Jeanne Copeland, M.S., CCC-SLP

KSHA, September 26, 2019

How to Survive…***AND THRIVE***!

Strategies for Success in Medical Speech-Language Pathology

Disclosure Statement

- I receive a salary from Genesis Rehab Services in my role as Regional Clinical Director
- I have no non-financial relationships to disclose

My perspective

- 4 years school-based SLP
- 4 years acute & post-acute care (combo)
- 11 years exclusively post-acute care
  - 5 years staff SLP
  - 2 years Assistant Director of Rehab (ADOR)
  - 4 years Regional Clinical Director (RCD)
  - 8 years Master Clinician
- Kansas StAMP Representative (State Advocate for Medicare Policy): 2019 - present
- In process: National Academies of Practice Professional Member

Your perspective

Objectives

- Describe **5 concepts** important for current and future success in medical speech-language pathology
- Understand introductory information about **Medicare and the PDPM** reimbursement model, and discuss considerations for medical Speech-Language Pathologists
- Examine examples of **ICD-10 coding** related to SLP clinical practice and PDPM
- Understand and discuss the relationship between **documentation, denials and patient advocacy**

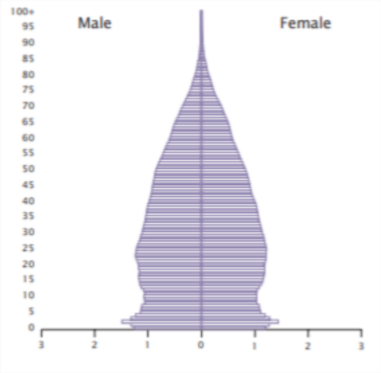
But first, let’s look into our **crystal ball…**

What will the future hold for Speech-Language Pathologists in the medical setting???

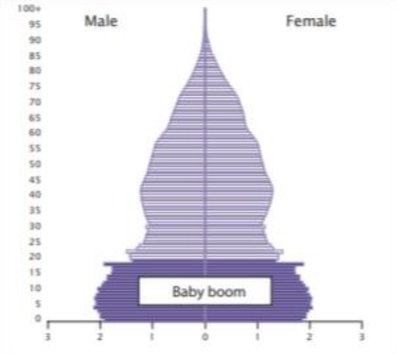
Age and Sex Structure for the Population of the United States

U.S. Census Bureau, 1945 to 2012 Population Estimates and 2012 National Projections

