ADL Coding Accuracy
Clinical and Financial Impact
4.20.18

Sally A. Fecto, RAC-CT
Harmony Healthcare International (HHI)
We **C.A.R.E.** About Care

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About Sally

@SallyFecto

Sally A. Fecto, RAC-CT, is a Senior Vice President of Field Operations for Harmony Healthcare International, a nationally recognized, premier Healthcare Consulting firm specializing in **C.A.R.E.** (**C**ompliance, **A**udit, **A**nalysis, **R**eimbursement and **R**egulatory, **E**ducation and **E**fficiency).

- Over 36 years of experience in Long-Term Care
- Quality Measure, PPS, Case-Mix & MMQ expertise
- Held positions including:
  - Vice President of Operations
  - Multi-Facility Regional Clinical Reimbursement Specialist
  - MDS Coordinator
  - Admissions Coordinator & More!

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Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose
- **Planners:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA
  - Pam Duchene, PhD, APRN-BC
  - Sally Fecto, RAC-CT
- **Presenter:** Sally Fecto, RAC-CT

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Program Objectives

1. Define the late-loss ADLs.
2. Define the levels of assistance (self-performance).
3. Identify the impact of ADL coding and the calculation of the ADL score.
4. Discuss the impact ADL scoring has on payment.
5. Discuss an ADL coding case study.

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CNA Role in Documentation

- Because the CNA is the direct caregiver and the person who spends the most time providing care, they are likely the first to see changes in function
- Accurate documentation is critical to identify changes and generate the appropriate referrals
- Decline in function is not a normal part of aging but rather a product of diseases and conditions

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CNA Role in Documentation

- Decline in function must be identified in order for it to be evaluated, a plan of care developed and treatment provided. Functional loss may become permanent when the resident functions below their capability for a prolonged period of time.

- Documentation may help to qualify the beneficiary for access to benefits and services. A resident inaccurately coded as independent may not qualify for coverage in a long-term care facility or access to coverage under their Medicare or Insurance Plans. The resident may therefore be discharged into a potentially unsafe situation.

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ADL Self-Performance

- Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale

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Document What Occurred

- Document actual resident performance and actual staff support provided
- Electronic Record: Document **each care encounter** at point of care. Your ROI is greater with multiple entries.
- Paper Record: Document the **highest level** over the course of the entire shift if only one entry is recorded.
- Never code based upon what the resident is "expected" or "capable" of doing. The residents' self-performance and support will naturally vary day-to-day and shift-to-shift due to a variety of medical, functional or psychosocial reasons.

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Document What Occurred

- Electronic ADL Documentation
  - How do we communicate to the direct caregivers the "care planned" level of assistance that is required, based on professional evaluations and assessments?
  - Review your system. Educate staff in how to add additional ADL entries once the minimum has been completed- light is off.
  - Is it accurately depicting resident self-performance and staff support?
  - Is the data "auto populating" the MDS?
  - Is the data "refreshed?"
  - Are inconsistencies or errors corrected?

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Document What Occurred

- Paper Documentation System
  - How do we communicate to the direct caregivers the “care planned” level of assistance that is required, based on professional evaluations and assessments? Cueing versus communicating the plan of care (MA).
  - Are there variations in coding over the shifts and/or within the days of the observation period?
  - How are inconsistencies and errors identified and corrected?

Late Loss ADLs

- Late loss ADLs are those considered the "last" to deteriorate. Research indicates that the late loss ADLs predict resource utilization most accurately.
- Assistance received by the resident to perform late loss ADL activities reflect the degree and amount of resources (staff time, number of staff and staff effort) provided by facility staff to provide appropriate care

Section G: Principles of Accurate Assessment

- 7-day look-back period (since admission or readmission only)
- Review Interdisciplinary documentation
- Assess each component of the ADL activity
- Observe the resident
- Consult with the interdisciplinary team across all shifts to capture accurate assist levels
- Ask probing questions, beginning with the general and proceeding to the more specific in breaking down each activity

