

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
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~~05-~~

RULE REVIEW CHECKLIST

05.0009.0472

DATE RULE RECEIVED 5-16-86
DATE FOR REVIEW
DATE DUE 5-23

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved 5228bmj C Disapproved Returned to Agency

Resubmitted
Approved Disapproved Due Returned to Agency

Date filed w/Secretary of State 5-23-86 Revisor approved disapproved

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✓ Rule as Adopted

✓ Rule as Proposed see S.R.

✓ Order Adopting 5.15.86 Date combined w/ F/F

✓ Notice of Intent to Solicit Outside Opinion SR. 2.24.86

✓ Order for rulemaking
N/A date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking see S.R.
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
3.25.86 At least ~~30~~ 25 days prior to ~~hearing~~/adoption

✓ Affidavit of Additional Mailing 3.27.86 Affidavit of Add. Mailing 3.31.86

✓ Mailing list Certificate

✓ Publication in State Register
3.31.86 At least ~~30/20~~ days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact combined w/ Orders Adopting

N/A LCRAR Report or agency Affidavit

✓ Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

N/A Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General to be submitted

EMERGENCY RULES

Proposed Emergency Rules
According to Minn. Stat. of 1984, §§ 14.29-14.30, state agencies may propose adoption of emergency rules if: 1) expressly required; 2) authorized by statute; or 3) if the manner permitted by a directive (given by statute, federal law or court order) does not allow for compliance with sections 14.14-14.28. The agency must, however, publish a notice of intent to adopt emergency rules, along with the rules themselves, in the *State Register*. The notice must advise the public:

1) that a free copy of the proposed emergency rule is available upon request from the agency;
2) that notice of the date that the rule is submitted to the attorney general will be mailed to persons requesting notification;
3) that the public has at least 25 days after publication of the proposed emergency rule to submit data and views in writing; and
4) that the emergency rule may be modified if the data and views submitted support such modification.

Adopted Emergency Rules
Emergency rules take effect five working days after approval by the attorney general, and after compliance with Minn. Stat. §§ 14.29-14.365. As soon as possible, emergency rules are published in the *State Register* in the manner provided for in section 14.18.

Emergency rules are effective for the period stated in the notice of intent to adopt emergency rules. This may not exceed 180 days.

Continued/Extended Emergency Rules
Adopted emergency rules may be continued in effect (extended) for an additional 180 days. To do this, the agency must give notice by: 1) publishing notice in the *State Register*; and 2) mailing the same notice to all persons who requested notification on rulemaking. No emergency rule may remain in effect 361 days after its original effective date. At that point, permanent rules adopted according to Minn. Stat. 14.14-14.28 supercede emergency rules.

MINNESOTA RULES AMENDMENTS AND ADDITIONS

DEPARTMENT OF HEALTH
4656.0010-.0100 (Temporary) 2011
DEPARTMENT OF PUBLIC WELFARE (Now HUMAN SERVICES)
9549.0050-.0059 (Temporary) 2016

Department of Health
Health Resources Division

Proposed Temporary Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

Notice of Proposed Adoption of Temporary Rule Amendments

Notice is hereby given that the Minnesota Department of Health proposes to adopt the above entitled temporary rule amendments. The statutory authority to adopt temporary rules is contained in Minnesota Statutes, section 256B.431, subdivision 6 as amended by Laws of Minnesota 1986, Chapter 316.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule amendments or any part or subpart of the rules in writing. Any comments must be submitted to Gary A. Goetzke, Minnesota Department of Health, 717 S.E. Delaware Street, P.O. Box 9441, Minneapolis, Minnesota 55440, (612) 623-5627.

Minnesota Rules, parts 4656.0010 to 4656.0100 [Temporary] require the Department of Health to conduct annual resident assessments in accordance with procedures established by 42 Code of Federal Regulations (C.F.R.), sections 456.600 to 456.614. The rules also incorporate by reference the March 17, 1986 versions of the *Facility Manual for Completing Case Mix Requests for Classification*, and the *Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications*, as well as the *Guideline for Isolation Precautions in Hospitals*. These documents are available for review at the Ford Law Library at 117 University Avenue, St. Paul, Minnesota 55155 and through the Minitex Interlibrary Loan System. In addition, the rules establish requirements for the assessment of mentally retarded residents; address the basis for making level of care recommendations; establish procedures for the classification of residents in nursing homes and boarding care homes participating in the Medical Assistance Program; provide a mechanism for reconsidering Department of Health classifications; and establish a process for auditing resident assessments completed by nursing homes or boarding care homes.

A free copy of the proposed temporary rules is available by contacting Gary A. Goetzke, Minnesota Department of Health, 717 S.E. Delaware Street, P.O. Box 9441, Minneapolis, Minnesota 55440, (612) 623-5627.

The proposed rules may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rules as noticed.

Upon adoption of the temporary rules by the agency, the rules as adopted and the required supporting documents will be delivered to the Attorney General for reviews as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Gary Goetzke.

The temporary rules will take effect five working days after approval by the Attorney General and be effective until June 30, 1987 unless otherwise superceded by rule.

Temporary Rules as Proposed

4656.0010 [Temporary] SCOPE.

Parts 4656.0010 to ~~4656.0070~~ 4656.0100 [Temporary] establish procedures ~~for the assessment~~ to review the appropriateness of care and services furnished to residents of facilities participating in the medical assistance program, and for the classification of residents of nursing homes and boarding care homes ~~required~~ participating in the medical assistance program to determine the operating cost payment rates for all nursing homes and boarding care homes participating in the medical assistance program under Minnesota Statutes, sections 256B.41 to 256B.48 and parts 9549.0050 to 9549.0059 [Temporary].

4656.0020 [Temporary] DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 4656.0010 to ~~4656.0070~~ 4656.0100 [Temporary] the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the department's quality assurance and review program ~~in effect on March 1, 1984,~~ and used for performing resident assessments. ~~The assessment form is incorporated by reference. It is available at Ford Law Library, 117 University Avenue, Saint Paul, MN 55155. It is available through the minitex interlibrary loan system. This form is not subject to frequent change.~~

Subp. 3. **Department.** "Department" means the Minnesota Department of Health.

Subp. 3a. **Guideline for Isolation Precautions in Hospitals.** "Guideline for Isolation Precautions in Hospitals" means the guidelines written by Julia S. Garner, RN, MN 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. The guidelines are incorporated by reference. They are available at the Ford Law Library, 117 University Avenue, Saint Paul, MN 55155, and through the minitex interlibrary loan system. This material is not subject to frequent change.

Subp. 4. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatments and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures and discharge potential.

Subp. 5. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 5a. **Resident.** "Resident" means an individual residing in a facility certified to participate in the medical assistance program.

Subp. 6. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 7. **Resident plan of care.** "Resident plan of care" for residents of nursing homes means the patient care plan specified in part 4655.6000. Resident plan of care for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319 (as amended through December 31, 1984).

Subp. 7a. **Resident record.** "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident 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, consultation, and other services;

F. a copy of any transfer data provided to another health care facility; and

G. a discharge summary.

Subp. 7b. **Review team.** "Review team" means the inspection team described by Code of Federal Regulations, title 42, section 456.602, as amended through December 31, 1984.

4656.0030 [Temporary] ANNUAL RESIDENT ASSESSMENT.

~~Subpart 1. **Annual assessment.** In accordance with Minnesota Statutes, sections 144.072 and 144.0721, the department shall conduct annual assessments of all residents in each nursing home and boarding care home participating in the medical assistance program.~~

~~Subp. 2. **Procedure for assessment.** A registered nurse and other appropriate health and social service personnel shall perform the assessment on each resident according to the QAR procedures of the department including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care and shall record the assessment on the assessment form defined in part 4656.0020 [Temporary], subpart 2.~~

~~Subp. 3. **Classification and notification.** Within 15 working days of receiving the completed assessment documents, the department must classify each resident into one of the resident classes prescribed by part 9549.0058 [Temporary], subpart 1, item F, and mail a written notice to the resident and the nursing home or boarding care home of the resident classification. The written notice must inform the resident and the nursing home or boarding care home of the opportunity to review the state's documents supporting the classification, and the right of the facility or the resident to request a reconsideration of the classification.~~

The department shall conduct annual assessments of all residents in each nursing home and boarding care home participating in the medical assistance program to determine the appropriateness and quality of care and services furnished to these residents. The assessments must be conducted in accordance with the inspection of care requirements established by Code of Federal Regulations, title 42, sections 456.600 to 456.614, as amended through December 31, 1984. However, those provisions regarding recommendations for changes in the level of care provided shall not apply to private paying residents.

4656.0040 [Temporary] ~~REVIEW AND CLASSIFICATION OF FACILITY AND PREADMISSION SCREENING PROCEDURES FOR~~ ASSESSMENTS.

~~Subpart 1. **Classification.** Within 15 working days of receiving each request for classification submitted in accordance with part 9549.0059 [Temporary], the department shall classify the resident into one of the resident classes established in accordance with part 9549.0058 [Temporary] or notify the individual completing the assessment or the nursing home or boarding care home furnishing the documentation of additional information necessary for determining the classification.~~

~~Subp. 2. **Notification of classification.** Within 15 days of receiving a complete and accurate request for classification, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification. The written notice must inform the resident and the nursing home or boarding care home of the right to review the department of health's documents supporting the classification and the right of the facility or the resident to request a reconsideration of the classification.~~

When performing assessments in accordance with part 4656.0030 [Temporary], team reviewers shall follow the assessment procedures and requirements established in the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications. The March 17, 1986, version of the manual is incorporated by reference. This manual is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change.

4656.0050 [Temporary] ~~AUDITS OF ASSESSMENTS OF NURSING HOME~~ ADDITIONAL REQUIREMENTS FOR ASSESSING MENTALLY RETARDED RESIDENTS.

~~Subpart 1. **Audits required.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 [Temporary] through desk audits and on-site reviews of residents and their records. The department shall reclassify a resident that it determines to have been incorrectly assessed.~~

~~Subp. 2. **Request for reconsideration.** Within five working days of a reclassification required by subpart 1, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification, the opportunity to review the Department of Health's documents supporting the classification, and the right of the facility or the resident to request reconsideration of the classification.~~

Subpart 1. **Active treatment.** Residents of intermediate care facilities for the mentally retarded (ICF/MR) shall be provided active treatment in accordance with the requirements established by Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Subp. 2. **Individualized program plan.** For the purpose of determining active treatment under this part, individual program plan means the individual written plan of care described under Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Team reviewers shall use the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications, to review the individual program plan for the purpose of determining the quality and adequacy of the facility's

in-house current individual program and the programs and services being provided to the resident outside the facility.

4656.0060 [Temporary] ~~REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION~~ LEVELS OF CARE.

~~Subpart 1. **Reconsideration permitted.** A nursing home or a boarding care home or resident, or the resident's authorized representative who is dissatisfied with the classification into a resident class by the department, may request that the department reconsider the classification.~~

~~Subp. 2. **Request for reconsideration.** A nursing home or boarding care home or a resident, or the resident's authorized representative who requests reconsideration of the resident's classification, shall file the request in writing within ten working days of receiving the notice of the resident's classification. The facility or the resident shall support the request with documentation that the resident's needs at the time of the assessment were different from those identified in the assessment, or that the needs identified in the assessment require a different resident classification than that assigned by the department. The nursing home or boarding care home must provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation shall be provided within one working day of receipt of a written request from the resident or the resident's authorized representative. If a facility requests the reconsideration of a resident's classification, a written notice must be provided to the resident on the date the request is submitted to the department. The notice to the resident shall contain the information provided to the department that supports the request for reconsideration.~~

~~Subp. 3. **Review of requests and notification.** The department shall review the requests for reconsideration and shall affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home of the classification within 20 working days.~~

~~Subp. 4. **Status of initial classification.** The resident classification established by the department must be the classification that applies to the resident while the request for reconsideration is pending.~~

Team reviewers shall base level of care recommendations upon the following categories:

A. skilled nursing care facility services, as defined by Code of Federal Regulations, title 42, section 440.40(a), as amended through December 31, 1984;

B. intermediate care facility services, including ICF I, ICF II, and ICF/MR, as defined by Code of Federal Regulations, title 42, section 440.150, as amended through December 31, 1984;

C. inpatient hospital services, including services as defined by Code of Federal Regulations, title 42, sections 440.10 and 440.140, as amended through December 31, 1984, and services provided in specialty hospitals;

D. inpatient psychiatric services for individuals under 21 years of age, as defined by Code of Federal Regulations, title 42, section 440.160, as amended through December 31, 1984;

E. mental hospitals, including hospitals that are licensed in accordance with Minnesota Statutes, sections 144.50 to 144.56, and meet the requirements of parts 4640.3600 to 4640.4300;

F. home or community-based services as defined by Code of Federal Regulations, title 42, section 440.180, as amended through December 31, 1984; and

G. semi-independent living services or SILS, which is a system of services that includes training, counseling, instruction, supervision, and assistance provided in accordance with the client's individual program plan. Services may include assistance in budgeting, meal preparation, shopping, personal appearance, counseling, and related social support services needed to maintain and improve the client's functioning. The services shall not extend to clients needing 24-hour per day supervision and services. Persons needing a 24-hour per day program of supervision and services shall not be accepted or retained in a semi-independent living service.

CASE MIX REIMBURSEMENT

4656.0070 [Temporary] ~~ASSESSMENT OF RESIDENTS ON JULY 1, 1985~~ CLASSIFICATION AND NOTIFICATION OF ANNUAL RESIDENT ASSESSMENTS.

~~The department shall mail a notice to each nursing home or boarding care home specifying the resident classes for all residents in the home for which the department has assessment information no later than one day after the effective date of parts 4656.0010 to 4656.0070 [Temporary]. Each nursing home or boarding care home shall assess each resident whose name does not appear on the department's classification list under the procedures prescribed by part 9549.0059 [Temporary], subpart 3, item B. The nursing home or boarding care home shall submit a request for classification for each resident assessed by the nursing home or boarding care home to the department no later than 15 days after receipt of the department's notice. The request for classification must include the completed assessment form and the resident's plan of care. The department shall classify each resident for whom a request for classification has been received by June 15, 1985, and notify the nursing home or boarding care home by June 20, 1985, of the~~

~~classification. For any facility in which an annual QAR assessment occurs between May 1, 1985, and June 30, 1985, the classifications established under part 4656.0030 [Temporary], subpart 3, shall apply.~~

Subpart 1. **Written notice.** Within 15 working days of receiving assessment documents submitted in accordance with part 4656.0030 [Temporary], the department shall classify each resident into one of the resident classes prescribed by part 9549.0058 [Temporary], subpart 1, item F, and mail a written notice of the classification to the resident and the nursing home or boarding care home in which the resident resides. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the department's documents supporting the classification and request a reconsideration of the classification.

Subp. 2. **Classification letter.** The nursing home or boarding care home must provide each resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home or boarding care home. If the resident's classification has changed, the nursing home or boarding care home must include the current rate for the new classification with the classification letter.