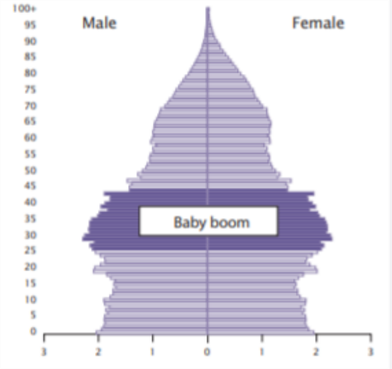
1945



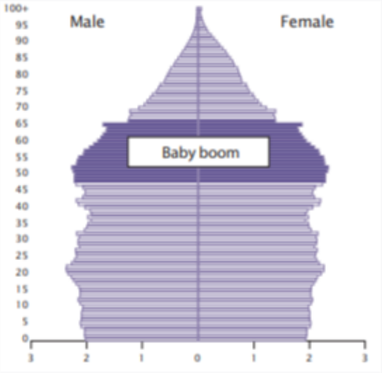
1965



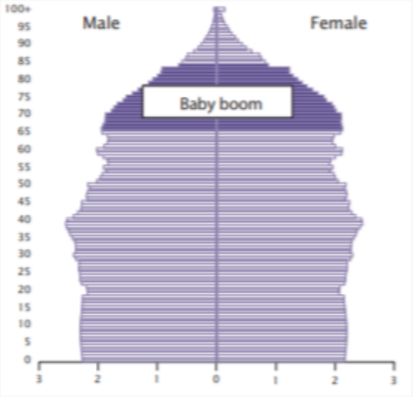
1990



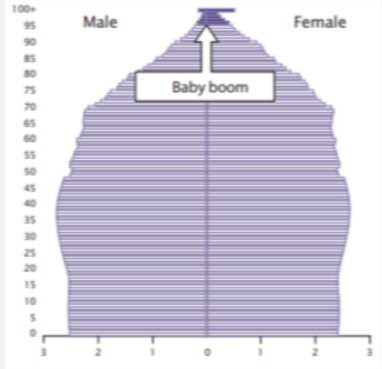
2012



2030

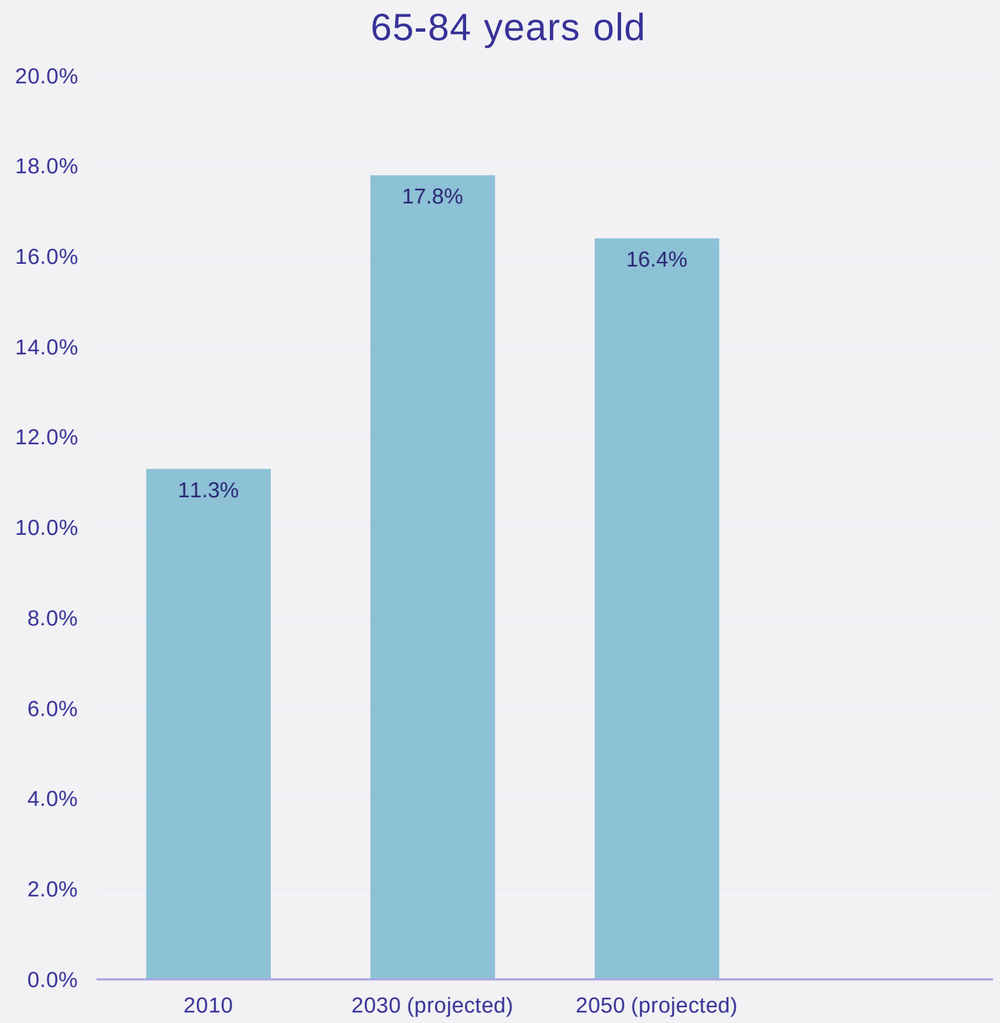


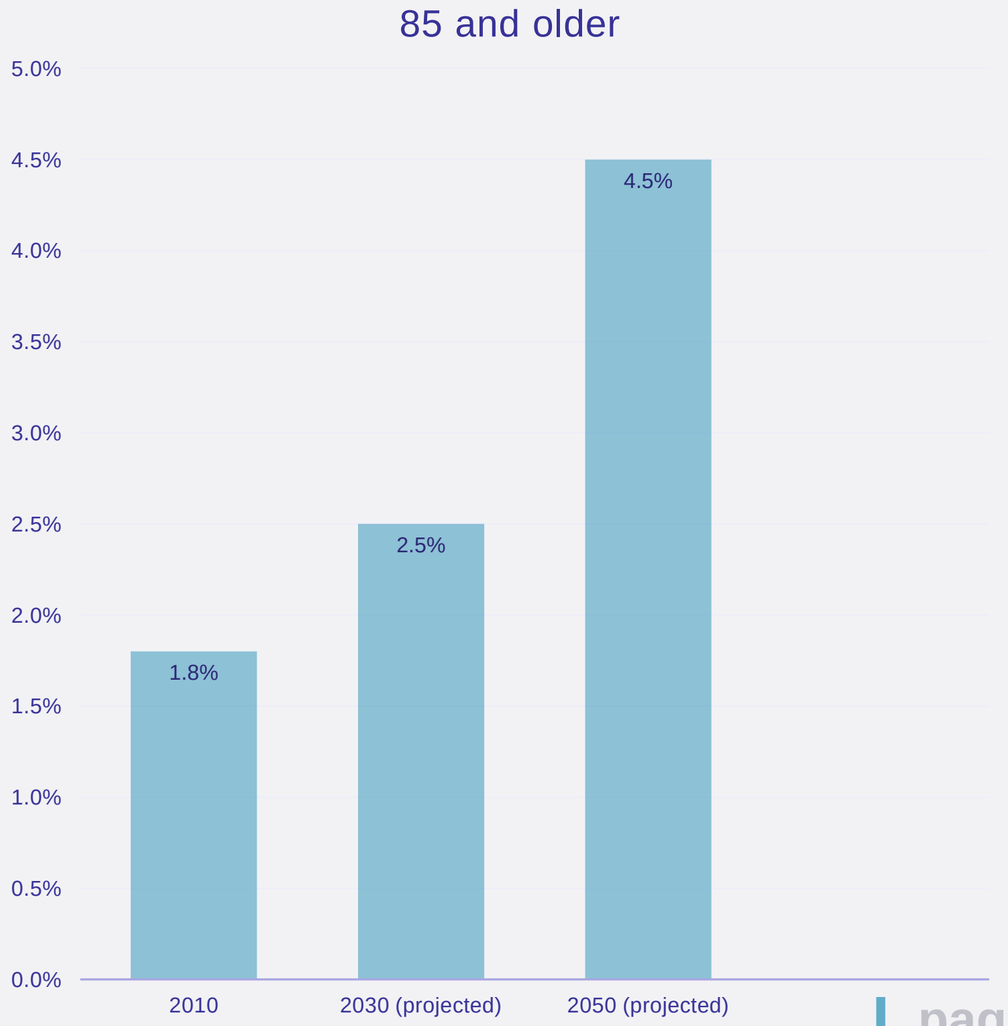
2050



Percent Distribution of the U.S. Population by Age Group: 2010, 2030, and 2050

U.S. Census Bureau, 1945 to 2012 Population Estimates and 2012 National Projections





Alzheimer’s Disease
Facts and Figures

https://www.alz.org/alzheimers-dementia/facts-figures

Alzheimer's Disease
Kansas Facts and Figures

HOSPITALS (2015)

1,308

# of emergency department visits per 1,000 people with dementia

18%

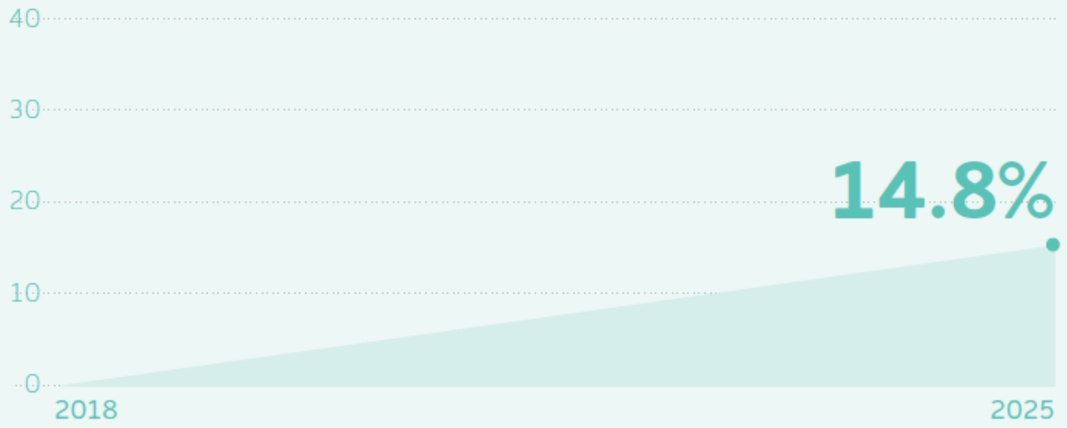
dementia patient hospital readmission rate