Section G: Principles of Accurate Assessment

- Do **not** include assistance provided by **family** or other **visitors** when capturing assist level
- Do **not** code ambulance transfer assistance or assistance from hospice
- Code assist provided by **facility staff** only
- Facility staff **does** includes direct employees and facility-contracted employees (contract therapy)
- Facility staff **does not** refer to individuals hired outside the facility's management and administration

Activities of Daily Living (ADLs) Key Points Regarding MDS Coding

- The intent is to document **what the resident actually does**, not what they could, would or should do
- Assistance needed **varies** from day to day, from shift to shift and even during a particular shift
- **The reason that the assistance was required is irrelevant**; it simply matters that it was needed and the root cause can be further assessed

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Late Loss ADLs

- Bed Mobility
- Transfers
- Eating
- Toileting

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MDS Coding

- Interpreting the ADL data

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Self Performance = 0 (Independent)

- No help or staff oversight at any time (and ADL occurred at least three times)

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Self Performance = 1 (Supervision)

- Oversight, encouragement, or cueing was provided three or more times

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Self Performance = 2 (Limited Assistance)

- Resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance three or more times

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Self Performance = 3 (Extensive Assistance)

- Weight-bearing support provided
- Full staff performance of activity during part but not all of the activity
- Three or more instances of weight bearing assistance

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Self Performance = 3 (Extensive Assistance)

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Self Performance = 3 (Extensive Assistance)

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Self Performance = 4 (Total Dependence)

- Full staff performance for the activity with **no participation by resident** for any aspect of the ADL activity. The activity occurred three or more times.
- The resident is **unwilling or unable** to perform any part of the activity

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ADL Self Performance

- Documenting the resident's performance over entire shift, not including set-up
  - **Independent:** No staff assistance or supervision
  - **Supervision:** Encouragement or cueing provided by the staff
  - **Limited Assistance:** The resident received physical help in guided maneuvering of limbs or other non weight-bearing assistance

ADL Self Performance

- **Extensive Assistance:** The resident performed part of the activity and received assistance of the following types
  - Weight-bearing support or
  - Full staff assistance in the task/or portion of the task, during part but not all shift
- **Total Dependence:** Full staff assistance of the entire activity each time it occurs. There was no participation by the resident.

Self Performance

- Activity Did Not Occur
  - The activity did not occur or family and/or non-facility staff provided care
  - Examples
    - The resident is on bed rest and the transfer did not occur
    - The resident received nothing by mouth in preparation for a test. No food or fluids were consumed.
    - The resident is non-ambulatory. Walking in the corridor did not occur.

ADL Flow Sheet vs. MDS Coding

- **ADL documentation** versus **MDS coding:**
  - **CNA ADL documentation:** Record the most dependent level and the most staff received by the resident over the shift. The flow sheet is a record of the care the resident received and not a record of staff activity. The CNA is the "keeper of the record" for their work shift and documents the care received by the resident. There is no **"rule of three"** with shift documentation.
  - **MDS coding** applies the "rule of three". The **"rule of three"** is applied in reviewing all ADL documentation and its translation for MDS coding.

ADL Occurred Two or Fewer Times

- (7) Activity occurred only once or twice – activity did occur but only once or twice in the entire 7-day period
- (8) Activity did not occur – if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Instructions for the Rule of 3

- When an activity occurs three times at any one given level, code that level
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are independent (0), total dependence (4) and activity did not occur (8)
  - Example: Three times extensive (3) and three times limited (2)- code Extensive Assistance(3)

Instructions for the Rule of 3

- When an activity occurs at various levels, but not three times at any given level, apply the following
- When there is a combination of:
  - Full staff performance (4), and Extensive Assistance(3)
    - Code Extensive Assistance(3)
  - When there is a combination of full staff performance (4), weight bearing assistance (3) and/or non-weight bearing assistance (2)
    - Code Limited Assistance(2)

Instructions for the Rule of 3

- If none of the preceding rules are met, code Supervision (1)
- Use the ADL Algorithm Chart (RAI User's Manual page G-6) to guide ADL coding decisions

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ADL Support

- **ADL Support Provided:** Document the **most support provided over the entire shift.** Code the MDS for the most support provided over the **observation period.**
  - No Support
  - Set up help only
  - One person physical assist
  - Two or more provided physical assist
  - Activity itself did not occur during entire shift

Late Loss ADLs Defined

- **Bed Mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture
- **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)

The Late Loss ADLs Defined

- **Eating** - How resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).

