walking</td><td>0-1</td><td>2-4</td></tr>
<tr><td>Toileting</td><td>0</td><td>1-6</td></tr>
</table>
</td>
<td>Case Mix Classification
________________</td>
</tr>
<tr>
<td>Step 2</td>
<td>Determine the ADL Category as follows:

Low ADL = Dependent in 0-3 key Activities of Daily Living
Medium ADL = Dependent in 4-6 key Activities of Daily Living
High ADL = Dependent in 7-8 key Activities of Daily Living</td>
<td></td>
</tr>
<tr>
<td>Step 3</td>
<td>Refer to the Resident Classification Decision Tree on page 24. Choose the branch of the tree which matches the residents ADL Category above, Low, Medium or High.</td>
<td></td>
</tr>
</table>

Step 4	Begin with the box marked Special Nursing in the appropriate ADL Category (Low, Medium or High), and determine whether or not the following Special Nursing criteria have been marked on the assessment form: 11. Special Treatments 1 = Tube feedings OR One or more of the following special treatments: TO MEET THE SPECIAL NURSING CRITERIA, THESE MUST BE MARKED IN CONJUNCTION WITH ASSESSMENT ITEM 12, CLINICAL MONITORING, WHICH MUST BE SCORED 2. 2 = Oxygen and Respiratory Therapy 3 = Ostomies and Catheters 4 = Wound Care/Decubiti 5 = Skin Care 9 = Hyperalimentation/Hickman Catheter 10 = Intravenous Fluids 11 = Intravenous Medications 12 = Blood Transfusions 13 = Drainage Tubes 14 = Symptom Control for the Terminally Ill 15 = Isolation Precautions Clinical Monitoring 2 = Monitoring on every shift. (Monitoring must need to take place on all shifts including weekends.) If the assessment form fits these criteria, the classification is:	**Case Mix Classification** Low ADL - C Medium ADL- F High ADL - K
Step 5	If the items marked on the assessment form do not meet the Special Nursing Criteria, proceed to the alternative box marked Not Special Nursing. For the High ADL category only, skip steps 6 and 7 and proceed to step 8.	
Step 6	For Low or Medium ADL categories, proceed to the box marked Behavior and review the score on the assessment form for Behavior. If the score is 2 or more on Behavior for Low or Medium ADL categories, the classification is:	Low ADL - B Medium ADL - E

Step 7	For Low or Medium ADL categories, if the items marked on the assessment form do not meet the Behavior criteria, proceed to the alternative box marked Not Behavior, the classification is:	Low ADL - A Medium ADL - D
Step 8	For the High ADL category (dependent in 7-8 ADLs), if the items marked on the assessment form do not meet the Special Nursing criteria specified in step 4, review the score on the assessment form for Eating. If the score is 2 or less, skip steps 9-11 and proceed to step 12. If the score is 3 or more, go on to step 9.	
Step 9	For a score of 3 or more in eating, proceed to the box marked Severe Neuro diagnoses. The list of neuromuscular diagnoses included in this category is taken from the publication "International Classification of Diseases" 9th Revision, Clinical Modification (ICD-9-CM), commonly referred to as the ICD-9 Code Book. This book should be available at any hospital and many nursing homes as well as most libraries. The list of codes is as follows: Diseases of nervous system excluding sense organs (320-359 excluding 331.0) Cerebrovascular Disease (430-438 excluding 437) Fracture of skull (800-804) excluding cases without intracranial injury Intracranial injury, excluding those with skull fracture (850-854) Fracture of vertebral column with spinal cord injury (806) Spinal cord injury without evidence of spinal bone injury (952) Injury to nerve roots and spinal plexus (953) Neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6) If any diagnosis which appears in the Current/Active Diagnosis Section (back of assessment form) is included within the list of codes above, the classification is:	High ADL - J
Step 10	If there is no diagnosis which is included in the above code list, review the score on the assessment form for behavior. If the score is 3-4, the classification is also:	High ADL - J
Step 11	If there is no diagnosis which is included in the above code list, and if the score on the Behavior is not 3-4, proceed to the alternative box marked Not Neuro diagnosis, the classification is:	High ADL - I

Step 12	If the score on the assessment form for Eating is 2 or less, proceed to the box marked Behavior. If the score is 2 or more for Behavior, the classification is:	High ADL - H
Step 13	If the assessment form score does not meet the criteria for Behavior, proceed to the alternative box marked Not Behavior, the classification is:	High ADL - G

VII. RESIDENT NOTIFICATION

The following procedure is from Minnesota Rules, part 4656.0060

Within three working days of receipt of the notice, the facility must provide the resident, the person responsible for the resident's payment, or another person designated by the resident with every classification notice mailed to the facility by the department under parts 46556.0040 4656.0050 and 4656.008. If the resident's classification has changed, the facility must include the current rate for the new classification with the classification letter. When the private paying resident is not responsible for payment, the classification letter must be sent to the person who is responsible for payment or to the person designated by the resident.

VIII. *RECONSIDERATION PROCEDURES*

A resident, a resident's authorized representative, or a nursing home or boarding care home in which the resident resides may request the commissioner to reconsider the resident classification.

The procedures for reconsiderations are contained in Minn. Stat. 144.0722, Subd. 3, 3a and 3b. The following outline is based on those provisions.

PROCESS FOR FILING:

A reconsideration can be requested by the resident, the resident's representative, or the nursing home or boarding care home. (The term 'resident's representative' includes the resident's guardian or conservator, the person authorized to pay the facility expenses of the resident, a representative of the nursing home ombudsman's office, or any other individual designated by the resident).