65+ NUMBER OF PEOPLE AGED 65 AND OLDER WITH ALZHEIMER'S BY AGE*

* Totals may not add due to rounding

Year	65-74	75-84	85+	TOTAL
2019	7,400	22,000	24,000	54,000
2025	9,000	27,000	26,000	62,000

Estimated percentage change



https://www.alz.org/getmedia/be32492e-edf9-4dd1-9b37-1bb70a8d572a/kansas-alzheimers-facts-figures-2019

Hospital Readmission
Facts and Figures

Percentage of Medicare enrollees aged 65 and older who were readmitted within 30 days of hospital discharge

The Dartmouth Atlas of Health Care, 2015

Hospital Readmission
Potentially Avoidable Reasons & Top Readmission Diagnoses

- Medication Errors
- Functional Status at Discharge
- Falls
- Transition / Discharge Planning
- Poor Health Literacy

- Heart Failure (HF)
- Myocardial Infarction (MI)
- Pneumonia (aspiration and sepsis)
- Chronic Obstructive Pulmonary Disease (COPD)
- Triad of Diagnoses (DM, CHF, COPD)

Why does it matter?

U.S. Census & Baby Boomers

Alzheimer’s Disease Facts and Figures

Hospital Readmission Statistics

Strategies for Success

Important Concepts for Medical SLPs

Medical Necessity & Skilled Need

Skilled Therapy

Value-Based Care

Top of License Practice

Lifelong Learning

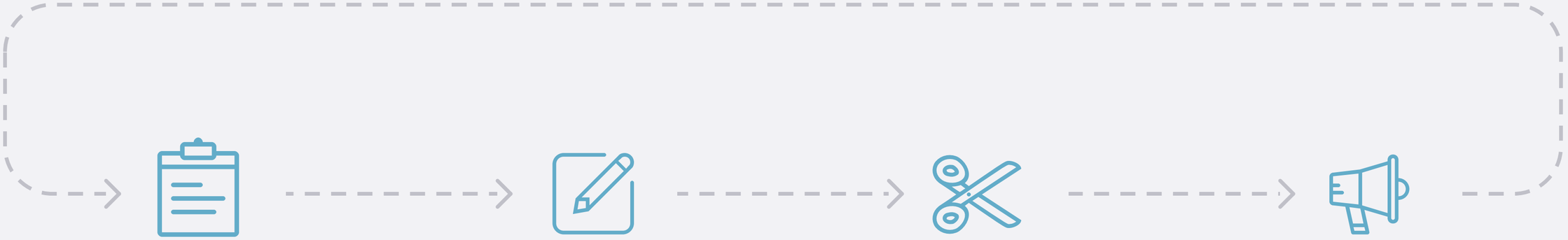
Last,
but DEFINITELY not Least…

Patient Advocacy

Legislative Advocacy

Advocacy for our profession

Patient Advocacy
Opportunities



Screening

- Current system(s)
- Cross-discipline referrals
- Additional reports

Comprehensive Assessment

- Full SLP scope of practice
- Dysphagia → Cog-Comm
- Cog-Comm → S/L
- S/L → Voice

Patient-Centered Care

- Provide a valuable service
- Prioritize
- Health literacy
- Does “one size fit all”?

Interprofessional Education

- Culture—”poor candidates”
- All are referral sources
- Demonstrate your value

Legislative and Professional Advocacy

State-Specific Opportunities

Legislative and Professional Advocacy
National Opportunities

Visit the ASHA Advocacy Page for information and how to get involved!

Recent Examples:

- 8/8/19: New Resource on Habilitation and Rehabilitation Coverage
- 7/31/19: 2020 Medicare Proposed Rules for Outpatient Services Released
- 7/26/19: Proposed Legislation Improves Access to Audiologists for Medicare Patients

Take Action!

Medicare

Four “Fast Facts” about Medicare

01 Medicare is for seniors and disabled

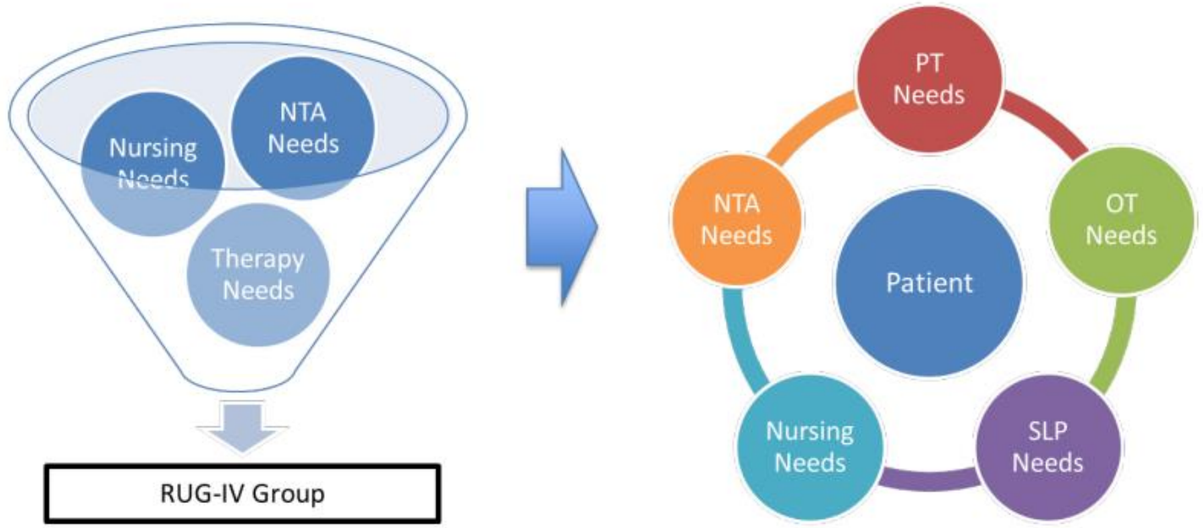
02 >58 million enrollees as of December 2017