- **Toilet use** - How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

Documentation Tips

- The CNA is the keeper of the resident's record for the shift
- Code care also observed/reported as provided by other individuals who are on the staff (or contract staff) of the facility. Communicate and document care provided to unassigned residents.
- If the care is provided by family or other non-facility staff for the entire shift, use the code of "8"

Documentation Tips

- Flow sheet/Electronic Records reflect the care received by the resident
- It is a must that documentation accurately reflects the true amount of staff time resources required for the care of the residents on the unit

Documentation Tips

- Review interactions with residents demonstrating behaviors, agitation or inability to follow commands which require staff to “touch” or “make physical contact” with the resident is a physical assist in the identified task
- Determine if assistance was provided with any ADL tasks such as physical assist or tactile cues with all ADL activities

Documentation Tips

- Example: Lifting the resident's hand and placing it on the walker with the resident to rise for a transfer
- Supporting any portion of resident weight with the use of a gait belt due to slight loss of balance with the transfer
- Both are examples of **Extensive Assistance**

Documentation Tips

- Does the resident require any hands on assistance to start an ADL activity due to impaired concentration or attention for task segmentation or an inability to follow verbal cues?
- **Example:** Lifting the resident's hand with a cup in it to the mouth in order to initiate the task of drinking
- This is an example of **Extensive Assist** even if the resident completes the meal independently after the assist to initiate

Documentation Tips

- Break each ADL activity into sub-tasks when considering final coding for the shift

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Documentation Tips

- An agitated or aggressive resident may require 2 staff members to provide care for the overall safety of resident and staff
- A resident may “sundown” and require more hands on assist later in the evening

Documentation Tips

- Rehabilitation residents may have pain or increased fatigue following therapy programs and thus require more help
- A resident may be quite capable of performing a task but due to depression or anxiety may lack motivation or become fearful of participating

Bed Mobility

- How the resident moves to and from a lying position (including lifting legs), turns side-to-side, and positions body while in bed

Bed Mobility

- Includes anything that happens while the resident is on the mattress or if the resident sleeps in a recliner chair or cardiac chair
- **Ask** How did the activity occur (resident move while in bed) regardless of skill or capability?

Bed Mobility

- **Ask** How much help did the resident receive to position while in bed?
- Keep in mind that if clinically the resident is unable to participate or needs Extensive Assist, two assist is warranted for resident and staff safety

Bed Mobility

- Includes
  - Positioning head on pillow, positioning legs or arms on pillow and positioning and repositioning side to side
  - Lifting hand to place on side rail to assist resident to turn
  - Swinging the legs on or off the bed following an independent transfer

Bed Mobility Includes

- Boosting towards the head of the bed, even if independently turning side to side
- Lifting hand to place on bed rail or grab bar to assist resident to turn
- Moving from supine (flat) to sitting
- Moving from sitting to supine (flat)

Bed Mobility Includes

- Putting your hand out for the resident to use to pull up
- Lifting limbs back into the bed for the restless resident trying to get up unassisted
- Assisting resident by **lifting hand** to reach trapeze to then independently boosts self up in bed

Transfers

- Transfers are defined as how the resident moves from one surface to the other
  - Chair to bed
  - Bed to chair
  - Chair to standing
  - Sit to stand

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Transfers

- Transfers are defined as how the resident moves from one surface to the other
  - Stand to sit
  - Ambulance to bed (only code staff assisted)
  - Ambulance to standing (only code staff assisted)
  - Wheelchair transfers
  - Staff assisted car transfers

Transfers

- **Example:** The resident is ambulatory with only distant supervision. The resident received a gentle boost to rise from a chair without arms in the dining room to stand. The resident can transfer independently when in her room in the appropriate chair with arms.
- **Coding:** The resident is an **Extensive Assist** as the highest level of support over the shift is extensive assist while in the dining room. Do not code due to capacity. Capture assist actually provided.