4656.0080 [Temporary] REVIEW AND CLASSIFICATION OF FACILITY AND PREADMISSION SCREENING ASSESSMENTS.

Subpart 1. **Assessment procedures.** Assessments which are performed in accordance with part 9549.0059 [Temporary] must be completed by following the assessment procedures and requirements established in the March 17, 1986, version of the Facility Manual for Completing Case Mix Requests for Classification. This manual is incorporated by reference and is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change.

Subp. 2. **Classification.** Within 15 working days of receiving each request for classification submitted in accordance with part 9549.0059 [Temporary], the department shall classify the resident into one of the resident classes established in accordance with part 9549.0058 [Temporary] or notify the individual completing the assessment or the nursing home or boarding care home furnishing the documentation of the need to submit additional information necessary for determining the classification.

Subp. 3. **Notification of classification.** Within 15 days of receiving a complete and accurate request for classification, the department shall mail a written notice of the resident's classification to the resident and the resident's nursing home or boarding care home. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the Department of Health's documents supporting the classification and the right to request a reconsideration of the classification.

Subp. 4. **Classification letter.** The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

4656.0090 [Temporary] REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION.

Subpart 1. **Reconsideration permitted.** A nursing home or a boarding care home, a resident, or the resident's authorized representative may request that the department reconsider the classification.

Subp. 2. **Request for reconsideration.** A reconsideration request must be in writing and submitted to the department within ten working days of receiving the notice of the resident's classification. Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that the needs identified in the assessment require a different resident classification than the classification assigned by the department. The nursing home or boarding care home shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests the reconsideration of a resident's classification, the facility must provide written notice to the resident or the person responsible for payment on the date the request is submitted to the department. The notice to the resident or the person responsible for payment must contain the information provided to the department that supports the request for reconsideration.

Subp. 3. **Review of requests and notification.** The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home by letter of the classification within 20 working days.

Subp. 4. **Status of initial classification.** The resident classification established by the department must be the classification that applies to the resident while the request for reconsideration is pending.

Subp. 5. **Additional information.** The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

4656.0100 [Temporary] AUDITS OF ASSESSMENTS OF NURSING HOME RESIDENTS.

Subpart 1. **Audits required.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 [Temporary] through desk audits and on-site reviews of residents and their records. The department shall reclassify a resident it determines to have been incorrectly assessed.

Subp. 2. **Audit reclassification.** Within 15 working days of a reclassification required by subpart 1, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification, the opportunity to review the Department of Health's documents supporting the classification, and the right of the resident, the resident's authorized representative, or the facility to request reconsideration of the classification.

Department of Human Services

Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

Notice of Proposed Adoption of Temporary Rule Amendments

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
3. Part 9549.0052 [Temporary] Establishment of Geographic Groups (editing changes only)
4. Part 9549.0053 [Temporary] Determination and Allocation of Fringe Benefits and Payroll Taxes, Food Costs and Dietician Consulting Fees
5. Part 9549.0054 [Temporary] Determination of Allowable Historical Operating Cost Per Diems
6. Part 9549.0055 [Temporary] Determination of the Operating Cost Adjustment Factors and Limits
7. Part 9459.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates
9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

A free copy of the proposed temporary rule is available by contacting Mary Ann Bredeson, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101.

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Adoption of Amendments to a Temporary Rule Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

SUPPLEMENTAL FINDING TO THE COMMISSIONER'S FINDINGS OF FACT, CONCLUSIONS AND ORDER ADOPTING RULE AMENDMENTS

On May 16, 1986, an order adopting the above - entitled temporary rule amendments with supporting findings of fact and conclusions were signed by the Commissioner of Health. A word was inadvertently omitted from part 4656.0080, subpart 3 of this rule. Subpart 3 now provides in pertinent part, "[w]ithin 15 days of receiving a complete and accurate request for classification, the department shall mail a notice..." This subpart should have read 15 working days. This omission was revealed to the Department by the State Attorney General's Office during their review of the rule in accordance with Minnesota Statutes, section 14.32 in effect on March 1, 1984.

The intent of the rules was to provide 15 working days in which to mail written notice of the resident's classification. This intent is apparent from a paralled provision contained in 4656.0080, subpart 2. Here, the rule provides that the department shall classify the resident,..."[w]ithin 15 working days of receiving each request for classification..."

The failure of the rule to provide for 15 working days in subpart 3 creates an ambiguity in the rule. To clarify the rule and eliminate this ambiguity, I find that it is necessary to insert the work "working".

Now, Therefore, It is Ordered

that this amendment be attached to and made a part of the Commissioner's Findings of Fact, Conclusions and Order Adopting Rule Amendments relating to the above-entitled rule, dated and signed on May 16, 1986.

Dated: May 22, 1986

Sister Mary Madonna Ashton

Commissioner of Health

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Adoption of Amendments to a Temporary Rule Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

COMMISSIONER'S FINDINGS OF FACT, CONCLUSIONS AND ORDER ADOPTING RULE AMENDMENTS

Minnesota Statutes, section 256B.431, subd. 6, as amended by Laws of Minnesota 1986, Chapter 316, authorizes the Commissioner of Health to adopt emergency rules necessary for the implementation and enforcement of the reimbursement system established in Laws 1984, Chapter 641, sections 10 to 20. This reimbursement system is commonly referred to as the case-mix reimbursement system.

Minnesota Statutes, section 256B.431, subd. 6, as amended by Laws of Minnesota 1986, Chapter 316, also provides that these rules be adopted in accordance with the provisions contained in Minnesota Statutes, sections 14.29 to 14.36 in effect on March 1, 1984. Other provisions governing adoption of these rules are also contained in that section. Proposed temporary rule amendments were published by the Commissioner of Health in the March 31, 1986 edition of the State Register.

After giving interested persons an opportunity to present comments on the proposed rule and having considered all of the written comments received, the Commissioner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. Minnesota Statutes, section 256B.431, subd. 6, as amended, authorizes the Commissioner of Health to adopt rules which are necessary for the implementation and enforcement of the case-mix reimbursement system. These rules amend the current procedures for conducting assessments of nursing home and boarding care home residents as previously established by Minnesota Rules,

parts 4656.0010 to 4656.0070 [Temporary], which became effective on June 17, 1985. The rules also amend the current procedures for assigning reimbursement classifications based on assessments conducted by Pre-Admission Screening Teams (PAS) and by facilities as established by the above - cited rules. These rule amendments are necessary to assure the continued implementation and enforcement of the case-mix reimbursement system. The completion of resident assessments and the assignment of reimbursement classifications are required under the provisions of the law and under the provisions of the Department of Human Services (DHS) rules. Additionally, these rules add procedures for conducting Inspections of Care as required by Title 42 Code of Federal Regulations (C.F.R.), sections 456.600 to 456.614.

2. The Department of Human Services is also in the process of amending temporary rules governing the case-mix reimbursement system. The rules being amended are Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary]. Staff from the Department of Health and from the Department of Human Services, as well as members of the Case Mix Advisory Committee have participated in the development of the rule amendments to assure the continued implementation and enforcement of the case-mix reimbursement system.

3. Minnesota Statutes, sections 256B.431, subd. 6, as amended, provides the Commissioner of Health with the authority to adopt these rule amendments.

4. On February 24, 1986, a Notice of Intent to Solicit Outside Opinion Concerning Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program was published in the State Register. (Exhibit 1)

5. On March 24, 1985, an Order for Publication of Temporary Rule Amendments was signed by the Commissioner of Health. (Exhibit 2)

6. On March 25, 1986, a Notice of Proposed Adoption of Temporary Rule Amendments and a copy of the proposed rule were mailed to all persons and associations registered with the Department of Health to receive notice of rule hearings. (Exhibit 3)

7. On March 27, 1986, the Notice of Proposed Adoption of Temporary Rule Amendments, a copy of the "Facility Manual for Completing Case Mix Requests for Classification," and a copy of the proposed rule were mailed to all nursing homes and certified boarding care homes participating in the Minnesota Medicaid Program and to interested persons included on a mailing list provided by the Department of Human Services. This list also includes members of the Case Mix Advisory Committee. (Exhibit 4)

8. On March 31, 1986, the Notice of Proposed Adoption of Temporary Rule Amendments and a copy of the proposed rule were published in the State Register. (Exhibit 5)

9. On March 31, 1986, a copy of the Notice of Proposed Adoption of Temporary Rule Amendments and a copy of the proposed rule were delivered to the Minnesota Senate and House of Representatives for distribution to members of the Legislature. (Exhibit 6)

10. In accordance with the provisions of Minnesota Statutes, section 14.30 in effect on March 1, 1984 the comment period for the rules closed on April 25, 1986.

11. The proposed temporary rule amendments have been developed in consultation with the Interagency Board for Quality Assurance, provider groups and consumers as required by Minnesota Statutes, section 256B.431, subd. 6, as amended.

12. Prior to the close of the comment period, numerous comments were received regarding this rule and the proposed rules of the Department of Human Services. (Exhibit 7)

Discussion of the Rule

13. This temporary rule amends the procedures for the assessment and classification of nursing home and boarding care home residents, and adds procedures for conducting Inspections of Care in accordance with 42 C.F.R. 456.600 to 456.614.

14. The rules amend part 4656.0020 [Temporary] entitled "Definitions" by adding several definitions which are intended to clarify the meaning and application of the rules. Also, the term "assessment form" has been amended by

deleting the incorporation by reference provision. Finally, this part has been amended by including an incorporation by reference to the "Guideline for Isolation Precautions in Hospitals."

15. The rules amend part 4656.0030 [Temporary] entitled "Annual Resident Assessment" by deleting the previous language and inserting language which requires Inspections of Care to be conducted in accordance with 42 C.F.R., 456.600 to 456.614. This provision is necessary to ensure that QA&R meets its responsibilities as established by federal regulations and by Minnesota Statutes, sections 144.072 and 144.0721. Such responsibilities include periodically inspecting the care and services provided to recipients in facilities participating in the Medicaid Program to determine the adequacy, appropriateness and quality of all services provided in each facility or through other arrangements, including physician services to recipients. These activities are separate from those activities required by Minnesota Statutes, section 144.0722 relating to Case Mix Reimbursement. This statute provides that the Commissioner of Health shall establish resident reimbursement classifications based upon the assessment of residents of nursing homes and boarding care homes conducted under sections 144.072 and 144.0721, or under rules established by the Commissioner of Human Services under sections 256B.41 to 256B.48. Prior to the implementation of the Case Mix reimbursement system, the Quality Assurance and Review Section was responsible for conducting the inspections of care required under the provisions of the federal Medicaid program. The federal regulatory authority for this activity is found in 42 C.F.R. 456.600 et. seq.. The provisions of Minnesota Statutes, section 144.072 subd. 1(a) recognize these federal responsibilities. Subdivision 2 of the statute which was added in 1984 provided that the policies and procedures of the

Department relating to these activities have the force and effect of law until June 30, 1986, unless otherwise superseded by law. (The provisions of Laws of Minnesota 1986, Chapter 316, extended this time frame to June 30, 1987). The amendments to parts 4656.0030 to 4656.0060 [Temporary] (Findings #16-18) reflect the federally mandated responsibilities imposed on the QA&R program. These amendments incorporate the provisions contained in the federal regulations. While there are similarities between the inspection of care activities and the Case Mix system, particularly in the area of resident assessment, the QA&R teams are required to do additional tasks under the federal program, such as making determinations as to the level of care and developing other recommendations to the facility. The incorporation of the federal regulations into these rules identifies the differences between the two programs.

16. Part 4656.0040 [Temporary] is now entitled "Procedures For Assessments." The previous language has been deleted, and language has been inserted which requires team reviewers to perform assessments in accordance with the assessment procedures and requirements established in the "Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications". This manual is incorporated by reference. This provision will ensure that assessments are properly and uniformily performed, in accordance with defined procedures. This manual differs from the facility manual incorporated under 4656.0080 in that the manual provided to the QA&R teams will contain the addtional information necessary to complete the federal inspection of care activities. The provisions of both manuals which relate to the Case Mix reimbursement system are identical.

17. Part 4656.0050 [Temporary] now is entitled "Additional Requirements For Assessing Mentally Retarded Residents." This part adds provisions relating to the assessment of residents of intermediate care facilities for the mentally retarded. These provisions provide that residents of these facilities must receive active treatment in accordance with 42 C.F.R., 435.1009, and also provide that team reviewers shall use the "Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications" to review each resident's Individual Program Plan. This will ensure that residents receive active treatment in accordance with the requirements of federal regulations. The previous language of 4656.0050 related to audits. These provisions have been deleted here, but are included under 4656.0100.

18. Part 4656.0060 [Temporary] is now entitled "Levels of Care." The previous provisions have been deleted and moved to 4656.0090. The current provisions simply require team reviewers to base level of care recommendations on federal regulations and state rules.

19. Part 4656.0070 [Temporary] relates to case mix reimbursement and is entitled "Classification And Notification Of Annual Resident Assessments." The previous language related to the assessment of residents on July 1, 1985, and was no longer relevant. The current language establishes procedures for the Department of Health to classify residents who were assessed by team reviewers. This language is essentially the same as provisions from the previous rule, with the exception being that portion of subpart 2 which specifically requires the facility to provide each resident or person responsible for payment with the classification letter within five days of receiving the letter. Additionally, the rule states that if the resident's classification changes, the facility must

include the current rate for that classification. The provision is intended to ensure that residents are properly notified of their classification, as well as the current rate for that classification. The five day time limit will also ensure that the resident or person responsible for payment is provided this information within sufficient time to request a reconsideration.

20. Part 4656.0080 [Temporary] is entitled "Review and Classification of Facility and Pre-Admission Screening." The provisions of this part incorporate by reference the "Facility Manual for Completing Case Mix Requests for Classification." This is to ensure that assessments performed either by Pre-admission Screening or by the facility are conducted properly and uniformly, in accordance with detined written procedures. This part also includes language which is essentially the same as language found in the previous rule, but also includes the language discussed in Finding 19 requiring that residents receive notice of their classification and of the current rate for that classification within a specified time frame.

21. Part 4656.0900 [Temporary] is entitled "Request For Reconsideration of Resident Classification." The reconsideration process as established by the previous rule is similar in substance to this rule. However, this language allows the Department to request additional documentation if necessary to make an accurate reconsideration determination. This provision will ensure that a party is not inadvertently penalized for not submitting all the relevant documentation required to make a proper determination.

22. Part 4656.0100 is entitled "Audits of Assessments of Nursing Home

Residents." The audit process has not been amended.

Comments

23. A number of comments have been received regarding the rules proposed by this Department and the Department of Human Services. The majority of the comments relating to this proposed rule were in the following areas: 1. the scope of the Commissioner's authority to adopt these amendments; 2. the wording of the "Scope" part of the rule; 3.the reconsideration process; 4. the form used for completing residents assessments; 5. the wording of specific portions of the "Facility Manual for Completing Case Mix Requests for Classification," including provisions relating to Special Treatments, Activities of Daily Living, Clinical Monitoring, and Behavior and Orientation; and 6.the documentation necessary for determining resident classifications.