03 Medicare is the largest insurer in the U.S.

04 Part A aka “hospital insurance”
Part B aka “medical insurance”

CMS
RUG-IV and PDPM Comparison

- While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:



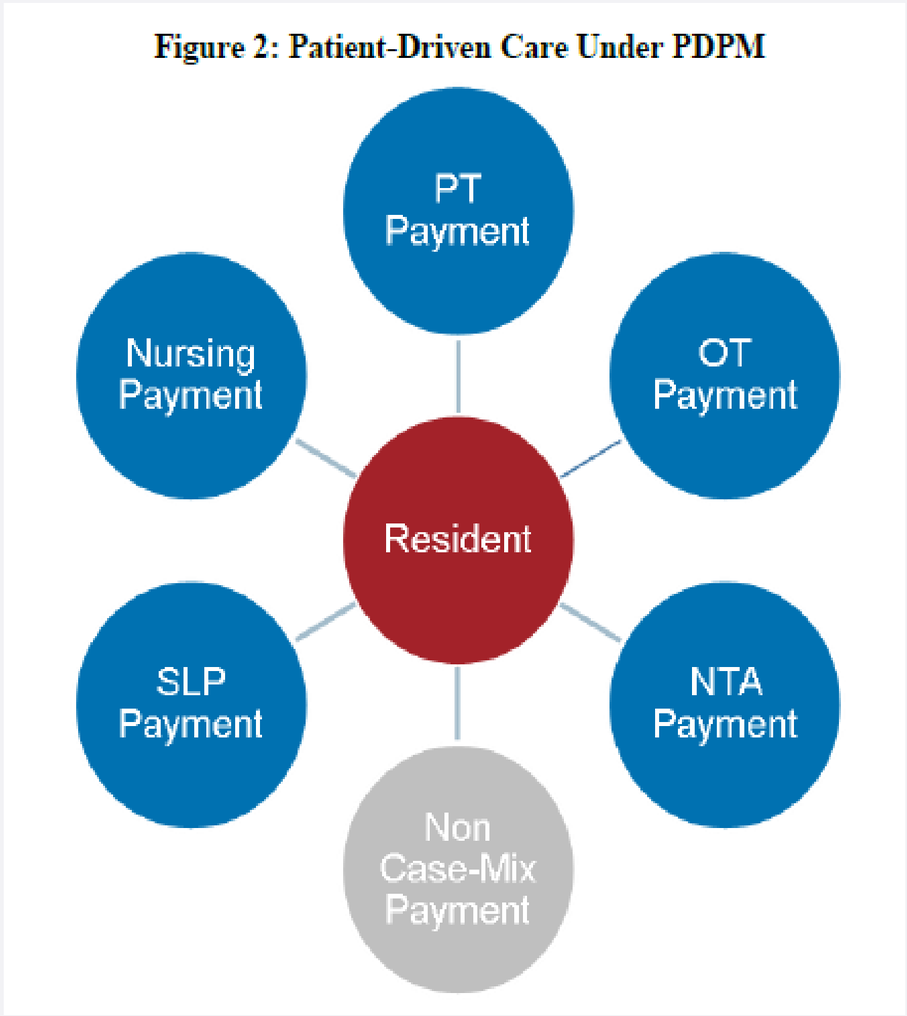
10

Medicare Learning Network

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MLN_CalL_PDPM_Presentation_508.pdf

Patient-Driven Payment Model (PDPM)
Overview

- Effective October 1, 2019
- Applies to patients receiving Medicare Part A benefits
- Does not change the requirements for provision of skilled service
- Access the PDPM Final Rule here (under “Special Filings,” dated July 30, 2019)
- Access the MDS 3.0 RAI Manual here (Version 1.17.1 October 2019)



Requirements for a skilled service under Medicare Part A

- Services are related to reason for hospitalization or for a condition that arose while receiving care in a SNF
- Ordered by a physician
- Skilled services are required daily (and can only be provided on an inpatient basis)
- Services are reasonable and medically necessary

Goals
of PDPM

- Improve Patient Outcomes
- Reduce burden through meaningful measures
- Account for individual severity of the patient’s needs

SLP-specific
Case Mix Index

01

Clinical Category

MDS Section I, ICD-10 Codes
2 options for SLPs:

- Acute Neurologic
- Non-Neurologic

02

Cognitive Status

MDS Section C: BIMS or CPS score

03

Swallowing Disorder

MDS Section K

04

Mechanically-Altered Diet

MDS Section K

05

SLP-Related Comorbidity

MDS Section I, ICD-10 Codes

SLP - Related Comorbidities

Aphasia	Laryngeal Cancer
CVA, TIA or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