Transfers

- **Low Beds:** How does the resident get up from the low bed. Keep in mind the resident may be a high fall risk during the night and may transfer independently after up and moving:
  - **Coding: Extensive Assist** x 2
  - Rationale: 2 staff members assist the resident from the low to floor bed to stand on this shift

Transfers

- **Bed Alarms:** Bed alarms may be in use for a resident that should not transfer independently. The staff responds to the alarm to ensure that the resident safely transfers.
- Any “touch assist” = Limited
- Any weight-bearing support = Extensive Assist

Transfers

- **Example:** On the day of admission, the resident arrives via stretcher and two facility staff assists with the transfer of the resident from stretcher to the bed. The two staff members boost the resident to the top of the bed utilizing the lift sheet and assisting in lifting the legs.
- **Coding:** Both transfer and bed mobility for this shift is **Extensive Assist** of 2
- Rationale: Resident received weight-bearing assistance and the most support provided was 2 or more assist

Eating

- Eating refers to how the resident takes in nourishment, foods and fluids
- This also includes tube feedings and IV hydration
- Eating is often under-coded as often it is considered in relationship to meals only

Eating

- Eating/fluid intake also occurs between meals and often at night
- Once physical contact is made, assist has been provided
- Coding is based on actual performance and not skill level

Eating

- **Example:** The resident is independent with breakfast, lunch and dinner and eats in the dining room. At 10 pm, the resident is in bed and calls for assist to hold the cup and bring it to her mouth.

- **Coding:** The resident is an **Extensive Assist**

Eating

- **Example:** The resident is too tired to finish meal. The CNA assist with spoon feeding the last of the meal and drink.
- **Coding: Extensive Assist**. The resident was dependent with a portion of the activity

Eating

- **Example:** This cognitively impaired resident is distracted during meal time. Staff lifts the hand with the fork in the resident's to start the task of feeding. Staff does this twice during the beginning of the meal and the resident is then able to finish the meal with verbal cues.
- Coding: **Extensive Assistance**. The staff member lifted the resident's hand with the fork to her mouth. There is no percent of feeding or weight bearing support factored into the coding of extensive assist.

Eating

- Set up of the tray is not considered an assist
- General supervision in a dining room due to facility policy does **not** mean the resident is a “supervised”

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Toileting

- Toileting refers to the **management of elimination**
- Toileting does not indicate that the resident actually used the toilet or commode

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Toileting

- Toileting includes
  - Incontinence care
  - Foley or external catheter care
  - Ostomy care
  - Toilet hygiene
  - Clothing/pad/brief management
  - Transfers on/off commode or toilet
  - Bedpan or urinal use

Toileting

- **Example:** The resident is a stand lift for transfers from bed to chair and requires two assist to transfer on and off the commode, complete hygiene and manage her clothing

- Coding: **Extensive Assist** of 2 staff members

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Additional ADLs

- The Massachusetts Management Minute Questionnaire (MMQ) is the current Medicaid reimbursement model. Additional ADLs of grooming, hygiene, dressing and mobility factor into reimbursement.
- The financial impact of accurately identifying all levels of assist is critical

Additional ADLs

- **Walk in room** - How resident walks between locations in his/her room
- **Walk in corridor** - How resident walks in corridor on unit
- **Locomotion on unit** - How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

Additional ADLs

- **Locomotion off unit** - How resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.
- **Dressing** - How resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.

Additional ADLs

- **Personal Hygiene** - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)

Additional ADLs

- **Example:** Resident may be Independent with dressing but unable to don shoes and socks. Staff performs this activity. The resident is coded as an **Extensive Assist.**
- **Example:** Resident does personal hygiene Independently. Staff shaves the resident daily. resident is now an **Extensive Assist** for grooming.

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What is a Subtask?

- A component (or part) of the activity
- For example, the subtasks of Toilet Use include:
  - Transferring on/off toilet
  - Cleansing self after elimination
  - Changing pads/briefs
  - Managing ostomy or catheter
  - Adjusting clothes

Examples of Subtasks

- Consider the subtasks of the following ADLs
  - Bed Mobility
  - Personal Hygiene
  - Dressing

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What is Set Up help?