24. The Minnesota Association of Health Care Facilities (MAHCF) argued that the proposed temporary rules exceed the statutory authority of 256B.431, subdivision 6, as amended. I do not find their arguments persuasive. First, Minnesota Statutes 256B.431, subdivision 6, as amended by Laws of Minnesota, Chapter 316, states that until June 30, 1987 any emergency rules adopted by the Commissioner of Health or the Commissioner of Human Services under section 256B.431, subdivision 6, shall be adopted in accordance with the provisions contained in sections 14.29 to 14.36 in effect on March 1, 1984. There is nothing in these provisions which prohibits the adoption of temporary rule amendments. Additionally, it is apparent that the Legislature, by enacting Chapter 316, intended that both Commissioners be able to amend the existing

temporary rules--- or in the alternative, promulgate new temporary rules. This intent is indicated by the specitic wording of the statute which provides in pertinent part, "the Commissioner of Health may adopt emergency rules.... emergency rules adopted under this subdivision have the force and effect of law and remain in effect until June 30, 1987, unless otherwise superceded by law." Finally, the Legislature was well aware of the status of the Case Mix process when the statute was amended. It was evident to the Legislature and to all parties involved in the process that the nursing home industry was in favor of a one year extension the temporary rules, with certain proposed modifications. During this one year extension, the "bugs" could be worked out of the process prior to the adoption of permanent rules. This extension would provide MDH and DHS time to gather useful data on which to base the permanent rules. Extending the authority to adopt temporary rules, also provides the department a mechanism to quickly remedy problems that occur during the implementation of the rules.

25. The Minnesota Nurses' Association (MNA) suggested that 4656.0010 be amended to include the words "assessment and" on line 13 after the words "for the." Line 13 would then read as follows: "for the assessment and classification of residents of nursing homes ..." The inclusion of this additional phrase will more accurately describes the scope of the rules; therefore, MNA's suggestion has been adopted.

26. The Department received a comment regarding the reconsideration process established by Minnesota Statutes, section 144.0722, subdivisions 3 and 4 provided for by part 4656.0090. The Nursing Homes Resident's Advocates would like to see the time period to request a reconsideration extended to 15 days. Also,

they would like to have the rule provisions more clearly address whether or not a party can ask for a second reconsideration. However, Minn. Stat. 144.0722, subdivision 3, specifically states that the request for reconsideration must be submitted to the Commissioner within ten working days of the receipt of the notice of resident classification. Additionally, subdivision 3 provides that the resident or the nursing home or boarding care home may request a reconsideration of the assigned reimbursement classification. Because these statutory provisions are so specitic, the changes suggested by the Nursing Home Resident's Advocates may only be addressed by amending the statute.

27. MNA & MAHCF also requested that the rule incorporate the assessment form by reference, as was done in the previous temporary rule. I have decided not to do this in order to allow the department the opportunity to amend the format of the assessment form. This will enable the Department to improve on the organization of the current form without changing the content of the form. These changes will also allow the Department to incorporate into the classification process new technological changes such as optical scanning of the assessment forms. Such a procedure would possibly require that the format of this document be changed.

28. a. MNA also pointed out that the facility manual on page 2 specifically requires that all assessment forms be completed by an RN. However, the inspection of care manual provides that a "reviewer" will be responsible for completing assessment forms. MNA saw this as a discrepancy in the manuals and requested that the inspection of care manual be amended to require an RN to complete the assessment form.

b. I find that this amendment is not necessary. Inspections of care are conducted by QA&R pursuant to federal regulations, 42 C.F.R. sections 456.600 to 456.614. These activities are separate from QA&R's Case Mix responsibilities. The federal regulations provide that inspections be performed by inspection teams consisting of at least one member who is a physician or registered nurse and other appropriate health and social service personnel. See 42 C.F.R. sections 456.602 (b). QA&R's inspection teams are composed of at least one registered nurse and one social worker, in accordance with the federal regulations. The registered nurse must sign the assessment form and is ultimately responsible for the accuracy of its contents.

29. MAHCF commented that the provisions of both manuals should be incorporated into the body of the rule. This suggestion has not been adopted for the temporary rulemaking process but may be considered for permanent rulemaking.

30. The Department received a number of comments regarding specific portions contained in the facility manual and the inspection of care manual that have been incorporated by reference. Also, MNA and MAHCF submitted proposed language for the manuals. Those comments and the proposed language revisions are addressed in greater detail below.

31. Parts 4656.0040 and 4656.0080 have been amended by changing the dates of the manuals which are incorporated into the rule by reference. This change was necessary because the Department must publish new manuals which will contain the changes addressed in these Findings of Fact. It is necessary to date the manuals so that everyone knows which manual version is being referred to. Parts 4656.0040 and 4656.0080 were also amended by specifically stating that the

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Attachments are not a part of the manuals. This was the original intention of the rule although it did not clearly state that the Attachments were not part of the manuals. These attachments include the following: The assessment form; a transmittal form for sending classifications to the Department; a classification notice which is sent to the facility and to the resident; a model medical plan of care; a listing of psychotropic drugs; and a reconsideration request form. Since these forms are primarily administrative in nature, the Department wishes to maintain flexibility in the design of these documents. This is similar to the reasons discussed in Finding 27 relating to the incorporation of the assessment format. The proposed amendment will clearly differentiate between the substantive portions of the manuals which are to be incorporated and the forms which were primarly included for reference. I find that these amendments to the proposed rules are not a substantial change. The changes do not create new subject matter or modify the rule in a manner fundamentally different from the proposed rule.

32. A nonsubstantial change was also made to the Introduction on page 2 of the facility manual. This change was made in order to emphasize that the facility is responsible for completing the identification information on the assessment form. This change does not create additional responsibilities to be met by a facility since the manual clearly requires that this identification information be provided on the assessment form. The amendment to the introduction is solely for the purpose of highlighting this requirement The additional language was added to the fifth paragraph on that page to make the sentence read, "[t]he facility is responsible for completing the identification information, retaining a photocopy and mailing the orginal to QA&R."

33. The schedule on page 4 of the facility manual has been amended to reflect a change in DHS rules. The line on the schedule, relating to a request for classification performed one month past readmission from the hospital, was deleted from the manual. This change was made because DHS deleted this reassessment provision from MN Rules, 9549.0059. I find that this deletion is not a substantial change. The assessment periods are specified within the provisions of the DHS rule. The material on page 4 of the manual is intended to provide a quick reference to these assessment points. The deletion of this particular element is required since DHS had eliminated this provision from their rule.

COMMENTS RELATING TO THE CASE-MIX MANUAL

34. The majority of the comments received by the Department raised concerns about provisions contained in the case-mix manuals. As noted in 4656.0040 and 4656.0080, the manuals have been incorporated by reference into the rules. The comments received fell into two major categories: the role of licensed practical nurses in facilities, especially their ability to chart in the resident's record; and the extent of documentation to be included in the resident medical record with special emphasis on the requirements of physician documentation. Since the manual provisions have raised a number of concerns, I believe that it is necessary to provide some background information on the development of these provisions and to describe the need for and the reasonableness of the requested information.

DEVELOPMENT OF MARCH 17 MANUAL

35. a. QA&R has been following procedures established in the June, 1985 version of the Quality Assurance and Review Instruction Manual since the adoption of 4656.0010 to 4656.0070 [Temporary] on June 17, 1985. In October of that year the Case Mix/Rule 50 Advisory Committee decided to review specific portions of that manual in anticipation of permanent rulemaking.

b. A clinical/nursing focus group was established to consider potential changes to the manual. The group identified Clinical Monitoring, Special Treatments and Behavior as components of the manual which needed either clarification, rewriting or substantive additions.

c. Out of these meetings evolved provisions for a revised version of the manual, to be incorporated by reference into the proposed permanent rule. This new manual was dated January 24, 1986. It contained language which embodied many of the concepts that were conveyed at the focus group meetings, including two new Special Treatment catagories: Isolation Precautions and Symptom Control for the Terminally Ill.

36. The permanent rulemaking process was cancelled with the enactment of Laws of Minnesota 1986, Chapter 316. On January 24th, 1986 the Department published a Notice to Solicit Outside Opinion for Temporary Rule Amendments. Concurrently, the Department reopened discussion on the manual by again presenting it to the Case Mix Advisory Committee. This was done at the February 24th meeting of the committee.

37. Subsequent to this meeting, and in response to the January 24, 1986 notice, MNA voiced their concerns with the January 24, 1985 version of the manual. In a letter dated March 7, 1986, MNA indicated "our primary concerns related to items requiring physician documentation as a condition for reimbursement in Minnesota's case mix system. While federal regulations do require physician documentation, we believe this should either remain in those regulations or be included in a manual seperate from that required for documentation for levels of case mix. Another acceptable approach would be to permit registered nurses to document for special treatments." In this letter MNA also proposed new language for Wound Care/Decubitus Care, Skin Care, Behavior & Clinical Monitoring. Exhibit 8.

b. MAHCF also submitted comments in response to the Notice. Among other things, MAHCF commented that in regards to physician documentation,"...there is not an actual requirement that behavior, skin care, symptom control for the terminally ill, clinical monitoring and wound care/decubitus care be documented by a physician every 60 days. If a physician's involvement in the plan of care is continous and frequent, the documentation requirement is unnecessary." (Exhibit 9)

38. It was apparent that the group represented a diversity of opinions and interests, and it would be difficult to write a manual which would reflect all the proposed ideas. However, after working with members of the advisory committee and after duly considering all the comments received in response to the Notice, the Department developed two proposed manuals containing revisions in the six areas previously discussed. One manual was for the facility's use,

the other was for use by QA&R. Both of the revised manuals were dated March 17, 1986 and were incorporated by reference into the proposed temporary rule amendments. MNA commented on the provisions contained in these manuals in a April 16th letter. This letter contained proposed modifications of portions of the March 17th facility manual. (Exhibit 10)

GENERAL ANALYSIS OF COMMENTS - MANUAL CHANGES

39. Based on the comments that have been received regarding provisions in the manual, it is clear that we cannot reach a consensus on the manual provisions at this time. Thus, it is necessary to balance a number of competing factors and to assure that the provisions contained in the manual establish appropriate requirements that accomplish the goals of the program without imposing unneccessary or unreasonable demands on facilities. For the purposes of case-mix reimbursement, the resident medical records must contain sufficient information to verify the claims made on the assessment form. For example, if the assessment form is marked showing that clinical monitoring is being provided, the medical record for that resident must contain the information specified in the manual under that heading. The information to be required must be described in such a manner to assure that the facility is aware of its obligations and to provide the necessary references to the QA&R staff who are responsible for completing annual assessments, for assigning classifications based on assessments performed by the facility on the pre-admission screening teams, and for auditing those classifications. The following findings will address specific comments received regarding the manual provisions and my response to those comments.

Role of Licensed Practical Nurses

40. a.) The Department received several comments which highlighted a perceived negative impact which these rules will have upon licensed practical nurses (LPNs). Most of the comments reflected a general concern that the proposed rules will eliminate LPNs from the long term health care field. They cite the following language to support this position:

1.) Wound Care/Decubiti, (4) (d) on page 11 which reads "registered nurses' progress notes indicating the resident's response to treatment;" and

2.) Symptom Control for the Terminally Ill, (14) (c) on page 13 which reads, "documentation by a registered nurse indicating that the symptom control program is being followed."

b.) The above - cited provisions require registered nurses'(RNs) progress notes. Several persons noted that such documentation is currently performed by LPNs. They argue that these provisions will place an added burden upon RNs, which will take away from patient care time, and will prohibit LPNs from performing tasks which they currently are responsible for and for which they are authorized to perform. The argument follows that if such activities must be performed by RNs, LPNs will no longer be needed or useful. Others observed that these requirements will create staff and budget burdens. Also, several comments indicated that there will not be enough RNs to fill future needs if these changes are adopted.

c.) However, certain comments indicated a recognized distinction between assessment and documentation. For example, Barbara Sawyer, an RN and Assistant Director of Nursing for the Minnesota Odd Fellows Home, writes that for Wound Care she believes that RNs should and do make the initial assessment. Also, proposed language submitted by the MNA indicates that they believe nursing assessments should be performed by a registered nurse, but that, licensed nurses should be able to document the resident's current status.

d.) I have thoroughly considered all views and data submitted on this topic and have decided to amend the proposed language of both manuals incorporated by reference in the rule. New language has been developed which recognizes a distinction between assessing needs, and documenting a resident's response to treatment. I find that these changes are consistent with the scope of the practice acts for registered nurses and for licensed practical nurses. I also find that these changes are not substantial in nature. The changes in the manual recognize existing practices by LPNs and RNs. These changes do not modify the scope of practice of these professionals but rather appropriately recognize the ability of LPNs to documents the current health status of the residents. The changes do not create new or additional responsibilities for professionals or for the facilities nor do the changes create a fundamental difference in the role.

e.) The provisions of the manuals relating to Clinical Monitoring, Symptom Control for the Terminally Ill, Skin Care, Isolation Precautions, Behavior and Wound Care/Decubiti have been amended. Each provision now allows licensed nurses to provide progress notes relating to the resident's response to treatment, with the exception of Clinical Monitoring, which allows licensed or

unlicensed nursing personnel to systematically record measurements, but requires registered nurses to interpret that data and communicate this to a physician.

f.) Exhibit 11 shows the changes that have been made to the appropriate portions of both the "Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classification and the "Facility Manual for Completing Case Mix Requests for Classification," both of which are incorporated into the rule by reference. The manuals will reflect these changes as of the date of the adoption of these rules.

Physician Documentation

41. a. The Department received several comments regarding specific portions of the manuals which require the facility to include in the medical record, documentation by the physician indicating the need for special treatment and the periodic reassessment of specific elements of a resident's condition.

b. Several people wrote that it was unfair to establish a process whereby facilities are reimbursed primarily according to physician documentation. Additionally, other writers indicated that the physician may not always see the resident often enough to meet these proposed requirements, and that in cases of Wound Care, for example, the wound may be healed before a routinely scheduled physician visit. Therefore, the registered nurse should be allowed to make the assessment and to request the physician to order proper treatment as necessary. Other comments observed that physicians are often in a hurry and don't always record information properly or adequately, and

that it should not be the responsibility of the facility to "train" physicians in the proper methods of documentation.

c. The Department also received several comments which supported the proposed language of the manuals. For example, Dr. Madeline Adcock, Director of Nursing Home Services for St. Paul Ramsey Medical Center wrote in pertinent part, "I feel all the physician's progress notes should reflect these problems and changes as you suggested." Also, Dr. Patrick W. Irving, Director of the Geriatric Medicine Division of the St. Paul Ramsey Medical Center wrote, "[I]t is my opinion that the wording contained in the draft of March 17, 1986 is reasonable." (Exhibit 12)

d. Comments submitted on April 21, 1986 by MNA included suggested revisions in the area of physician documentation in the following portions of both manuals: Skin Care, Behavior, Clinical Monitoring, Isolation Precautions, Wound Care/Decubiti and Symptom Control for the Terminally Ill. Similar comments and suggestions were also incorporated into the comments submitted on behalf of MAHCF on April 25, 1986. Those changes were intended to provide for consistency in the documentation requirements for the special treatments and to ease implementation of those requirements.