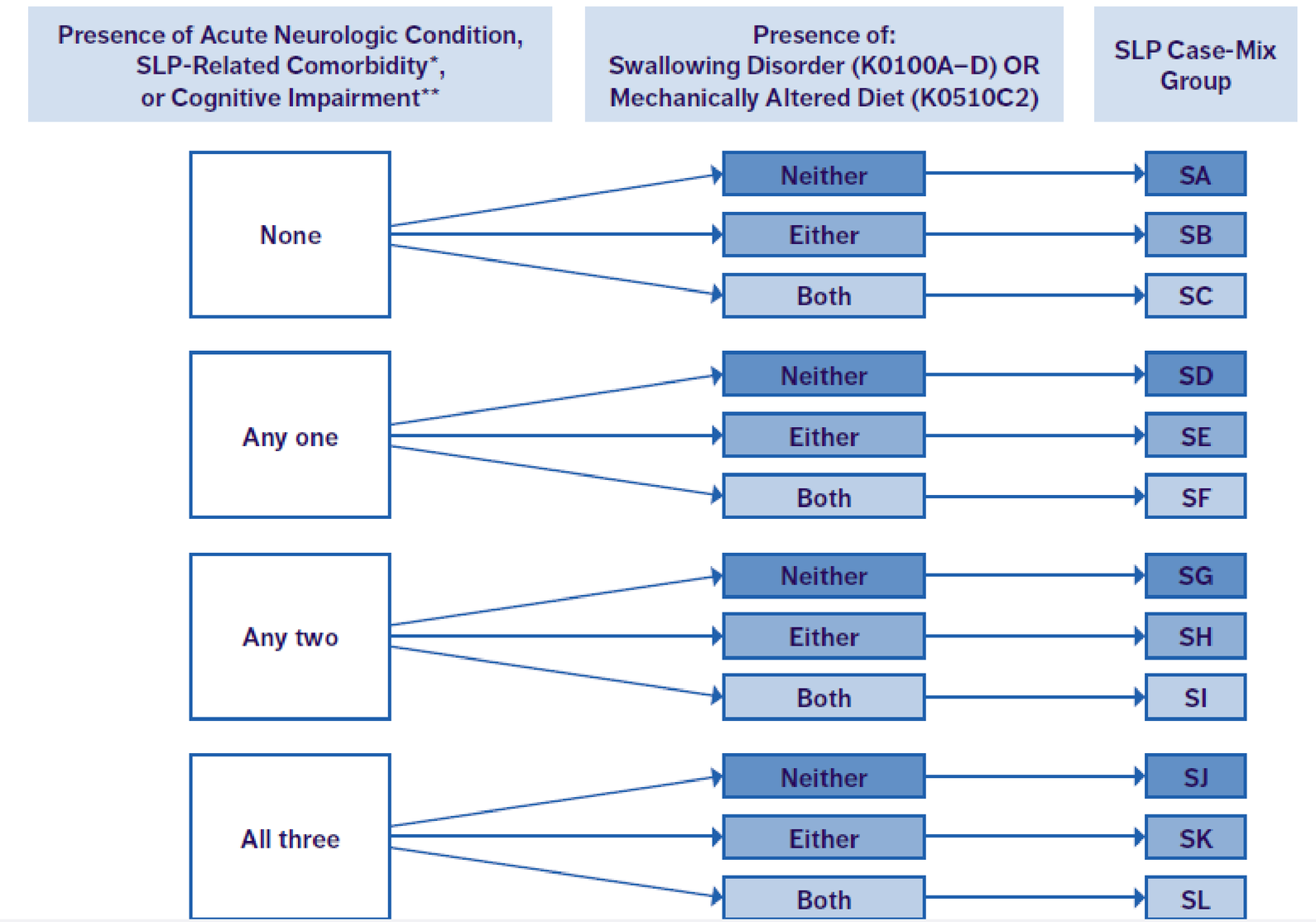
See CMS PDPM ICD-10 Mappings for specific ICD-10 codes included in SLP-related comorbidities. ***ADDITIONAL CODES LISTED AS "RETURN TO PROVIDER" MAY BE APPROPRIATE TO INCLUDE IN ORDER TO CODE COMPREHENSIVELY.***

PDPM
Cognitive Scoring & Classification

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13 – 15	0
Mildly Impaired	8 – 12	1 - 2
Moderately Impaired	0 – 7	3 - 4
Severely Impaired	-	5 - 6

Cognitive Levels	BIMS	BCAT	BCAT-SF	MMSE	MoCA
Mild Dementia	0-12	25-33	11-15	0-23	0-18
Mod - Severe Dementia	0-7	0-24	0-10	0-23	0-18

PDPM
SLP Component



The American Speech-Language-Hearing Association

October 10 at 8:05 PM ·

Under the final rule for a new payment system, skilled nursing facilities (SNFs) will receive reimbursement based on a patient's clinical characteristics, rather than the amount of therapy the patient needs.
The new system, which takes effect Oct. 1, 2019, removes incentives for SNFs to increase their reimbursement levels by providing more therapy than may be medically necessary. Over the past several years, many SNFs and rehabilitation companies have paid billions of dollars to settle allegations of this type of Medicare fraud.

LEADER.PUBS.ASHA.ORG

Final Rule Overhauls Medicare Therapy-Based SNF

"It certainly is about time [that] this is put into effect. The new rule allows us to provide services based on need and not on minutes especially if the patient is not well enough to be seen or is [not] ready for therapy…This does eliminate unnecessary services and the potential for fraud."

“Further devaluing the SLP’s role in rehab. Supposedly, the opposite is supposed to happen; however, the majority of SNFs I am in/around are decreasing the number of SLPs and caseloads have plummeted.”

What else
does ASHA say?

What SLPs Need to Know About the New Medicare SNF Payment Model

The transition to PDPM will not lead to the end of employment for SLPs in SNFs.

If PDPM is appropriately implemented by SNFs, SLPs will be empowered to identify and treat patients who need their clinically necessary services rather than count the minutes of therapy provided to each patient. SNFs who state that SLPs are being laid off because of the transition to PDPM are not being transparent about the rationale for terminating therapists. SNFs that plan for the transition and appropriately assess the role of SLPs are not likely to terminate employees.

ASHA PDPM Resources

Let’s Refocus…

Patient Advocacy

Legislative Advocacy

Advocacy for our profession

Becoming an *Advocate*

ASHA Scope of Practice in Speech-Language Pathology

Practice within the full scope of your license

Professional Practice Domains

- *Advocacy and outreach*
- Supervision
- Education
- Administration/Leadership
- Research

Service Delivery Domains

- Fluency
- Speech Production
- Language
- Cognition
- Voice
- Resonance
- Feeding and Swallowing
- Auditory Habilitation / Rehabilitation

Becoming An Advocate
SLP & Fall Risk Management

Screen comments, but no ST orders were requested

At this time PT to evaluate and then determine if other disciplines indicated.

patient had items under w/c cushion which caused her to slip out of w/c- no therapy services indicated

Secondary to poor cognitive function; attempted transfer alone.

Resident was seen under Part B services earlier in year (Jan/Feb) and was discharged within age/gender-related norms on standardized tests. Resident with significant decline in functional mobility.

Pt is at prior level of function and is poor candidate for rehab as pt demonstrates with no carry over

Is there an opportunity?