- Providing the resident with **materials or devices necessary to perform the ADL independent**
- This can include giving or holding out an item that the resident takes from the caregiver

Examples of Set Up

- Bed Mobility: Handing the trapeze for resident use
- Transfer: Positioning the walker in front of resident
- Dressing: Putting items of clothing on the bed
- Eating: Specific preparation of food items
- Toilet Use: Providing toilet hygiene items
- Personal Hygiene: Preparing toothbrush with toothpaste and placing on table

ADL Practice – Bed Mobility

- Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every two hours without any physical participation at any time from her at any time. She does verbally direct the staff as to how she wants to be positioned.

ADL Practice - Transfer

- Staff must supervise Mrs. Q as she transfers from her bed to wheelchair daily. Staff bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

ADL Practice - Eating

- Mr. F. begins eating each meal daily by himself. Today, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

ADL Practice – Toilet Use

- Mrs. M. has had recent bouts of dizziness. The resident required one staff member to assist and provide weight-bearing support as she transferred to the bedside commode.

How Is ADL Status Reported and Recorded in Your Facility?

- Discuss **the system** in your facility to report/record **ADL status**
- Does it **work well**?
- Are you capturing **the true picture** of the resident?
- Why or why not?
- How can it be **improved**?

Calculating the Late Loss ADL Score

- The four late loss ADLs are used to calculate the Late Loss ADL score
- This score influences the final RUG-III or RUG-IV classification
- It is important that staff who are participating in the RAI Process know how to calculate a Late Loss ADL score

RUG-IV ADL Score
Step One

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I).

Self-Performance Column 1	Support Column 2	ADL Score
-,0,1,7 or 8	Any number	0
2	Any number	1
3	-,0-2	2
4	-,0-2	3
3 or 4	3	4

RUG-IV ADL Score Step Two

To calculate the ADL score for eating (G0110H), use the following chart

Self-Performance Column 1	Support Column 2	ADL Score
-,0,1,2,7 or 8	-,0, 1,8	0
2, 7	2	2
3	2	3
4	2	4

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RUG-IV ADL Score Step Three

- Add the four Late Loss ADL scores for the total Late Loss ADL score
- The score can range from 0-16
- 0 = very independent resident
- 16 = totally dependent resident

Lets Practice for RUG-IV

- Bed Mobility: Extensive assist of 1
- Transfer: Extensive assist of 1
- Eating: Independent
- Toileting: Limited assist of 1

- Final Late Loss ADL Score: _____

Lets Practice for RUG-IV

- Bed Mobility: Extensive assist of 1
- Transfer: Extensive assist of 1
- Eating: Independent
- Toileting: Limited assist of 1

- Final Late Loss ADL Score: 5

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Lets Practice for RUG-IV

- Bed Mobility: Extensive assist of 2
- Transfer: Extensive assist of 1
- Eating: Independent
- Toileting: Limited assist of 1

- Final Late Loss ADL Score: _____

Lets Practice for RUG-IV

- Bed Mobility: Extensive assist of 2
- Transfer: Extensive assist of 1
- Eating: Independent
- Toileting: Limited assist of 1

- Final Late Loss ADL Score: 7

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Lets Practice for RUG-IV

- Bed Mobility: Total assist of 2
- Transfer: Extensive assist of 2
- Eating: Extensive assist of 1
- Toileting: Total assist of 2

- Final Late Loss ADL Score: _____

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Lets Practice for RUG-IV

- Bed Mobility: Total dependence of 2
- Transfer: Extensive assist of 2
- Eating: Extensive assist of 1
- Toileting: Total dependence of 2

- Final Late Loss ADL Score: 15

Financial Impact of MDS Accuracy

- MDS 3.0 assessment accuracy fosters **resident-centered and individualized clinical care plans**
- Assessment accuracy leads to **accurate reimbursement** for the care provided to the resident
- The following examples are intended to highlight the clinical implications of **accurate** MDS 3.0 assessments