42. I have carefully considered all of the comments regarding suggested changes for the provisions contained in the manual. I agree that the manual provisions should not create problems in implementation and that the provisions regarding special treatment documentation should be as consistent as possible. However, it is also imperative that the manual provisions assure that the information required to verify the need for these special treatments or to support the

conclusions contained on the assessment form is contained within the official medical record for each resident.

43. In response to these comments, amendments to the March 17 manual have been made. The revisions to these portions of the manuals are identified on Exhibit 11 and will become effective as of the date of my adoption of these findings and rules. The revisions attempt to maintain consistency in the approach and in the documentation required by the facility. The generic elements include a statement identifying the particular resident need, the plan to address the need, the ongoing review of the resident's response to that plan and continued physician input. This approach is reasonable and conforms to accepted nursing and medical practice. This approach does not create the need for a new method of documentation beyond that which is already required under the licensure or certification standards. Those standards require that facilities have the health related needs of residents assessed by a physician and a registered nurse; that, appropriate written plans of care based upon physician orders be developed; that those plans be followed and progress notes recorded in the resident records; and finally, that a physician be involved in the ongoing care of the residents.

44. The assessments and the information necessary to verify these assessments will play an integral role in the reimbursement provided to the facility. For this reason, it will be necessary to ensure that the medical record contain the necessary information to address the dependencies and special care needs of residents. Thus, where detailed information is required, I find that this information is appropriate and not beyond what would be required by the

licensure and certification standards.

e. In response to the concerns regarding physician documentation, the responsibility of QA&R to ensure the adequacy and appropriateness of care and services provided to residents, requires that a certain body of information be available which will document the provision of these services. Relevant licensure and certification rules require physicians to assess and periodically reassess the resident's medical condition, and to order treatments as necessary; thus, these rules do not impose any additional requirements on physicians. Detailed discussion of the areas in the manual that are amended follows.

Clinical Monitoring

A. Amendments

45. Exhibit 11 includes the language from the clinical monitoring portions of the March 17, manuals as amended by these findings.

a. The March 17 manuals for clinical monitoring and for the other 5 sections included in Exhibit 11 state that: "The medical record must include:" This lead-in statement has been changed in each of the specific sections to read: "The medical record must establish that" "As noted in Findings 39 and 42, the purpose for the review of medical records by QA&R is to determine that the material contained in the medical record is sufficient to verify the claims made on the assessment form. As noted in Finding 42, the licensure and certification standards for nursing homes establish the regulatory requirements governing the contents of medical records maintained in these facilities. The amendment to

these lead-in phrases more clearly recognizes the fact that the medical record must establish the claims asserted on the assessment form without creating an implication that additional documentation must be included in the medical records for the purposes of the Case-Mix Reimbursement System. Since the amendment merely provides clarification, I do not find that this amendment constitutes a substantial change in the manual provisions. It does not create additional responsibilities or change the subject matter of the rule, nor does the amendment change the effect of the manual provisions. As will be noted by a review of the amended portions of the manual, the change in the lead-in language also necessitated grammatical editing of the specific elements in each of the six categories to conform with the new language.

b. Item a. now reads as follows:

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

The amendment deleted the first three words requiring "a statement by"; deleted the phrase requiring periodic reassessment from this item (see new item f.) and added the phrase "for which clinical monitoring is needed." The first three words of this item were deleted to conform with the change made in the lead-in statement. The amendment will require that the medical record establish that the physician has identified the medically unstable condition. The inclusion of the phrase "for which clinical monitoring is needed" provides an essential element of clarification which was implied in the original manual provision. I find that it is necessary to provide this element of clarification. The inclusion of this phrase does not create new subject matter nor make a major

change in the rule, and, therefore, does not constitute a substantial change.

c. Item b. now reads as follows:

b.) a registered nurse has completed an assessment identifying the high risk condition(s);

This item was amended by the addition of the phrase "has completed an assessment." The original version required the identification of high risk factors by a registered nurse. Such an identification would need to be based on an assessment completed by the registered nurse. I find that the addition of this phrase provides clarification and does not expand on what would have been required under the original manual language. The restructuring of the wording of this section follows the changes made in the lead-in phrase.

d. Item c now reads as follows:

c.) a written plan for clinical monitoring has been developed;

The addition of the word "written" merely adds clarification to this element. The original language of the manual would have required that the plan be in writing since it needed to be included in the medical record. The other changes in this item also were done to conform with the lead-in language change. I find that these changes are not substantial since they provide necessary clarification to the rule, and do not impose any additional requirements not intended by the original language.

e. The changes made in item d were made to conform with the style of the new lead-in language by indicating that the "medical record must establish that:, systematically recorded measurements. have been made." These changes do not alter the substance of this element.

f. Item e has also been changed to conform to the style of the lead-in language and now reads:

> e.) the clinical monitoring data has been interpreted by a registered nurse and communicated to the physician.

These changes do not change the substance of the original language nor do the changes create new responsibilities.

g. The new item f. is based on the provisions originally contained in item a, requiring ongoing physician review.

This items reads:

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

Structural changes were made in this section to conform to the new lead-in language. The requirement that the periodic reassessment be documented by the physician was part of the original manual provision. An additional phrase

"documented the need for continued clinical monitoring" has been included. I rind that this phrase also provides necessary clarification. The review of the residents medical status must include an assessment of the condition of the resident, the types of treatments being provided and a decision by the physician as to whether these treatments should be stopped, continued or modified. I find that the specific requirement asking the physician to determine whether the clinical monitoring procedures should be continued is not an additional responsibility beyond what would be considered during the periodic reassessment of the resident's condition. For that reason, I find that the addition of this phrase is not a substantial change.

h. As has been noted above, the changes made in the clinical monitoring portion of the manual have added needed clarification to the requirements or have been required by the change in the lead-in sentence. These changes do not alter the requirements contained in the original portion of the manual nor do the changes create new subject matter of significant substantive effect. The changes clearly emphasize what the contents of the medical record must establish in order to support a claim that clinical monitoring is required. The changes do not affect classes of people differently from the previous language, do not make changes that were not raised by the original language of the rule nor result in language fundamentally different from the original rule. I find that a substantial change does not result from these amendments.

I also rind that the changes made are responsive to the concerns raised in the comments. The amended language focuses on the use of the medical record to verify the claims made on the assessment form. As has been previously mentioned, the amendments also respond to the issues relating to charting by

licensed practical nurses. Finally, the amendments in this section and in the other remaining manual sections provide for an orderly and consistent approach in implemention starting with the need assessment, the plan, monitoring the plan, and ongoing physician review and input. I also find that the amended portions of the manual do not create inconsistencies with the licensure and certification rules which establish medical record contents and establish time frames for physician and nurse reviews.

Wound Care/Decubiti

46.a. Amendments similar to those made for Clinical Monitoring were made for Wound Care/Decubiti. First, for reasons discussed under Finding 45, the lead-in language of this component was amended to read, "the medical record must establish that." Second, the amended language requires a "written" wound treatment plan. As discussed earlier, such a requirement was implied but never stated, and therefore is not a substantial change. Third, for the same reasons as for Clinical Monitoring, and to be consistent with those provisions, item d, which relates to physician documentation, has been amended to include the phrase "determined the need for continued wound care."

b. Two additional changes have been made to Wound Care/Decubiti. One amendment allows either a physician or a registered nurse to document the presence of a wound. (Item a.) Previously, only the registered nurse was specifically identified as the person responsible for such documentation. Since physician documentation establishing the presence of a wound is also acceptable, the amendment removes any ambiguity from this item. The other amendment was made in response to comments which the Department

received related to licensed practical nurses. See Finding 40 for a complete discussion of the comments.

c. For reasons stated in Finding 45(h), I find that these amendments do not create a substantial change. As indicated, they do not impose new requirements, but merely clarify what is required. Finally, where changes were made for the purpose of consistency, the amendments have no impact upon the intent or meaning of the provisions.

Symptom Control for the Terminally Ill

47.a. The majority of the amendments to this portion of the manual also result from the change in the lead-in statement (Finding 45) and from comments received regarding charting by licensed practical nurses (Finding 40). The other change is in item d.. The original language has been deleted and replaced by the following:

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

The new language is consistent with the language contained in the other manual provisions. I find that this language does not consitute a substantial change from the proposed language of the manual. The original item d. required a physician assessment, the determination of the need for continued symptom control and physician reassessment. The new language focuses on the last two elements of the original language by requiring that the resident reassessment

look at the status of the resident's medical condition as it relates to the symptom control plan. The original element requiring a regular assessment of symptoms would be included in the development of the diagnosis.

b. Again, for the reasons addressed in Finding 45(h), I find that the changes made in this portion of the manual are not substantial changes. Different requirements have not been imposed on physicians as the result of these changes and the substance of the provision has not been modified.

Skin Care, Isolation Precautions and Behavior

48.a. The amendments to these three sections of the manual are similar. Those amendments are required as the result of the change in the lead-in statement indicating that the "medical record must establish that" (Finding 45); and on the comments received regarding the ability of licensed practical nurses to complete progress notes. (Finding 40)

b. In addition to the changes discussed above, item (a) of the skin care portion of the manual was amended to include the phrase "for which skin care is needed." This additional phrase provides clarification which was implied by the original language of this item. The original language required that the physician identify the medical condition or the registered nurse identify high risk factors. When that entire section is reviewed, it is clear that the purpose for the identification of the medical condition or the high risk factors is to ascertain the reason why a resident is in need of skin care. The addition of this phrase does not create any additional responsibilities. Item (b) of the skin care portion of the manual was deleted since the identification of high

risk factors by a registered nurse would require a nursing assessment. Thus item (b) was (a) duplicate requirement that is not needed in the rule. The last change in this portion of the manual was the addition of the word "written" in item c. As noted in the discussion of the clinical monitoring portion, this additional word was clearly implied by the original language.

c. The isolation precaution portion of the manual also contained additional minor changes not addressed in paragraph a., above. Item (a) of that provision was amended by the addition of the phrase "infectious agent." This addition was suggested in comments received by MNA and by MAHCF. The need to initiate isolation precautions could result from the exposure to an infectious agent and this amendment would be consistent with infection control procedures in health care facilities. This amendment does not expand the scope of the original rule or create additional responsibilities for facilities. Item c. has been deleted from this section since the scope of this provision is similar to item b. In addition, the primary focus of this portion is on the provision of the isolation precautions and not the resident's response to those precautions. This deletion does not modify the substance of the rule. The last change in this section is in item c, where the word "medical" and the phrase" as it relates to the need for isolation precautions" has been added. This item addresses the physician's periodic reassessment and, for the reasons stated in the clinical monitoring discussion, (Finding 45.g.), the additional phrase provides clarification and does not impose additional duties on the physician. The periodic reassessment by the physician would take into consideration the need for continued isolation precautions. The word "medical" also provides clarification that the "medical condition" of the resident is to be reassessed.

d. The only addition to Behavior that was not addressed by the changes referenced in paragraph a, above is found in item b. The words "these findings" have been added to that part. I find that this also adds clarification to this item since it states that the "findings" of the behavior assessment are to communicated to the physician.

e. For the reasons discussed in paragraph 45.h., I find that the amendments to these three portions of the manuals do not constitute a substantial change.

Based upon the foregoing Findings of Fact, I make the following:

CONCLUSIONS

1. That the Department gave proper notice concerning the adoption of the proposed temporary rule amendments.

2. That the Department has fulfilled the procedural requirements contained in Minn. Stat. section 245B.431, subd. 6, as amended, and the provisions of Minn. Stat. section 14.29 to 14.36 in effect on March 1, 1984.

3. That the Department has the statutory authority to adopt these rule amendments.

4. That the proposed rule amendments are needed and reasonable.

5. That any Findings which might properly be termed Conclusions and any

Conclusions which might properly be termed Findings are hereby adopted as such.

Based upon the foregoing Findings of Fact and Conclusions, the Commissioner issues the attached Order.

NOW, THEREFORE, IT IS ORDERED

that these rules, identified as Minnesota Rules, parts 4656.0010 to 4656.0100 (Temporary) as modified are adopted this 15th day of May, 1986, pursuant to the authority vested in me by Minnesota Statues, section 256B.431, subd. 6 as amended.

STATE OF MINNESOTA

Sr. Mary Madonna Richter

Commissioner of Health

SF-00006-03

STATE MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO: SISTER MARY MADONNA ASHTON
Commissioner of Health

ATTN: JOHN A BREVIU
Special Assistant Attorney General

DATE: 5/23/86

FROM: MARTHA J. CASSERLY
Special Assistant Attorney General

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of Rules Relating to Review of Care and Classification of Residents In Facilities Participating in the Medical Assistance Program

The above-referenced rule has been approved as to its legality by the Attorney General on May 22, 1986.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies of the approved rule with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth copy is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

MJC:pmf

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

Duane Harves
Chief Administrative Law Judge
Office of Administrative Hearings

RR1277

Minnesota Nurses Association
1821 UNIVERSITY AVENUE, SUITE N-377
ST. PAUL, MINNESOTA 55104
(612) 646-4807

RECEIVED
MAY 22 1986
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

May 22, 1986

The Office of the Attorney General
204 Administration Building
50 Sherburne Avenue
Saint Paul, Minnesota 55155

RE: Minnesota Department of Health

In the Matter of the Proposed Adoption of the Rule relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

ANNUAL RESIDENT ASSESSMENT

The Minnesota Nurses Association (MNA) is objecting to the findings by the Minnesota Department of Health (MDH) relative to section 4656.0030 - annual resident assessment. We contend that the legal rationale for the findings in item 28 is inappropriate, and that the rule be amended as we originally requested.

In item 28, MDH states that the MNA is requesting that the assessment forms for the federal inspection of care and for the facility review be completed only by the Quality Assurance and Review (QA & R) R. N. MNA's request does not relate to MDH's current responsibility to conduct federal inspection of care according to federal regulations, 42 C. F. R., sections 456.600 - 456.614!

Rather, MNA requested that language be inserted that requires the R. N. member of the MDH QA & R team to conduct the annual resident assessments for assignment of case mix reimbursement classifications.

As noted in the findings on page 12, the state QA & R case mix responsibilities are separate from the federal inspection of care regulations and thus have different legal purposes.

- 5-23-86
- talked w/ G. Goetzke - Fed language RN to perform assessment as well Social worker + dr, MDH does not want to add suggested language bc it could be construed to narrow Fed/law
- approved rule - objection is policy concern agency had demonstrated findings

MDH's reliance on Federal Regulations 42 C. F. R., 456.600 - 456.614 is inappropriate as these federal regulations do not address the issue of who does the assessment for case mix. That decision is within the purview of state law and rules. We find our request consistent with the current MDH case mix rule as well as requirements in the Department of Human Services Nursing Home Payment Rule, Section 9549.0059 and Minnesota Statutes 256B.091 that consistently require an R. N. to conduct resident assessments.