Documentation & Coding

Successful Documentation is…

- **A**ccurate: describes the care provided
- **C**ode-able: supports CPT & ICD-10-CM codes
- **U**nderstandable: clear to any reader
- **T**imely: recorded at time of service
- **E**rror free: stands alone as a legal document

Module Three: Documentation of SLP Services in Difference Settings. (n.d.). Retrieved February 8, 2019, from https://www.asha.org/Practice/reimbursement/Module-Three/

Painting the Picture
of Medical Necessity

ICD-10 Coding

Description of Illness

PLOF vs. CLOF

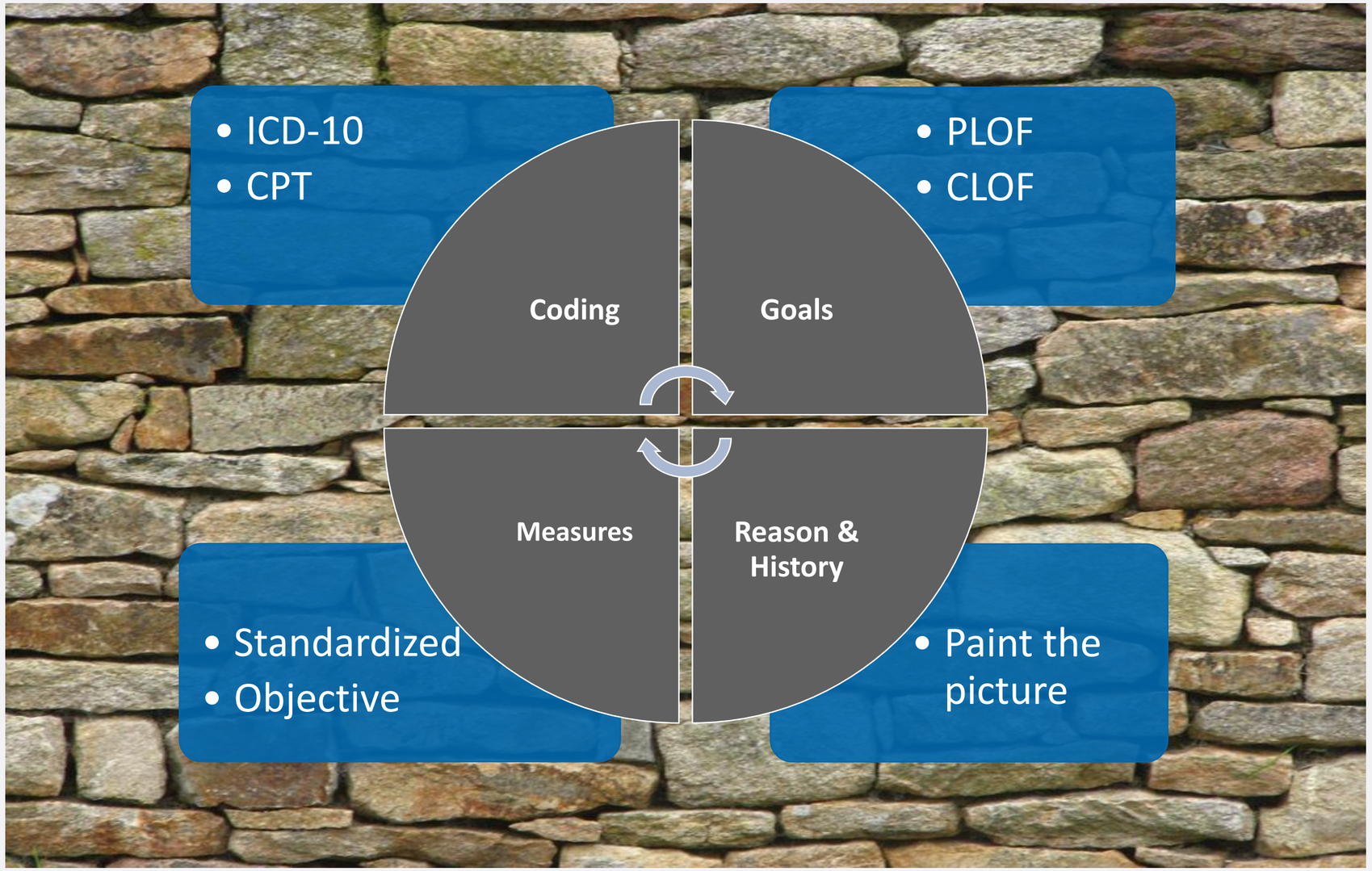
Clinical Impression

Individualized Reason for Referral

Objective Measures

Justification

Setting
the Foundation…



ICD-10 & CPT Coding
Should…

01

Reflect the *patient's health condition and/or the procedures* done to maintain or improve that condition

02

Support the goals and plan of care to demonstrate "value – based" and "accountable" services

03

Represent the *severity, risk & complexity of the condition*

Types of Codes

ICD-10

- Medical Diagnosis Codes (assigned by physician)
- Treatment Diagnosis Codes (assigned by therapist)
- Up to 7 digits
- Both numbers and letters
    - R13.12 (Oropharyngeal Dysphagia)

CPT

- Billing Codes
- 5-digit number sequence
    - 92523 (Speech & Language Evaluation)
    - 92526 (Dysphagia Treatment)

Medical
Diagnoses

- Reason for SNF Care
- Pertinent Comorbidities
- Code to the highest degree of specificity

Medical Diagnosis Coding
Decisions, Decisions…

Does the diagnosis affect your clinical decision-making?

Will the diagnosis affect your outcomes?

If "yes" to either question, add the code

Treatment
Diagnoses

Related to the Medical Diagnosis

Supported by objective measures

Accepted by insurance

Related to problems being addressed in therapy

Code to the most specific degree

ICD-10 Coding
Example #1

Diagnoses		
Type	**Code**	**Description**
Med	F03.90	Unspecified dementia without behavioral disturbance
Med	N19	Unspecified kidney failure
Med	F20.89	Other schizophrenia
Med	F41.9	Anxiety disorder, unspecified
Med	I10	Essential (primary) hypertension
Med	F31.9	Bipolar disorder, unspecified
Med	G47.00	Insomnia, unspecified
Med	E03.9	Hypothyroidism, unspecified
Med	R45.87	Impulsiveness
Med	R29.6	Repeated falls
Tx	R48.8	Other symbolic dysfunctions
Tx	R47.01	Aphasia

ICD-10 Coding
Example #2

Can there be TOO MANY codes???