ADL Scoring Part A Impact

- Bed Mobility: 3,3 = 4
- Transfer: 3,2 = 2
- Eating: 1,1 = 0 → 1,2 = 2
- Toileting: 3,3 = 4

Total 10 → 12

RVC vs. RVB = $637.36 - $551.93 = $85.43 x 30 days = $2,562.90 (potential)

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ADL Scoring Part A Impact

– Bed Mobility:	2,2 = 1	3,2 → 2
– Transfer:	2,2 = 1	3,2 → 2
– Eating:	0,0 = 0	0
– Toileting:	3,2 = 2	2
Total	4	6

RUB vs. RUA = $742.95 - $621.22 = $121.73 x 14 days x 20 residents monthly = $34,084.40 or $409,012.80 annually

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ADL Scoring Part A Impact

- Resident performs tracheostomy care and ADLs are coded inaccurately as Independent
- The resident is provided contact guard assist each night while getting in and out of bed and walking to the bathroom with oxygen. The Extensive Services RUG defaults to Clinical Complex due to the ADL Score of 0. Accurate ADL Score is 2.
- **Financial impact:** ES2 vs. CA1 = $700.37 - $296.75 = $403.62 x 30 days = $12,108.60 (potential)

ADL Impact Case Mix

- State Medicaid: Various RUG Models.
- Bed Mobility for Total Dependent Residents requiring two person transfer is coded as assist of one. ADL Score (RUG III-34).
- Moving 14 → 16 ADL score
- SSB vs. SSA = $145 vs. $130 = $15 x 10 residents per day x 31 days = $4,650 x 3 months = **$13,950** (potential)

ADL Impact MMQ

- Inaccurate ADL documentation in bathing dressing grooming and mobility
- Scored as J = $150
- Accurate score is N = $213
- Impacts 15 residents in facility over the next 6 months
- $63 per day x 15 residents = $945
- x 180 days = **$170,100** (gain)

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Key Points for the Nursing Assistant

- When in doubt ask the MDSC or Medicare/Medicaid nurse to assist in breaking down the activity for more accurate coding
- Each situation is unique and all portions of the activity weighed carefully to make the proper coding decision
- Clearly identify the value of your hard work, as a vital member of the interdisciplinary team you have the most accurate information as the direct caregiver

Key Points for the Nursing Assistant

- Your input helps identify issues that result in the best care delivery
- Do not feel compelled to code the rehab resident higher than actual function in order to show progress
- The resident needs to be performing at a consistent level upon therapy discharge and accuracy may identify additional areas of focus to achieve this desired level

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Closing Thoughts

- When in doubt ask the MDSC or Medicare/Medicaid nurse to assist in breaking down the activity for more accurate coding
- Each situation is unique and all portions of the activity weighed carefully to make the proper coding decision
- Clearly identify the value of your hard work, as a vital member of the interdisciplinary team you have the most accurate information as the direct caregiver

Closing Thoughts

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Closing Thoughts

- Documentation to support coding is a must
- Focus on four late loss ADLs
- Accuracy begins at the bedside with the CNA all three shifts (don't forget nights!)
- Ensure reporting and/or documentation all other disciplines regarding ADLs
- Educate frontline nursing staff as well as IDT
- Ensure an audit protocol (MDS and documentation)

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- Harmony Healthcare International (HHI)
- 800.530.4413
- www.Harmony-Healthcare.com
- sfecto@harmony-healthcare.com