Language that would meet our request is: (4656.0030) "A registered nurse shall perform the assessment on each resident according to the QAR procedures of the department including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care and shall record the assessment on the assessment form defined ...."

QUALITY ASSURANCE AND REVIEW MANUAL

In section 46, MDH notes that amendments made under wound care/ decubiti are "similar" to those made for clinical monitoring. We disagree with this as the concept embodied in item "e" under Clinical Monitoring, Exhibit 11, which states "the clinical monitoring data has been interpreted by a registered nurse and communicated to the physician" is absent from wound care/decubiti. It is our opinion that a similar statement needs to be added to wound care/decubiti in order for both to be considered similar. The item related to skin care does not contain such a statement either and adding one would create consistency with clinical monitoring.

Please forward a copy of the attorney general's decision upon completion. We thank you for consideration of our requests.

Sincerely,

Mary T. Absolon, RN, MSN
Staff Specialist
Governmental Affairs

Kathleen Cota, RN, JD
Associate Executive Director
Policy Analysis and Advocacy

Association Legal Counsel

cc: Gary A. Goetzke
Fran Bly, RN

MTA/KC:hc

→ policy concern - tq has no juris
→ while could be clearer - not ambig

Department of Health

Adopted Temporary Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

Rules as Adopted, Temporary

4656.0010 [Temporary] SCOPE.

Parts 4656.0010 to 4656.0100 [Temporary] establish procedures to review the appropriateness of care and services furnished to residents of facilities participating in the medical assistance program, and for the assessment and classification of residents of nursing homes and boarding care homes participating in the medical assistance program to determine the operating cost payment rates for all nursing homes and boarding care homes participating in the medical assistance program under Minnesota Statutes, sections 256B.41 to 256B.48 and parts 9549.0050 to 9549.0059 [Temporary].

4656.0020 [Temporary] DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 4656.0010 to 4656.0100 [Temporary] the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the department's quality assurance and review program and used for performing resident assessments.

Subp. 3. **Department.** "Department" means the Minnesota Department of Health.

Subp. 3a. **Guideline for Isolation Precautions in Hospitals.** "Guideline for Isolation Precautions in Hospitals" means the guidelines written by Julia S. Garner, RN, MN 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. The guidelines are incorporated by reference. They are available at the Ford Law

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Library, 117 University Avenue, Saint Paul, MN 55155, and through the minitex interlibrary loan system. This material is not subject to frequent change.

Subp. 4. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatments and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures and discharge potential.

Subp. 5. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 5a. **Resident.** "Resident" means an individual residing in a facility certified to participate in the medical assistance program.

Subp. 6. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 7. **Resident plan of care.** "Resident plan of care" for residents of nursing homes means the patient care plan specified in part 4655.6000. Resident plan of care for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319 (as amended through December 31, 1984).

Subp. 7a. **Resident record.** "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident 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, consultation, and other services;

F. a copy of any transfer data provided to another health care facility; and

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G. a discharge summary.

Subp. 7b. **Review team.** "Review team" means the inspection team described by Code of Federal Regulations, title 42, section 456.602, as amended through December 31, 1984.

4656.0030 [Temporary] ANNUAL RESIDENT ASSESSMENT.

The department shall conduct annual assessments of all residents in each nursing home and boarding care home participating in the medical assistance program to determine the appropriateness and quality of care and services furnished to these residents. The assessments must be conducted in accordance with the inspection of care requirements established by Code of Federal Regulations, title 42, sections 456.600 to 456.614, as amended through December 31, 1984. However, those provisions regarding recommendations for changes in the level of care provided shall not apply to private paying residents.

4656.0040 [Temporary] PROCEDURES FOR ASSESSMENTS.

When performing assessments in accordance with part 4656.0030 [Temporary], team reviewers shall follow the assessment procedures and requirements established in the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications. The ~~March 17~~ May, 1986, version of the manual, excluding the attachments, is incorporated by reference. This manual is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change.

4656.0050 [Temporary] ADDITIONAL REQUIREMENTS FOR ASSESSING MENTALLY RETARDED RESIDENTS.

Subpart 1. **Active treatment.** Residents of intermediate care facilities for the mentally retarded (ICF/MR) shall be provided active treatment in accordance with the requirements established by Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Subp. 2. **Individualized program plan.** For the purpose of

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determining active treatment under this part, individual program plan means the individual written plan of care described under Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Team reviewers shall use the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications, to review the individual program plan for the purpose of determining the quality and adequacy of the facility's in-house current individual program and the programs and services being provided to the resident outside the facility.

4656.0060 [Temporary] LEVELS OF CARE.

Team reviewers shall base level of care recommendations upon the following categories:

A. skilled nursing care facility services, as defined by Code of Federal Regulations, title 42, section 440.40(a), as amended through December 31, 1984;

B. intermediate care facility services, including ICF I, ICF II, and ICF/MR, as defined by Code of Federal Regulations, title 42, section 440.150, as amended through December 31, 1984;

C. inpatient hospital services, including services as defined by Code of Federal Regulations, title 42, sections 440.10 and 440.140, as amended through December 31, 1984, and services provided in specialty hospitals;

D. inpatient psychiatric services for individuals under 21 years of age, as defined by Code of Federal Regulations, title 42, section 440.160, as amended through December 31, 1984;

E. mental hospitals, including hospitals that are licensed in accordance with Minnesota Statutes, sections 144.50 to 144.56, and meet the requirements of parts 4640.3600 to 4640.4300;

F. home or community-based services as defined by Code of Federal Regulations, title 42, section 440.180, as amended through December 31, 1984; and

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

G. semi-independent living services or SILS, which is a system of services that includes training, counseling, instruction, supervision, and assistance provided in accordance with the client's individual program plan. Services may include assistance in budgeting, meal preparation, shopping, personal appearance, counseling, and related social support services needed to maintain and improve the client's functioning. The services shall not extend to clients needing 24-hour per day supervision and services. Persons needing a 24-hour per day program of supervision and services shall not be accepted or retained in a semi-independent living service.

CASE MIX REIMBURSEMENT

4656.0070 [Temporary] CLASSIFICATION AND NOTIFICATION OF ANNUAL RESIDENT ASSESSMENTS.

Subpart 1. **Written notice.** Within 15 working days of receiving assessment documents submitted in accordance with part 4656.0030 [Temporary], the department shall classify each resident into one of the resident classes prescribed by part 9549.0058 [Temporary], subpart 1, item F, and mail a written notice of the classification to the resident and the nursing home or boarding care home in which the resident resides. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the department's documents supporting the classification and request a reconsideration of the classification.

Subp. 2. **Classification letter.** The nursing home or boarding care home must provide each resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home or boarding care home. If the resident's classification has changed, the nursing home or boarding care home must include the current rate for the new classification with the classification letter.

4656.0080 [Temporary] REVIEW AND CLASSIFICATION OF FACILITY AND

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PREADMISSION SCREENING ASSESSMENTS.

Subpart 1. **Assessment procedures.** Assessments which are performed in accordance with part 9549.0059 [Temporary] must be completed by following the assessment procedures and requirements established in the ~~March 17~~ May, 1986, version of the Facility Manual for Completing Case Mix Requests for Classification. This manual, excluding the attachments, is incorporated by reference and is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change.

Subp. 2. **Classification.** Within 15 working days of receiving each request for classification submitted in accordance with part 9549.0059 [Temporary], the department shall classify the resident into one of the resident classes established in accordance with part 9549.0058 [Temporary] or notify the individual completing the assessment or the nursing home or boarding care home furnishing the documentation of the need to submit additional information necessary for determining the classification.

Subp. 3. **Notification of classification.** Within 15 working days of receiving a complete and accurate request for classification, the department shall mail a written notice of the resident's classification to the resident and the resident's nursing home or boarding care home. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the Department of Health's documents supporting the classification and the right to request a reconsideration of the classification.

Subp. 4. **Classification letter.** The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the

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classification letter.

4656.0090 [Temporary] REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION.

Subpart 1. **Reconsideration permitted.** A nursing home or a boarding care home, a resident, or the resident's authorized representative may request that the department reconsider the classification.

Subp. 2. **Request for reconsideration.** A reconsideration request must be in writing and submitted to the department within ten working days of receiving the notice of the resident's classification. Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that the needs identified in the assessment require a different resident classification than the classification assigned by the department. The nursing home or boarding care home shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests the reconsideration of a resident's classification, the facility must provide written notice to the resident or the person responsible for payment on the date the request is submitted to the department. The notice to the resident or the person responsible for payment must contain the information provided to the department that supports the request for reconsideration.

Subp. 3. **Review of requests and notification.** The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home by letter of the classification within 20 working days.

Subp. 4. **Status of initial classification.** The resident

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classification established by the department must be the classification that applies to the resident while the request for reconsideration is pending.

Subp. 5. **Additional information.** The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

4656.0100 [Temporary] AUDITS OF ASSESSMENTS OF NURSING HOME RESIDENTS.

Subpart 1. **Audits required.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 [Temporary] through desk audits and on-site reviews of residents and their records. The department shall reclassify a resident it determines to have been incorrectly assessed.

Subp. 2. **Audit reclassification.** Within 15 working days of a reclassification required by subpart 1, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification, the opportunity to review the Department of Health's documents supporting the classification, and the right of the resident, the resident's authorized representative, or the facility to request reconsideration of the classification.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
MAY 23 1986
Joan Anderson Growe
Secretary of State
9:41 AM

APPROVED AS TO FORM AND LEGALITY
May 22 1986
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY MJ Casserly
SPECIAL ASSISTANT ATTORNEY GENERAL

AG copy

Department of Health

Adopted Temporary Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

Rules as Adopted, Temporary

4656.0010 [Temporary] SCOPE.

Parts 4656.0010 to 4656.0100 [Temporary] establish procedures to review the appropriateness of care and services furnished to residents of facilities participating in the medical assistance program, and for the assessment and FF25 classification of residents of nursing homes and boarding care homes participating in the medical assistance program to determine the operating cost payment rates for all nursing homes and boarding care homes participating in the medical assistance program under Minnesota Statutes, sections 256B.41 to 256B.48 and parts 9549.0050 to 9549.0059 [Temporary].

4656.0020 [Temporary] DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 4656.0010 to 4656.0100 [Temporary] the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the department's quality assurance and review program and used for performing resident assessments.

Subp. 3. **Department.** "Department" means the Minnesota Department of Health.

Subp. 3a. **Guideline for Isolation Precautions in Hospitals.** "Guideline for Isolation Precautions in Hospitals" means the guidelines written by Julia S. Garner, RN, MN 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. The guidelines are incorporated by reference. They are available at the Ford Law

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Subp. 4. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatments and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures and discharge potential.

Subp. 5. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 5a. **Resident.** "Resident" means an individual residing in a facility certified to participate in the medical assistance program.

Subp. 6. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 7. **Resident plan of care.** "Resident plan of care" for residents of nursing homes means the patient care plan specified in part 4655.6000. Resident plan of care for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319 (as amended through December 31, 1984).

Subp. 7a. **Resident record.** "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident 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, consultation, and other services;

F. a copy of any transfer data provided to another health care facility; and

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

G. a discharge summary.

Subp. 7b. **Review team.** "Review team" means the inspection team described by Code of Federal Regulations, title 42, section 456.602, as amended through December 31, 1984.

4656.0030 [Temporary] ANNUAL RESIDENT ASSESSMENT.

The department shall conduct annual assessments of all residents in each nursing home and boarding care home participating in the medical assistance program to determine the appropriateness and quality of care and services furnished to these residents. The assessments must be conducted in accordance with the inspection of care requirements established by Code of Federal Regulations, title 42, sections 456.600 to 456.614, as amended through December 31, 1984. However, those provisions regarding recommendations for changes in the level of care provided shall not apply to private paying residents.

4656.0040 [Temporary] PROCEDURES FOR ASSESSMENTS.

When performing assessments in accordance with part 4656.0030 [Temporary], team reviewers shall follow the assessment procedures and requirements established in the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications. The ~~March 17~~ May, 1986, version of the manual, excluding the attachments, is incorporated by reference. This manual is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change. FF31

4656.0050 [Temporary] ADDITIONAL REQUIREMENTS FOR ASSESSING MENTALLY RETARDED RESIDENTS.

Subpart 1. **Active treatment.** Residents of intermediate care facilities for the mentally retarded (ICF/MR) shall be provided active treatment in accordance with the requirements established by Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Subp. 2. **Individualized program plan.** For the purpose of

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

determining active treatment under this part, individual program plan means the individual written plan of care described under Code of Federal Regulations, title 42, section 435.1009, as amended through December 31, 1984.

Team reviewers shall use the Inspection of Care Instruction Manual: with Procedures for Completing Case Mix Requests for Classifications, to review the individual program plan for the purpose of determining the quality and adequacy of the facility's in-house current individual program and the programs and services being provided to the resident outside the facility.

4656.0060 [Temporary] LEVELS OF CARE.

Team reviewers shall base level of care recommendations upon the following categories:

A. skilled nursing care facility services, as defined by Code of Federal Regulations, title 42, section 440.40(a), as amended through December 31, 1984;

B. intermediate care facility services, including ICF I, ICF II, and ICF/MR, as defined by Code of Federal Regulations, title 42, section 440.150, as amended through December 31, 1984;

C. inpatient hospital services, including services as defined by Code of Federal Regulations, title 42, sections 440.10 and 440.140, as amended through December 31, 1984, and services provided in specialty hospitals;

D. inpatient psychiatric services for individuals under 21 years of age, as defined by Code of Federal Regulations, title 42, section 440.160, as amended through December 31, 1984;

E. mental hospitals, including hospitals that are licensed in accordance with Minnesota Statutes, sections 144.50 to 144.56, and meet the requirements of parts 4640.3600 to 4640.4300;

F. home or community-based services as defined by Code of Federal Regulations, title 42, section 440.180, as amended through December 31, 1984; and

APPROVED BY THE
REVISOR OF STATUTES
OFFICE BY:

G. semi-independent living services or SILS, which is a system of services that includes training, counseling, instruction, supervision, and assistance provided in accordance with the client's individual program plan. Services may include assistance in budgeting, meal preparation, shopping, personal appearance, counseling, and related social support services needed to maintain and improve the client's functioning. The services shall not extend to clients needing 24-hour per day supervision and services. Persons needing a 24-hour per day program of supervision and services shall not be accepted or retained in a semi-independent living service.

CASE MIX REIMBURSEMENT

4656.0070 [Temporary] CLASSIFICATION AND NOTIFICATION OF ANNUAL RESIDENT ASSESSMENTS.

Subpart 1. **Written notice.** Within 15 working days of receiving assessment documents submitted in accordance with part 4656.0030 [Temporary], the department shall classify each resident into one of the resident classes prescribed by part 9549.0058 [Temporary], subpart 1, item F, and mail a written notice of the classification to the resident and the nursing home or boarding care home in which the resident resides. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the department's documents supporting the classification and request a reconsideration of the classification.