Diagnoses		
Type	**Code**	**Description**
Med	F33.1	Major depressive disorder, recurrent, moderate
Med	F41.1	Generalized anxiety disorder
Med	I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
Med	R29.898	Other symptoms and signs involving the musculoskeletal system
Med	M62.838	Other muscle spasm
Med	F10.21	Alcohol dependence, in remission
Med	E78.5	Hyperlipidemia, unspecified
Med	F31.9	Bipolar disorder, unspecified
Med	I10	Essential (primary) hypertension
Med	K21.9	Gastro-esophageal reflux disease without esophagitis
Med	G47.00	Insomnia, unspecified
Med	R13.12	Dysphagia, oropharyngeal phase
Med	F34.1	Dysthymic disorder
Med	E55.9	Vitamin D deficiency, unspecified
Med	R48.9	Unspecified symbolic dysfunctions
Med	Z91.81	History of falling
Med	K59.00	Constipation, unspecified
Med	G89.29	Other chronic pain
Med	I70.91	Generalized atherosclerosis
Med	R32	Unspecified urinary incontinence
Med	R26.2	Difficulty in walking, not elsewhere classified
Med	E03.9	Hypothyroidism, unspecified
Med	Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
Med	D50.9	Iron deficiency anemia, unspecified
Med	R27.8	Other lack of coordination
Med	M62.81	Muscle weakness (generalized)
Med	R26.9	Unspecified abnormalities of gait and mobility
Med	F20.0	Paranoid schizophrenia
Tx	R13.10	Dysphagia, unspecified

ICD-10 Coding
Example #3

Not ENOUGH codes?

Diagnoses		
Type	**Code**	**Description**
Med	F03.90	Unspecified dementia without behavioral disturbance
Tx	R13.10	Dysphagia, unspecified

ICD-10 Coding
ASHA resource

ASHA Speech-Language Pathology
The Largest Association of Speech-Language Pathology Professionals

2019 ICD-10-CM Diagnosis Codes
RELATED TO SPEECH, LANGUAGE, AND SWALLOWING DISORDERS

https://www.asha.org/uploadedFiles/ICD-10-Codes-SLP.pdf

I69.09		Other sequelae of nontraumatic subarachnoid hemorrhage
✓	I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
✓	I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
		Use additional code to identify the type of dysphagia, if known (R13.1-)
✓	I69.092	Facial weakness following nontraumatic subarachnoid hemorrhage Facial droop following nontraumatic subarachnoid hemorrhage
	I69.093	Ataxia following nontraumatic subarachnoid hemorrhage
	I69.098	Other sequelae following nontraumatic subarachnoid hemorrhage

✓ Code typically used by SLPs ❖ Additional digits not listed here

PDPM SLP – Related Comorbidities
ICD-10 Code Mapping

Aphasia	Laryngeal Cancer
CVA, TIA or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

Examples included in SLP Comorbidity mapping:

- Dysphagia: I69.991
- Apraxia: I69.990
- Laryngeal Cancer: C32.0, C32.1, C32.2, C32.3 and C32.8
- Speech and Language Deficits: I69.928, I69.920, I69.921, I69.922, I69.923 and I69.928

PDPM SLP – Related Comorbidities
ICD-10 Code Mapping

Mapping of Comorbidities Included in the PDPM SLP Component to ICD-10-CM Codes

Overview

Sort Order	Comorbidity Description	ICD-10-CM Code	ICD-10-CM
1	ALS	G12.21	Amyotrophic lateral sclerosis
2	Apraxia	I69.090	Apraxia following nontraumatic subarachnoid hemorrhage
3	Apraxia	I69.190	Apraxia following nontraumatic intracerebral hemorrhage
4	Apraxia	I69.290	Apraxia following other nontraumatic intracranial hemorrhage
5	Apraxia	I69.390	Apraxia following cerebral infarction
6	Apraxia	I69.890	Apraxia following other cerebrovascular disease
7	Apraxia	I69.990	Apraxia following unspecified cerebrovascular disease
8	Dysphagia	I69.091	Dysphagia following nontraumatic subarachnoid hemorrhage
9	Dysphagia	I69.191	Dysphagia following nontraumatic intracerebral hemorrhage
10	Dysphagia	I69.291	Dysphagia following other nontraumatic intracranial hemorrhage
11	Dysphagia	I69.391	Dysphagia following cerebral infarction
12	Dysphagia	I69.891	Dysphagia following other cerebrovascular disease
13	Dysphagia	I69.991	Dysphagia following unspecified cerebrovascular disease
14	Laryngeal Cancer	C32.0	Malignant neoplasm of glottis
15	Laryngeal Cancer	C32.1	Malignant neoplasm of supraglottis
16	Laryngeal Cancer	C32.2	Malignant neoplasm of subglottis
17	Laryngeal Cancer	C32.3	Malignant neoplasm of laryngeal cartilage
18	Laryngeal Cancer	C32.8	Malignant neoplasm of other specified sites of larynx

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Commonly Used SLP Treatment Diagnosis Codes that (Currently) Do Not Map

Treatment ICD-10 codes commonly used by Speech-Language Pathologists such as R13.12 (Oropharyngeal Dysphagia), R41.841 (Cognitive Communication Deficit) and R48.8 (Other Symbolic Dysfunction) do not currently map to the "Acute Neurological" category and are not included in the SLP comorbidity mapping.

However, these diagnoses may be appropriate coding to support medical necessity of SLP services.

ICD-10 Coding
Additional Resources

ASHA ICD-10 Guidance
Codes typically used by SLPs

CMS ICD-10 Website
Guidance for use of Z-codes
Excludes notes (“Excludes1” and “Excludes2”)

ICD10data.com
Look up codes—including history
Description & Synonyms
Excludes notes

CMS ICD-10 Tabular Index
Similar information to ICD10data.com but different format

For additional coding questions, contact your Kansas State Advocate for Medicare Policy Network (StAMP)

Jeanne.Copeland@genesishcc.com

https://www.asha.org/Practice/reimbursement/medicare/StAMP/

Denial Prevention

Reasons cited for SLP denials

“Lack of required ICD-10 coding required by the LCD to support medical necessity”

“Speech therapy services denied as not reasonable and necessary.”

“Section ‘B’ of the MDS assessment, ARD 7.2.2017, supported he had clear speech with distinct intelligible words, he made himself understood and he understood with clear comprehension.”

More reasons cited for SLP denials

"Section 'C' of the MDS assessment, ARD 7.2.2017, supported his BIMS (brief interview for mental status) was 14/15 indicating he was not cognitively impaired, additionally, section 'C' supported he did not have an acute mental status change and did not exhibit inattention, disorganized thinking or altered level of consciousness."

"Nurse practitioner documentation supported his judgement and insight were intact, he oriented to time, place, person and situation and his long and short term memory were intact. Nursing documentation supported he was alert and oriented and able to make his needs known. Physical therapy noted he was alert and oriented with communication intact. For these reasons, Speech therapy is denied in full."