@SallyFecto @Harmonyhlthcare

facebook.com/HarmonyHealthcareInternational

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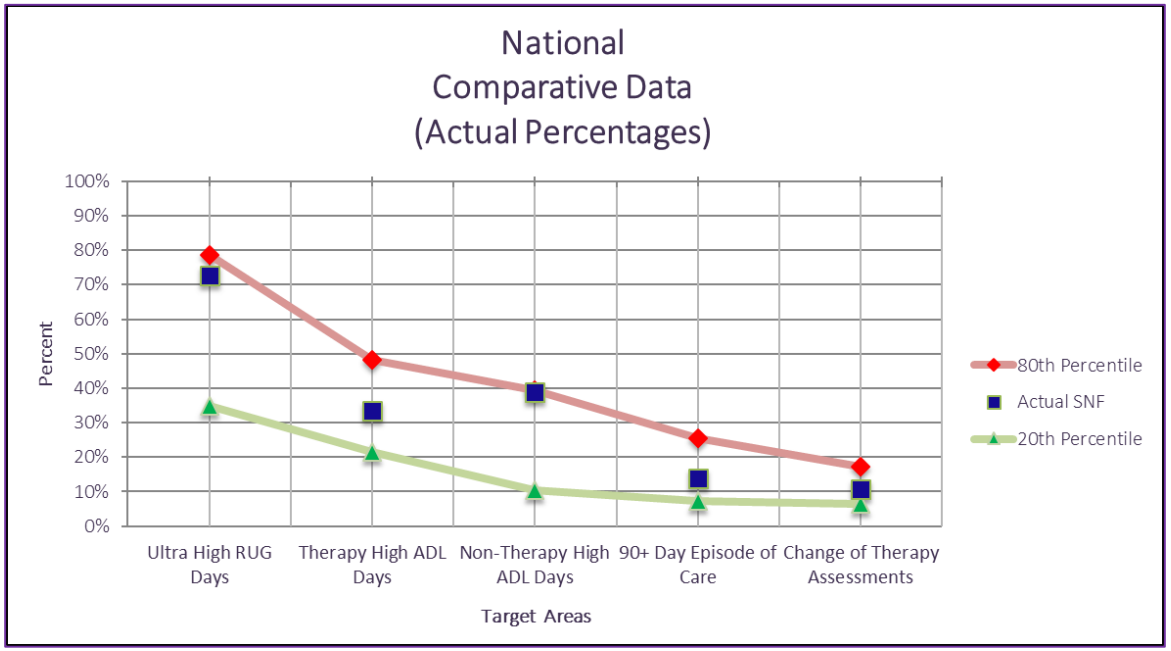
Free PEPPER Analysis



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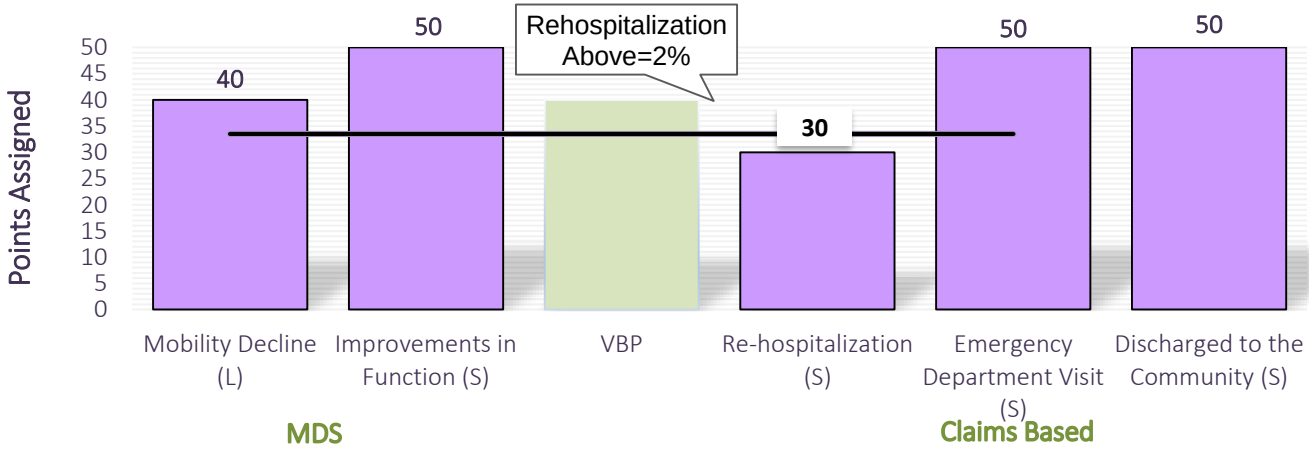
Complimentary

New Five-Star Quality Measure Points Analysis



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Free Medicare Part A Revenue and Risk Analysis

Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73

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