Subp. 2. **Classification letter.** The nursing home or boarding care home must provide each resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home or boarding care home. If the resident's classification has changed, the nursing home or boarding care home must include the current rate for the new classification with the classification letter.

4656.0080 [Temporary] REVIEW AND CLASSIFICATION OF FACILITY AND

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

PREADMISSION SCREENING ASSESSMENTS.

Subpart 1. **Assessment procedures.** Assessments which are performed in accordance with part 9549.0059 [Temporary] must be completed by following the assessment procedures and requirements established in the ~~March 17~~ May, 1986, version of the Facility Manual for Completing Case Mix Requests for Classification. This manual, excluding the attachments, is incorporated by reference and is available at the Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155 and through the minitex interlibrary loan system. This material is not subject to frequent change.

FF31

Subp. 2. **Classification.** Within 15 working days of receiving each request for classification submitted in accordance with part 9549.0059 [Temporary], the department shall classify the resident into one of the resident classes established in accordance with part 9549.0058 [Temporary] or notify the individual completing the assessment or the nursing home or boarding care home furnishing the documentation of the need to submit additional information necessary for determining the classification.

Subp. 3. **Notification of classification.** Within 15 days of receiving a complete and accurate request for classification, the department shall mail a written notice of the resident's classification to the resident and the resident's nursing home or boarding care home. The written notice must specify that the resident or the resident's authorized representative and the nursing home or boarding care home have the right to review the Department of Health's documents supporting the classification and the right to request a reconsideration of the classification.

? appears to conflict with subp 2 - "working" days.

NW checked w/ MDH - Yes, should be "working"

Subp. 4. **Classification letter.** The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter within five days of the receipt of the classification letter by the nursing home. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

4656.0090 [Temporary] REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION.

Subpart 1. **Reconsideration permitted.** A nursing home or a boarding care home, a resident, or the resident's authorized representative may request that the department reconsider the classification.

Subp. 2. **Request for reconsideration.** A reconsideration request must be in writing and submitted to the department within ten working days of receiving the notice of the resident's classification. Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that the needs identified in the assessment require a different resident classification than the classification assigned by the department. The nursing home or boarding care home shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests the reconsideration of a resident's classification, the facility must provide written notice to the resident or the person responsible for payment on the date the request is submitted to the department. The notice to the resident or the person responsible for payment must contain the information provided to the department that supports the request for reconsideration.

Subp. 3. **Review of requests and notification.** The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home by letter of the classification within 20 working days.

Subp. 4. **Status of initial classification.** The resident classification established by the department must be the

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OFFICE BY:

classification that applies to the resident while the request for reconsideration is pending.

Subp. 5. **Additional information.** The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

4656.0100 [Temporary] AUDITS OF ASSESSMENTS OF NURSING HOME RESIDENTS.

Subpart 1. **Audits required.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 [Temporary] through desk audits and on-site reviews of residents and their records. The department shall reclassify a resident it determines to have been incorrectly assessed.

Subp. 2. **Audit reclassification.** Within 15 working days of a reclassification required by subpart 1, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification, the opportunity to review the Department of Health's documents supporting the classification, and the right of the resident, the resident's authorized representative, or the facility to request reconsideration of the classification.

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

EXHIBIT 1.

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinions from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Health
Health Resources Division

Outside Opinion Sought Concerning Rules Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program

Notice is hereby given that the Minnesota Department of Health plans to adopt amendments to Emergency Rule parts 4656.0010 to 4656.0070 relating to the review of care and classification of residents in facilities participating in the medical assistance program. Promulgation of these amendments is dependent on passage of legislation which has been introduced in the legislature to extend Emergency Rule parts 4656.0010 to 4656.0070. If the legislation does not pass, the department will discontinue the amendment process and continue the permanent rule-making process.

Emergency Rule parts 4656.0010 to 4656.0070 are authorized by Minnesota Statutes, section 256B.431, subdivision 6.

All interested or affected persons or groups are requested to participate. Statements of information and comments may be made orally or in writing. Written statements may be addressed to:

Gary A. Goetzke
Quality Assurance and Review
Minnesota Department of Health
717 Delaware Street S.E.
P.O. Box 9441
Minneapolis, Minnesota 55440

Oral statements of information and comments will be received over the phone at 612/623-5627 between 8:00 a.m. and 4:30 p.m. Monday through Friday.

Statements of information and comments will be received until March 7, 1986. Any written material received by the Department in response to this notice will become a part of the rule record.

Department of Human Services

Hospital Cost Index

Pursuant to Minnesota Rules, Part 9500.1120 hospitals participating in the Medical Assistance and General Assistance Medical Care programs are subjected to a Health Cost Index (HCI) that is used in the determination of prospective inpatient hospital rates. Each hospital whose fiscal year starts during a given calendar quarter shall be notified of the HCI to be used 30 days prior to the start of that quarter. It has been determined that the HCI is 4.0 percent according to an independent source, Data Resources, Inc. for Health Care Costs for hospitals whose fiscal years begin during the calendar quarter beginning April 1, 1986.

Leonard W. Levine
Department of Human Services

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

EXHIBIT 2.

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

IN THE MATTER OF THE PROPOSED
ADOPTION OF TEMPORARY RULES
RELATING TO REVIEW OF CARE AND
CLASSIFICATION OF RESIDENTS IN
FACILITIES PARTICIPATING
IN THE MEDICAL ASSISTANCE PROGRAM

ORDER FOR PUBLICATION
OF TEMPORARY RULE
AMENDMENTS

It is ordered this 24th day of March, 1986 that the proposed temporary rule amendments in the above-entitled matter be published in the State Register.

Dated:

State of Minnesota

Sister Mary Madonna Ashton
Commissioner of Health

EXHIBIT 4.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED
ADOPTION OF TEMPORARY RULE
AMENDMENTS RELATING TO
REVIEW OF CARE AND CLASSIFICATION
OF RESIDENTS IN FACILITIES PARTIC-
IPATING IN THE MEDICAL ASSISTANCE
PROGRAM

AFFIDAVIT OF MAILING
NOTICE OF PROPOSED ADOPTION
OF TEMPORARY RULE AMENDMENTS

STATE OF MINNESOTA)
) s.s.
COUNTY OF HENNEPIN)

Gary A. Goetzke, being first duly sworn, deposes and says:

That on the 27th day of March 1986, in the City of Minneapolis, County of Hennepin, State of Minnesota, he served the attached Notice of Proposed Adoption of Temporary Rule Amendments by depositing in the United States mail at said City of Minneapolis, a copy thereof, properly enveloped, with postage prepaid, to all facilities participating in the Minnesota Medicaid Program.

Gary Goetzke

Subscribed and sworn to before me
this 28th day of March 1986.

Evelyn I. Costello
Notary Public

EVELYN I. COSTELLO
NOTARY PUBLIC - MINNESOTA
ANOKA COUNTY
MY COMMISSION EXPIRES 1-21-87

EXHIBIT 6.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED
ADOPTION OF TEMPORARY RULE
AMENDMENTS RELATING TO
REVIEW OF CARE AND CLASSIFICATION
OF RESIDENTS IN FACILITIES PARTIC_
IPATING IN THE MEDICAL ASSISTANCE
PROGRAM

AFFIDAVIT OF MAILING
NOTICE OF PROPOSED ADOPTION
OF TEMPORARY RULE AMENDMENTS

STATE OF MINNESOTA)
) s.s.
COUNTY OF HENNEPIN)

Rebecca Corey, being first duly sworn, deposes and says:

That on the 31st day of March 1986, in the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Proposed Adoption of Temporary Rule Amendments by delivering to the Senate Mail Room, B-40 Capitol Building, St. Paul, Minnesota 55155, and to the House Mail Room, B-50, State Office Building, St. Paul, Minnesota 55155, a copy thereof, to all Minnesota Senate and House Members.

Rebecca Corey

Subscribed and sworn to before me
this 31st day of March 1986.

EVELYN I. COSTELLO
NOTARY PUBLIC - MINNESOTA
ANOKA COUNTY
MY COMMISSION EXPIRES 1-21-87

Evelyn I. Costello

Notary Public

EXHIBIT 3.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED
ADOPTION OF TEMPORARY RULE
AMENDMENTS RELATING TO
REVIEW OF CARE AND CLASSIFICATION
OF RESIDENTS IN FACILITIES PARTIC-
IPATING IN THE MEDICAL ASSISTANCE
PROGRAM

AFFIDAVIT OF MAILING
NOTICE OF PROPOSED ADOPTION
OF TEMPORARY RULE AMENDMENTS

STATE OF MINNESOTA)
) s.s.
COUNTY OF HENNEPIN)

Gary A. Goetzke, being first duly sworn, deposes and says:

That on the 25th day of March 1986, in the City of Minneapolis, County of Hennepin, State of Minnesota, he served the attached Notice of Proposed Adoption of Temporary Rule Amendments by depositing in the United States mail at said City of Minneapolis, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who requested notice of any rulemaking proceedings, as required by Minnesota Statutes, section 14.30.

Gary Goetzke

Subscribed and sworn to before me
this 25th day of March 1986.

Notary Public

EVELYN I. COSTELLO
NOTARY PUBLIC - MINNESOTA
ANOKA COUNTY
MY COMMISSION EXPIRES 1-21-87

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

IN THE MATTER OF THE PROPOSED
ADOPTION OF TEMPORARY RULES
RELATING TO REVIEW OF CARE
AND CLASSIFICATION OF RESIDENTS
IN FACILITIES PARTICIPATING IN
THE MEDICAL ASSISTANCE PROGRAM.

CERTIFICATION

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, that their names be placed on file with, and maintained by, the Minnesota Department of Health for the purpose of receiving notice of rule hearings, is accurate and complete as of 10:00 a.m., this 31st day of March, 1986.

D. H. Woodard

D. H. Woodard
Minnesota Department of Health

Michael J. Ahern
Moss and Barnett
1200 Pillsbury Center
Minneapolis, MN 55402

Alpha Homes, Inc.
P.O. Box 487
Spicer, MN 56288

Donna M. Anderson
Dakota County Community Health Services
Human Services Building
1600 Highway 55
Hastings, MN 55033

Herbert Anderson
418 Eighth Street South
Virginia, MN 55792

James F. Andre, City Manager
City of Roseville
2660 Civic Center Drive
Roseville, MN 55113

Anoka County Health Department
c/o Robert M. Hutchison
Courthouse - Fourth Floor
Anoka, MN 55303

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MN Manufactured Housing Association
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St. Paul, MN 55117

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Southwestern Mental Health Center
P.O. Box D
Luverne, MN 56156

Assisi Residences of Faribault County, Inc.
218 South Linton
Blue Earth, MN 56013

Association for Retarded Citizens of Olmsted County
903 West Center
Rochester, MN 55902

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President-elect, MN Psychiatric Society
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and Social Service Department
Anoka County Courthouse - Fourth Floor
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South St. Paul, MN 55075

Jean Dawson
Minnesota Government Report
Room B-28, Press Room, State Capitol
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United Way of Minneapolis
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Minnesota AFL-CIO
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Harry Meyering Center
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Mankato, MN 56001

Gail Lee
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Virgil H. Lee, R.Ph.
St. Mary's Hospital -
Pharmacy Services
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Northern States Power Company
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Georgianne Lowney
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Waconia, MN 55387

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City of Minneapolis
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Minneapolis, MN 55415

Mary Luth
Washington County Public Health
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Minnetonka, MN 55345-0249

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Region 9 Development Commission
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Nurse Manager - Crisis Intervention Unit
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D. Bill Olson
P.O. Box 123
Windom, MN 56101

Olson Well Service
Donald Olson
Halstad, MN 56548

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Minnesota Chiropractic Association
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Texasgulf Minerals and Metals, Inc.
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Golden, CO 80403

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The Residence, Inc.
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State Planning Agency
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South Center Manor
Park Island
Center City, MN 55012

Valley Group Home
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Moorhead, MN 56560

Mark Wiger
801 Center Street
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State and Federal Association
Regulatory Services Division
1110 Vermont Avenue Northwest #110
Washington, D.C. 20005

James Varpness, State Ombudsman
MN Board on Aging
204 Metro Square Building
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Michael A. Steffel
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Terri Williams
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Suite 195
Brooklyn Center, MN 55430

Linda Stratton
Metropolitan Senior Federation
1885 University Avenue
St. Paul, MN 55104

W. C. Viitala
Public Affairs Department
Honeywell
P.O. Box 524
Minneapolis, MN 56267

H. A. Swift
5165 North St. Albans
St. Paul, MN 55126

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES RELATING TO REVIEW OF CARE AND CLASSIFICATION OF RESIDENTS IN FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedue Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

John A. Breviu

Special Assistant
Attorney General

STATE OF MINNESOTA

COUNTY OF HENNEPIN

AFFIDAVIT OF MAILING THE NOTICE OF SUBMISSION OF TEMPORARY RULE TO THE ATTORNEY GENERAL

IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE RELATING TO REVIEW OF CARE AND CLASSIFICATION OF RESIDENTS IN FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM

H. Michael Tripple, being sworn says:

That on the 16th day of May, 1986, in the City of Minneapolis County of Hennepin, State of Minnesota, I mailed the attached Notice of Submission to the Attorney General by depositing in the United States mail, a copy thereof, with postage prepaid, to all persons and associations who requested notice that the rule in the above-entitled matter has been submitted to the Attorney General, and also to other interested parties as indicated by the attached mailing list.

H. Michael Tripple

Subscribed and sworn to before me
this 21st day of May, 1986

Frederick L. King

FREDERICK L. KING
NOTARY PUBLIC — MINNESOTA
WASHINGTON COUNTY
My commission expires Feb. 22, 1991

Beverly Enterprises
Ms. Fran Bly
500 Ford Road
Mpls, MN 55426

Ebenezer Society
Ms. Jeanette Metz
Luther Hall
2636 Park Avenue
Mpls, MN 55407

Fridley Convalescent Home
Mrs. Jacqueline Jedlicki
7590 Lyric Lane Northeast
Fridley, MN 55432

as requested

Good Neighbor Care Association
Ms. Mary Alcorn
2177 Youngman Avenue
St. Paul, MN 55116

Minnesota Association of Health Care Facilities
Ms. Sue Voight
2850 Metro Drive
Suite 429
Bloomington, MN 55420

as requested

Minnesota Association of Homes for the Aging
Mr. Darrell R. Shreve
Director of Research and Regulation
2221 University Avenue Southeast
Mpls, MN 55414-3085

Minnesota Nurse's Association
Ms. Mary Absolon
1821 University Avenue
St. Paul, MN 55104

STATE OF MINNESOTA

DEPARTMENT OF HEALTH

In the Matter of the Proposed Adoption of the Rule Relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program	NOTICE OF SUBMISSION OF TEMPORARY RULE TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.32:

PLEASE TAKE NOTICE that the above-captioned temporary rule as adopted has been submitted to the Office of the Attorney General on the date of this notice, May 16th, 1986, for review as to legality and form to the extent form relates to legality. The proposed temporary rule, the rule as adopted, all the notices, all written comments received and other required documents also have been submitted to the attorney general.