The request must be submitted in writing to the Department within 30 days of receipt of the classification notice:

- Facilities are required to distribute classification notices within 3 working days after receipt from the department

- The time period for filing a request by or on behalf of the resident starts as of the date the resident or the resident's representative receives the notice

- If a private paying resident is not responsible for payment, the classification notice must be sent to the person responsible for payment or to the person designated by the resident

The request for reconsideration must include:

- The name of the resident
- The name and address of the facility
- The reasons for the reconsideration
- The requested classification change, AND
- Documentation supporting the requested change

Documentation supporting the request is limited to information which established that the resident's needs at the time of the assessment resulting in the disputed classification justify a change in the classification.

(continued next page)

VIII. Reconsideration Procedures (cont.)

ACCESS TO INFORMATION:

Minnesota Statutes specify the resident's or the resident's representative's right to have access to and copies of the material necessary to document a reconsideration request.

- Upon written request, the facility must provide a copy of the assessment form and other documentation provided to the Department
- Access to and copies of other information requested to support a resident's reconsideration request must also be provided
- Copies of requested material must be provided within three working days of receipt of a written request
- The failure to provide the information within the specified time period will subject the facility to the issuance of a correction order and fine for noncompliance

FACILITY INITIATED REQUESTS FOR RECONSIDERATION:

In addition to the above requirements, a reconsideration request from a facility must contain the following information:

- The date the classification notices were received
- The date the notices were distributed
- A copy of a notice sent to the resident or the resident's representative. This notice shall inform the resident that a reconsideration request has been submitted; the reason for the request; the fact that the reimbursement rate for the resident will change if the request is approved; the extent of the change in rate, that copies of the request and supporting documentation are available for review; and that the resident also has the right to request a reconsideration

The failure of the facility to include this information in its reconsideration request will result in the denial of the request and no further requests on that specific classification will be allowed.

See pages 35 and 36: **HOW TO SUBMIT A REQUEST FOR RECONSIDERATION OF A NURSING FACILITY CASE MIX CLASSIFICATION**

HOW TO SUBMIT A REQUEST FOR RECONSIDERATION OF A NURSING FACILITY CASE MIX CLASSIFICATION

SEE	FACILITY MANUAL FOR COMPLETING CASE MIX REQUESTS FOR CLASSIFICATION Section VIII, **RECONSIDERATION PROCEDURES**

A request for reconsideration can be processed promptly and a response sent to the facility in a timely manner when the request is submitted with all the required information.

When to submit? No more than 30 days after receipt of the classification list/letter

What to include?

1. Completed Transmittal Sheet. See attachment VI of the manual.
2. A copy of the assessment form with the items you believe to be incorrect items circled.
3. Documentation from the resident's medical record supporting the requested change(s), e.g.:
   a. Nursing notes describing the resident's care needs and which services were provided on and prior to the date of the assessment.
   b. Physician notes/orders.
   c. A copy of the interdisciplinary care plan.
   d. Any other information which may support the request (e.g. diagnoses, admitting orders, medication/treatment sheets, behavior management plan, clinical monitoring data.
4. For requests initiated by the facility: A copy of the notice informing the resident that the facility has requested a reconsideration.
   (See page 2 for more information and a sample notification letter)

How long does it take? The Department has 15 working days after receiving all the information to notify the facility in writing of the result.

Denial of a request is usually based on one or more of the following reasons:

1. The request was not submitted within 30 days after receipt of the classification letter.
2. The documentation does not support a change in the classification because (a) it was insufficient to establish a dependency or (b) it covered a time period after the assessment date.
3. The requested change in the assessment, if granted, would not result in a change in the classification.
4. No written notice regarding the facility's intent to submit a request was given to the resident or the resident's representative, or a copy of that notice was not submitted with the request.
5. The assessment in question was audited by the Health Department simultaneously with the submission of the request for reconsideration. Since the audit is based on the same information as was submitted with reconsideration there is not need to process both. The determination is based on the audit result.

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REQUEST FOR RECONSIDERATION - RESIDENT NOTIFICATION

A nursing facility is required to give written notice to a resident or resident's representative of the facility's intent to file for a reconsideration of the resident's classification. State of Minnesota Statute (144.0722) requires that this notice contain certain information and that a copy of the notice must be submitted with the reconsideration request to the Health Department. **The request must be denied and no further requests by the facility on that specific classification will be allowed if the facility fails to include a copy with the reconsideration request or if any of the required elements* are omitted from the notice.** Telephone notification to the resident or the resident's representative is not acceptable.

***The notice must inform the resident of the following:**

1.	That a request for reconsideration has been submitted
2.	The reason for the request
3.	That the reimbursement rate for the resident will change if the request is granted
4	The extent of the change in rate
5.	That copies of the request and supporting documentation are available for review by the resident or the resident's representative
6.	That the resident also has the right to submit a request for reconsideration if they do not agree with the determination

SUGGESTED FORMAT FOR A NOTIFICATION LETTER

Name
Address
City, State, Zipcode
Date

This notice is to inform you that ______(Facility name)_____ is requesting a reconsideration of the case mix classification assigned to ______(Resident's name)______ by the Minnesota Department of Health. We feel that the assessment is inaccurate in the following areas:____

____

The present case mix classification assigned is ____, for which the rate is $_______ per day. If the reconsideration request is granted, the case mix classification would change to ____ , and the rate would be $_______ per day.

Copies of the request and supporting documentation are available for your review and may be obtained from the Director of Nursing. You also have the right to request a reconsideration if you do not agree with the determination.

Sincerely,