MDS Sections
Important for SLPs

- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section I & O: Clinical Category (including comorbidities)
- Section K: Swallowing & Nutritional Status

Other sections may also be clinically relevant to SLPs, especially during an interdisciplinary (IDT) screening process (e.g., pain, recent falls, shortness of breath, skin conditions, functional status).

ASHA support for
SLP involvement in MDS

Demonstrating the Value of SLP Services in the New SNF Payment Model

Involve SLPs in the completion of the Minimum Data Set (MDS)

Engaging SLPs in the completion of relevant sections of the minimum data set (MDS) ensures accuracy of the data, helps identify patients who need speech-language pathology services, and facilitates interprofessional practice. SLPs can contribute to this process either directly or in consultation with the MDS coordinator.

Look back period for all items is 7 days unless another time frame is indicated

Section B	Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Section B

Hearing
Speech Clarity
Makes Self Understood
Ability to Understand Others

Brief Interview for Mental Status (BIMS)

Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue*** *and* ***bed****. Now tell me the three words."*

Number of words repeated after first attempt:

☐ **0. None** ☐ **1. One** ☐ **2. Two** ☐ **3. Three**

After the resident's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

Temporal Orientation (orientation to month, year and day)

Ask resident: *"Please tell me what year it is right now."*

Able to report correct year

- ☐ **0. Missed by > 5 years**, or no answer
- ☐ **1. Missed by 2-5 years**
- ☐ **2. Missed by 1 year**
- ☐ **3. Correct**

Ask resident: *"What month are we in right now?"*

Able to report correct month

- ☐ **0. Missed by > 1 month**, or no answer
- ☐ **1. Missed by 6 days to one month**
- ☐ **2. Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Able to report correct day of the week

- ☐ **0. Incorrect**, or no answer
- ☐ **1. Correct**

Recall

Ask resident: *"Let's go back to the earlier question. What were the three words that I asked you to repeat?"*
If unable to remember a word, give cue (*"something to wear," "a color," "a piece of furniture"*) for that word.

Able to recall "sock"	☐ **0. No - could not recall**	☐ **1. Yes, after cueing ("something to wear")**	☐ **2. Yes, no cue required**
Able to recall "blue"	☐ **0. No - could not recall**	☐ **1. Yes, after cueing ("a color")**	☐ **2. Yes, no cue required**
Able to recall "bed"	☐ **0. No - could not recall**	☐ **1. Yes, after cueing ("a piece of furniture")**	☐ **2. Yes, no cue required**

BIMS

Section C
15 point scale
Not sensitive to MCI

Section C	Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home/hospital swing bed**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Section C, cont.

Cognitive Performance Scale (CPS)

Do not conduct if BIMS was completed

I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code

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

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

I0020B. ICD Code

Section I

Active Diagnoses & Comorbidities

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

Section O

Special Treatments, Procedures, and Programs (last 14 days)

Tracheostomy care
Mechanical Ventilation

Section K — Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ Check all that apply

- ☐ A. Loss of liquids/solids from mouth when eating or drinking
- ☐ B. Holding food in mouth/cheeks or residual food in mouth after meals
- ☐ C. Coughing or choking during meals or when swallowing medications
- ☐ D. Complaints of difficulty or pain with swallowing
- ☐ Z. None of the above

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches	**A. Height** (in inches). Record most recent height measure since the most recent admission/entry or reentry
☐☐☐ pounds	**B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0310. Weight Gain

Enter Code ☐

Gain of 5% or more in the last month or gain of 10% or more in last 6 months
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last **7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)		☐
Z. **None of the above**	☐	☐

Section K

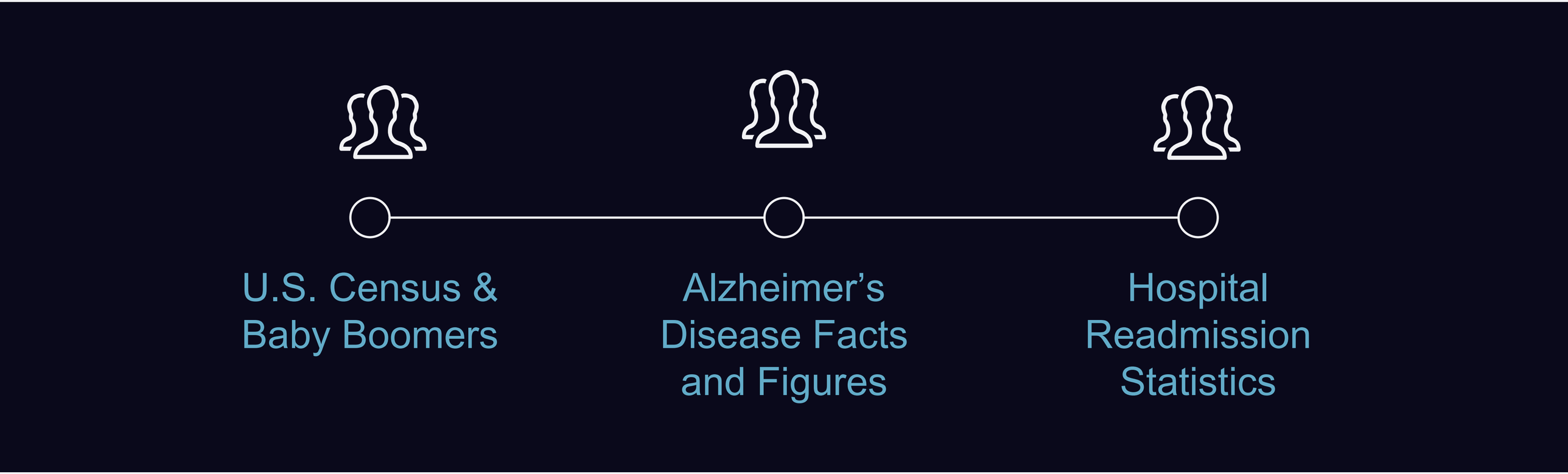
Swallowing / Nutritional Status

Swallowing Disorder
Weight Loss
Mechanically Altered Diet

Key Point for
Denial Prevention under PDPM

Does rehab documentation support what's been captured on the MDS???

Back to our view from 30,000 feet



Summary of critical concepts for SUCCESS!

Provide reasonable and necessary services

Provide (and document) skilled therapy

Provide services that others see as valuable

Work at the top of your license

Be a lifelong learner

Be an ADVOCATE!

Thank you!

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