The proposed temporary rule which was published in the State Register and made available to the public on March 31, 1986, has been modified. A free copy of the temporary rule as modified as well as the findings of fact, conclusions, and order explaining the amendments and adopting the rule is available upon request from the Department of Health.

The rule and any modifications must be approved or disapproved by the Attorney General within five working days.
You may submit written comments directly to the Attorney General. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule.

You may receive a copy of the attorney general decision upon written request to the Attorney General. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
204 Administration Building
50 Sherburne Avenue
Saint Paul, Minnesota 55155
Telephone: (612) 296-1288

Any written comments submitted to the Attorney General should also be submitted simultaneously to:

Gary A. Goetzke
Quality Assurance and Review
Minnesota Department of Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, Minnesota 55440

Dated: May 16th

Sr. Mary Madonna Ashton
Sister Mary Madonna Ashton
Commissioner of Health

To: Marty.
Date: 5.20.86
Re: MDH – Classification of Residents in Facilities Participating in MA program

Rules as Adopted

p.6, line 21 .0080, subp. 3.

Gary Goetzke, MDH, agreed with me that "working" must be inserted between "15" and "days" to agree with "15 working days" period established in subpt. 2 above

Affidavit of Mailing Notice of Submission to Attorney General

MDH to submit ASAP

minnesota department of health
717 s.e. delaware st. p.o. box 9441 minneapolis 55440
(612) 623-5000

RECEIVED
MAY 16 1986
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

May 16, 1986

Office of the Attorney General
G-25 State Administration Building
50 Sherburne Avenue
St. Paul, MN 55155

Enclosed please find two copies of Minnesota Rule, parts 4656.0010 to 4656.0100 [Temporary] as modified as well as the findings of fact, conclusions, and order explaining the amendments and adopting the rule. Also enclosed are the proposed rule, all the notices, all written comments and other required documents.

We are requesting Attorney General review of this rule as to legality and form to the extent form relates to legality. The Department of Health nas promulgated this timporary rule in accordance with Minn. Stat., section 256B.431, subd. 6 which states in pertinent part as follows, "...any emergency rules adopted...under this section shall be adopted in accordance with the provisions contained in sections 14.29 to 14.36 in effect on March 1, 1984." Because of this requirement, our notice states that these rules will be approved or disapproved by your office within five working days.

Thank you in advance for your assistance on this matter.

Sincerely,

Gary Goetzke

Gary Goetzke

an equal opportunity employer

FACILITY MANUAL FOR COMPLETING

CASE MIX REQUESTS FOR CLASSIFICATION

QUALITY ASSURANCE AND REVIEW PROGRAM

MINNESOTA DEPARTMENT OF HEALTH
717 SOUTHEAST DELAWARE STREET
MINNEAPOLIS, MINNESOTA 55440

612/623-5312

MAY 1986

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INTRODUCTION

Minnesota Laws of 1985 established a new 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 Quality Assurance and Review Program (QA&R) or by the county pre-admission screening team.

This instruction manual outlines procedures for completing the assessments. Additional instructions regarding the case mix reimbursement systems are found in Minnesota Rules Parts 9549.0050 to 9549.0059 [Temporary] and Parts 4656.0010 to 4656.0100 [Temporary]. Further instructions for pre-admission screening teams are found in the December 1985 PAS/ACG Program policy and procedures manual.

All assessments are based on the Quality Assurance and Review procedures established by the Department of Health and must be recorded on the forms developed by the Quality Assurance and Review Program (See Attachment I for sample form).

All assessment forms are completed by RN's. All residents of certified nursing homes or boarding care homes, 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 QA&R program assigns the case mix classification for each assessment form completed. Each completed assessment form must be mailed to QA&R as a Request for Classification (RFC.) The facility must mail the original copy of the assessment form and the required documentation to QA&R. The 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 QA&R and provide the facility with the copy. The facility is responsible for completing the identification information, retaining a photo copy and mailing the original to QA&R. Facilities must not alter the assessment items completed by the pre-admission screening team.

All RFC's must include a Transmittal Sheet. The Transmittal Sheet provides space for facility identification and a re-order form for supplies. (See Attachment II for a sample.)

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

Quality Assurance and Review Program
717 Delaware Street S.E.
P.O. Box 9441
Minneapolis, Minnesota 55440

Upon receipt of the RFC, the MDH QA&R program will review the documentation and assessment form and will assign the classification. QA&R will also provide both the facility and the resident with a letter notifying them of the classification assigned. (See Attachment III for sample notification letter.)

See page 4 for the schedule for Requests for Classifications.

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 to QAR and carbon copy to facility. Facility completes items needed for resident identification, records Medical diagnoses, and attaches Medical Plan of Care Transmittal Sheet	Assessment must be done within 10 working days prior to admission or 10 working days after admission. Forms mailed to QAR within 5 working days of completion.	Date of Admission
New Admission (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Same as above	Date of Admission
Transfer from another facility (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Same as above	Date of Admission
Move between licensure levels within facility (Assessed by Facility)	Assessment form Resident's Plan of Care Transmittal Sheet	Same as above	Date of Admission
Readmission from the hospital (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Assessment completed and mailed to QAR within 5 working days	Date of Admission
Annual Inspection of Care (QAR Team Visit)	Assessment Form	Annually as scheduled by MDH	First day of the month following the day of the team exit
Semi Annual Assessment (Assessed by Facility)	Assessment form Resident's Plan of Care Transmittal Sheet with census on day assessments were completed. (Include explanation of any discrepancy between the daily census and number of assessments submitted.)	No earlier than 170 days and no later than 190 days after the most recent QAR 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

KEY DEFINITIONS

The following definitions are from Minnesota Rules Parts 4656.0010 to 4656.0100 and 4549.0050 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 diagnoses, 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 homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Resident record. "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident 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, consultation, and other services;

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, MN 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 Ford Law Library, 117 University Avenue, Saint Paul, MN 55155, and through the minitex interlibrary loan system.

GENERAL INSTRUCTIONS

FOR COMPLETING QA&R FORM

The Quality Assurance Review form is to be completed for each RFC (REQUEST FOR CLASSIFICATION).

The resident information portion will be completed with a ball point pen with black ink or typed. The resident information portion may be entered by any discipline in the facility.

The patient assessment and diagnoses list must be entered by a registered nurse.

The mark sense portion will be completed by marking a straight horizontal line in the center of the box using a number two lead pencil. The line should intersect the sides of the box but should not extend into the next box. Do not make any stray marks in this portion.

Corrections can be made in the mark sense boxes, using white correction fluid on the original. Redraw the box in pencil over the whiteout. The facility copy can be corrected in the same manner.

The CURRENT/ACTIVE DIAGNOSES portion should be completed with a ball point pen with black ink.

I. INSTRUCTIONS FOR RESIDENT INFORMATION PORTION



MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street, S.E., P.O. Box 9441
Minneapolis, Minnesota 55440
(612) 623-5312

1. CLAIMS PROCESSING DOCUMENT NO.

USE A # 2 PENCIL



QA REVIEW

▶ SEE INSTRUCTIONS IN QA REVIEW MANUAL FOR COMPLETING THIS REVIEW.

Except for summary data, the information requested on this form is classified private and shall not be disclosed except in accordance with Minn. Statutes sections 144.0721 and 13.46.

2. FACILITY NAME	3. FACILITY NO.	4. RECIPIENT'S NAME	
5. MEDICAL ASSISTANCE NUMBER	6. BIRTHDATE	7. SEX	8. LEVEL OF CARE
9. PROVIDER NO.	10. DATE ORIGINALLY ENTERED FACILITY	11. CASE OPEN DATE	

Block 1. CLAIMS PROCESSING DOCUMENT NUMBER
Enter the QA&R Location Code Number.

Block 2. Facility Name
Enter facility name as listed on current license. Nursing Home (NH) or Health Care Center (HCC) may be abbreviated.

Block 3. FACILITY NUMBER
Enter the Minnesota Department of Health facility identification number.

Block 4. RESIDENT'S NAME
Enter last name first, then first name and middle initial.

Block 5. MEDICAL ASSISTANCE NUMBER AND PRIVATE PAY CODES

MEDICAID RECIPIENTS

Enter 16 digit Medical Assistance Number for Medicaid residents.

Medicaid recipients from other states may have less than a 16 digit code. Enter the first three digits; enter the remainder of the number at the end of the digit field preceded by as many zeros as needed to complete the field.

Example: ND8464646464
ND8000046464646464

PRIVATE PAY RESIDENT

To arrive at a 16 digit number:

DIRECTION	EXAMPLE
Digits 1-3 Enter PSP (Primary Source of Payment)	PSP
Digit 4 Enter the appropriate code to indicate the type of PSP 1. Personal income or family support: includes personal income and savings, health insurance, retirement funds, and social security. 2. Medicare: includes money received under the Medicare program of health insurance for elderly and/or disabled persons (Title XVIII of the Social Security Act). 3. Other Government Assistance, includes sources of government assistance (federal, state or local) other than Medicare or Medicaid. 4. All other sources: includes religious organizations, foundations, volunteer agencies, Veterans Administration contracts, initial payment arrangements, life care arrangements, miscellaneous sources, and no-charge arrangements. 9. Unknown	PSP1 Personal income (could also be 2, 3,4 or 9) check guidelines for options.
Digits 5-7 Enter "SSA" when the resident has a social security number. Enter "XXX" when the resident does not have a social security number, including situations where a resident is receiving benefits and using their spouse's social security number.	EXAMPLE PSP1SSA Resident has a social security number. PSP1XXX Resident has no social security number or is receiving benefits from spouse's account.

Digits 8-16

Enter social security number for all residents who have social security numbers. When a resident does not have a social security number, but receives benefits from their spouse's number, enter their spouse's social security number if available. In all other situations, enter the resident's case number at the end of the 16 digit field, preceded by as many zeros as necessary to complete the field.

EXAMPLE

PSP1SSA501606464
Enter social security number

PSP1XXX501606464
Enter social security number. Resident is receiving benefits from spouse's account.

PSP1XXX000000437
Enter medical record number preceded by enough zeros to total 16 digits for the resident who is private pay and has no social security number.

(It is suggested that the facility record the Private Pay Code for use on subsequent RFC's (Request for Classification). This number will change only if the primary source of payment changes.)

6. BIRTHDATE

Enter two digits for the month, two digits for the day, three digits for the century and year.

Examples: Code April 14, 1986 as 04 14 896 (seven digits)

7. SEX

Enter F for female, M for male

8. LEVEL OF CARE

Enter codes for current living arrangement for all residents as follows:

01 - Skilled nursing home

02 - Intermediate care facility I (licensed nursing home)

03 - Intermediate care facility II (licensed boarding care home)

05 - State Hospital

25 - ICF-MR (Community residential facility)

9. PROVIDER NUMBER

Enter the DHS (DPW) provider number.

10. DATE ORIGINALLY ENTERED FACILITY

Enter the first admission date to the present facility. Example: Code March 3, 1984 as 03 03 84 (six digits)

11. CASE OPEN DATE

Enter the date the current assistance program was effective. This date is the same as the date of admission in authorization block 11 on the 1503 (six digits)

Leave blank for all Private Paying residents and for MA residents if you cannot find the date.

II. INSTRUCTIONS FOR MARK SENSE PORTION

12. ADMITTED FROM

0 = No record
1 = Home
2 = Hospital
3 = State MI-MR Facility
4 = Other Long Term Care Facility

13. PHYSICIAN'S STATEMENT OF GENERAL CONDITION

Interpret physician's current progress note and code as:

0 = No record

1 = Improving

2 = Stable

3 = Unstable

4 = Declining

5 = Terminal

14. SPECIAL TREATMENTS

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 (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.

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 resident 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
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, R.N. Mn and Bryan P. Simmons, M.D., 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.

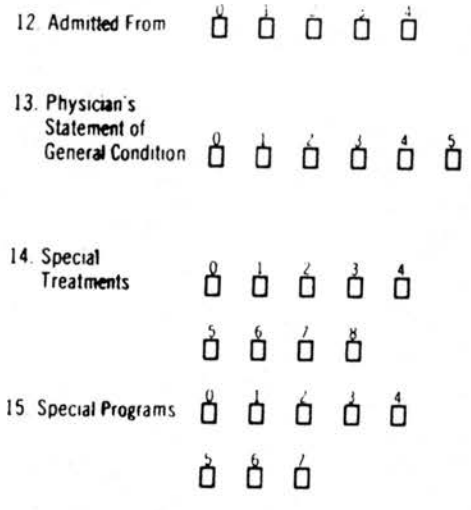
The medical record must include establish that:

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.

If any of the above special treatments (9-15) are being done in the facility, draw a box(s) at the end of line 14. Place an X in the box. Number the box(s) with the appropriate number.



15. 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 licensed psychologist or behavior analyst. Program designed to change behavior and/or explores 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

Obtain information from the health records. Code the number that best describes the resident.

16. DRESSING

0 = Dresses without help of any kind

1 = Receives supervision or programming (MR). Record for resident who receives assistance to lay out clothes, fasten clothing, or monitor performance

2 = Receives help from another person to put on clothing (Resident participates)

3 = Is dressed (does not participate)

4 = Never dressed

17. GROOMING

0 = Grooms self without help of any kind

1 = Receives supervision or programming (MR)

2 = Receives help from another person in 2 or 3 areas

3 = Is groomed (does not participate)

18. BATHING

0 = Bathes without help of any kind

1 = Receives minimal supervision or programming (MR) in bathing

2 = Receives supervision only

3 = Receives help in and out of tub

4 = Receives personal help washing and/or drying body

5 = Is bathed (does not participate)

19. EATING

0 = Feeds self without help of any kind

1 = Receives minimal supervision (reminders) or programming in eating

2 = Receives personal help to cut meat, arrange food, butter bread, etc.

3= Receives partial feeding from another person. Include observation for choking or inappropriate behavior (taking food from others, throwing food)

4 = Receives total feeding from another person, tube feeding, or intravenous feeding

20. BED MOBILITY

0 = Moves self in bed without help

1 = Receives occasional help from another person to sit up

2 = Always receives help from another person to sit up

3 = Must be turned and positioned

21. TRANSFERRING

0 = Transfers without help of any kind

1 = Receives guidance only. Requires physical presence of another person during transfer

2 = Receives physical aid of one person

3 = Receives aid of two persons or mechanical device (Does not participate)

4 = Remains bedfast

22. WALKING

0 = Walks without help of any kind

1 = Receives the help of a device (cane, walker, crutch)

2 = Receives the personal help of one person

3 = Receives the personal help of two persons

4 = Does not walk
(Help with a few steps from bed to chair does not constitute walking.)

23. WHEELING

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

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

2 = Receives total help with wheeling

24. 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

25. HEARING

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

26. VISION

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

27. 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

28. BEHAVIOR

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

0 = Behavior requires no intervention

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

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

4 = Behavior presents management problems and requires staff intervention because resident is physically abusive to self and others. Resident physically resists re-direction.

(continued next page)

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 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.

29. 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.

0 = Independent
Includethe resident who manages the problem of dribbling.

1 = 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

30. 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 2 and 3

MEDICATIONS

31. ORAL DOSES/DAY

Code "0" if the person does not receive oral medications.
Code the range of doses administered as 1-2, 3-4, 5-9, 10-14, 15+.
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 range as 1-3, 4-7, or 8+, indicating the number of injections administered within the last week

33. OTHER MEDICATIONS/DAY

Code "0" if person does not receive other medications.
Code the range of times administered as 1-3, 4-7, 8+.
Include topicals, eye drops, irrigation fluids, medicated enemas or suppositories, etc. ordered by physician.
Include an average number of p.r.n. (other) medications administered per day.

34. 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 documentated periodic reassessment of the resident's medical status and documented the need for continued clinical monitoring.

Scale

0 = Once a day or less

1 = One or two shifts a day

2 = Monitoring on every shift

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)

RECOMMENDATIONS

39. LEVEL OF CARE
Leave blank

40. COMPONENT OF CARE
Leave blank

41-46. CURRENT/ACTIVE DIAGNOSES

Enter the physician's current active medical diagnoses as recorded in the medical record.
Include severity of retardation for MR's.
Diagnoses should not extend into coding boxes at the end of the line.

SIGNATURES/DATE

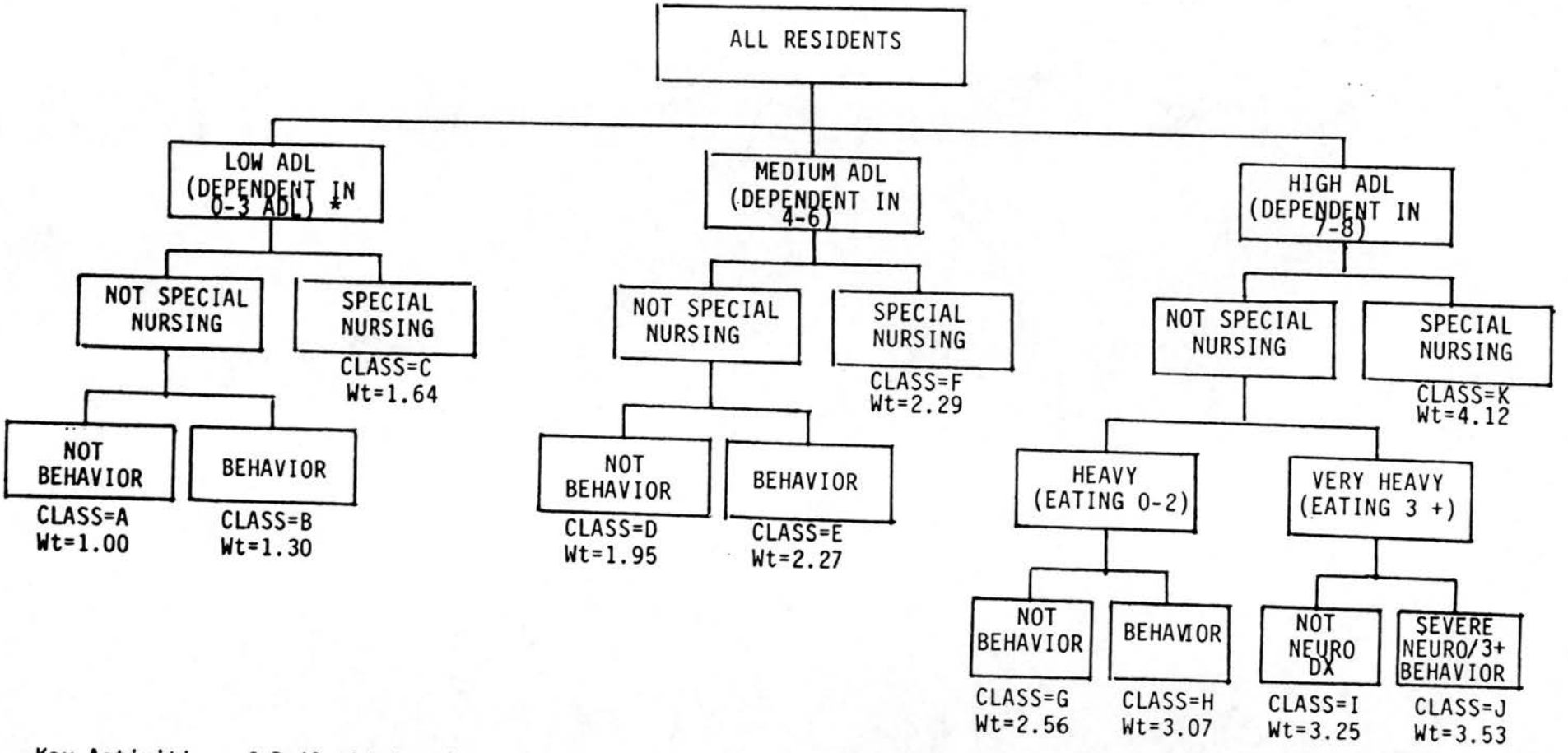
Signature of the registered nurse performing the assessment.
Date of assessment

Include WORK PHONE NUMBER.

Note: Block entitled ICF-MR Residents only, applies only to Intermediate Care Facilities for the mentally retarded.

RESIDENT CLASSIFICATION SYSTEM

Decision Tree



Key Activities of Daily Living (ADL's)

		Not Dependent	Dependent
16	Dressing	0-1	2-4
17	Grooming	0-1	2-3
18	Bathing	0-3	4-5
19	Eating	0-1	2-4
20	Bed Mobility	0-1	2-3
21	Transferring	0-1	2-4
22	Walking	0-1	2-4
29	Toileting	0	1-6

Classification	Weight (Relative Resource Use)
A Low ADL	1.00
B Low ADL Behavior	1.30
C Low ADL Special Nursing	1.64
D Medium ADL	1.95
E Medium ADL Behavior	2.27
F Medium ADL Special Nursing	2.29
G High ADL	2.56
H High ADL Behavior	3.07
I Very High ADL (Eating 3-4)	3.25
J High ADL Severe Neurological Impairment	3.53
K High ADL Special Nursing	4.12

HOW TO ARRIVE AT A CASE MIX CLASSIFICATION

Introduction

The case mix classification is determined by applying criteria to each completed QA&R 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.

Step 1. 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:

QAR Form Item	ADL	Not Dependent	Dependent
16	Dressing	0-1	2-4
17	Grooming	0-1	2-3
18	Bathing	0-3	4-5
19	Eating	0-1	2-4
20	Bed Mobility	0-1	2-3
21	Transferring	0-1	2-4
22	Walking	0-1	2-4
29	Toileting	0	1-6

Step 2. 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

Step 3. 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.

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:

14. 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 34, CLINICAL MONITORING, WHICH MUST BE SCORED 2.

2 = Oxygen and Respiratory Therapy
3 = Ostomies and Catheters
4 = Dressings
5 = Skin Care
9 = Hyperalimentation/Hickman Catheter
10 = Intravenous Fluids
11 = Intravenous Medications
12 = Blood Transfusions
13 = Drainage Tubes
14 = Symtom Control for the Terminally Ill
15 = Isolation Precautions

34. Clinical Monitoring

2 = Monitoring on every shift. (Monitoring must take place on all shifts including weekends.)

Case Mix Classification

If the assessment form fits these criteria, the classification is:

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 item 28, 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 ADL), if the items marked on the assessment form do not meet the Special Nursing criteria specified in step 4, proceed to the box marked Very Heavy Eating 3+. Review the score on the assessment form for item 19, Eating. If the score is 2 or less, skip steps 9-12 and proceed to step 13. 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 intercranial injury
Intercranial 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 assessment items 41-46 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 the assessment form for item 28, behavior. If the score is 3-4, the classification is also: High ADL - J

Case Mix Classification

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 item 19, Eating, is 2 or less, proceed to the box marked Behavior. If the score is 2 or more for item 28, 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

RESIDENT NOTIFICATION

The following procedures are from Minnesota Rules, parts 9549.0050 to 9549.0059 and Parts 4656.0010 to 4656.100 [Temporary].

The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Minnesota Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative.

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.

A reconsideration request must be in writing and submitted to the commissioner within ten working days of the receipt of the notice of resident classification. (See Attachment VI for sample form.) Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that those needs identified in the assessment require a different resident classification than the classification assigned by the department. The nursing home or boarding care home shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests reconsideration of a resident's classification, the facility must provide a written notice to the resident or the person responsible for payment on the date the request is submitted to the department. The notice to the resident or the person responsible for payment must contain the information provided to the department supporting the request for reconsideration.

The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home by letter of the classification within 20 working days.

The resident classification established by the department must be the

The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Any change in a resident classification due to a reconsideration must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

ATTACHMENT I

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street, S.E., P.O. Box 9441
Minneapolis, Minnesota 55440
(612) 623-5312

1. CLAIMS PROCESSING DOCUMENT NO.

Q'A REVIEW

▶ SEE INSTRUCTIONS IN QA REVIEW MANUAL FOR COMPLETING THIS REVIEW.

Except for summary data, the information requested on this form is classified private and shall not be disclosed except in accordance with Minn. Statutes sections 144.0721 and 13.46.

USE A # 2 PENCIL
MARK BOXES THIS WAY

2. FACILITY NAME	3. FACILITY NO.	4. RECIPIENT'S NAME	
5. MEDICAL ASSISTANCE NUMBER	6. BIRTHDATE	7. SEX	8. LEVEL OF CARE
9. PROVIDER NO.	10. DATE ORIGINALLY ENTERED FACILITY	11. CASE OPEN DATE	

12. Admitted From: 0 1 2 3 4

13. Physician's Statement of General Condition: 0 1 2 3 4 5

14. Special Treatments: 0 1 2 3 4 5 6 7 8

15. Special Programs: 0 1 2 3 4 5 6 7

ICF - MR RESIDENTS ONLY

INDIVIDUALIZED PROGRAM PLANS

A. Current Individualized Program: 0 1 2 3 4 5 6

B. Outside Facility Program/Services: 0 1 2 3 4

INDIVIDUAL DEPENDENCIES

16. Dressing: 0 1 2 3 4
17. Grooming: 0 1 2 3
18. Bathing: 0 1 2 3 4 5
19. Eating: 0 1 2 3 4
20. Bed Mobility: 0 1 2 3
21. Transferring: 0 1 2 3 4
22. Walking: 0 1 2 3 4
23. Wheeling: 0 1 2
24. Communication: 0 1 2 3 4
25. Hearing: 0 1 2 3 4
26. Vision: 0 1 2 3 4
27. Orientation: 0 1 2 3 4 5
28. Behavior: 0 1 2 3 4
29. Toileting: 0 1 2 3 4 5 6
30. Self Preservation Skills: 0 1 2 3 4

MEDICATIONS

31. Oral Doses/Day: 0 1-2 3-4 5-9 10-14 15+
32. Injections/Week: 0 1-3 4-7 8+
33. Other Meds/Day: 0 1-3 4-7 8+
34. Clinical Monitoring: 0 1 2

PSYCHOTHERAPEUTIC DRUG USE

35. Anti-psychotic Tranquilizers: 0 1 2
36. Anti-anxiety Tranquilizers: 0 1 2
37. Anti-depressants: 0 1 2
38. Sedatives/Hypnotics: 0 1 2

RECOMMENDATIONS

39. Level of Care: 0 1 2 3 4 5 6 7 8
40. Component of Care: 0 1 2 3 4 5 6 7 8 9 10 11 12

CURRENT/ACTIVE DIAGNOSIS

41.
42.
43.
44.
45.
46.

47. Explanations

R.N.'S SIGNATURE/DATE	SOCIAL WORKER'S SIGNATURE/DATE	M.D.'S SIGNATURE/DATE

ORIGINAL: QUALITY ASSURANCE AND REVIEW PROGRAM — COPY: FACILITY

ATTACHMENT II

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street S.E.,
Minneapolis, Minnesota 55440
(612)623-5312

TRANSMITTAL OF REQUESTS FOR CLASSIFICATION

FACILITY NAME _____

ADDRESS _____

CITY _____

TELEPHONE NO. (_____) _____

DATE _____

TOTAL NO. OF REQUESTS FOR CLASSIFICATION _____

1. NEW ADMISSIONS _____
   - SCREENED BY PAS _____
   - ASSESSED BY FACILITY _____
2. READMISSION FROM HOSPITAL _____
3. RFC RETURNED WITH CORRECTIONS _____
4. REQUEST FOR RECONSIDERATION _____
5. SEMI-ANNUAL ASSESSMENTS _____

   FACILITY CENSUS ON DAY OF COMPLETION OF SEMI-ANNUAL ASSESSMENTS _____ DATE OF CENSUS _____

   (If total no. of assessments differs from census, use reverse side of form for explanation)

NEED TO REORDER? QUANTITY

- ASSESSMENT FORMS #HE-01201-03 (9/85) _____
- MEDICAL PLAN OF CARE #HE-01269-03 _____
- TRANSMITTAL FORMS #HE-01271-04 _____
- INSTRUCTION GUIDES _____
- REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION HE-01279-02 _____

FACILITY NAME _____ CITY _____

ATTACHMENT III

minnesota department of health
717 s.e. delaware st. p.o. box 9441 minneapolis 55440
(612) 623-5000

To: 03/14/86

FROM: Quality Assurance and Review
(612) 623-5312

SUBJECT: Classification Notice

Minnesota Laws of 1984 establish a new reimbursement system for residents in nursing homes and boarding care homes certified to participate in the Medicaid Program. The new system establishes eleven payment classifications based on residents' care needs. Those needs will be identified by assessments conducted at different intervals by the facility, by the Department of Health, or by pre-admission screening.

A nurse employed by your facility completed an assessment form describing your care needs on 02/20/86. Based on the assessment your care needs show that your payment classification is -- B --. The payment rate which corresponds to this classification will be provided to you by the administration of your facility. This classification is effective as of 3/ 1/86.

If you want a copy of the assessment form, the Administrator or a designee must provide you a copy, as well as any other documents used for the assessment, and discuss it with you. If you need clarification of your payment classification, you may contact the Case Mix Coordinator of the Minnesota Department of Health by calling (612) 623-5312.

You, or a person you select, have the right to request a reconsideration of this payment classification if you disagree with it. If you do so, you will have up to ten (10) working days from the receipt of this letter to notify the Department of Health.

This notice to us must be in writing and must be accompanied by documentation which supports your request. A form has been provided to the facility for your convenience. With this form, include documentation such as a statement from your physician, or other documents to show that your care needs were different from those identified in the assessment form at the time the assessment was made.

Your may obtain assistance in making a reconsideration request by contacting your Nursing Home Ombudsman Program. The Ombudsman Program is designed to assist nursing home residents, and is independent of the Health Department and your nursing home. Their number in your area is 612/825-6861.

an equal opportunity employer

ATTACHMENT IV

Minnesota Department of Health
Quality Assurance and Review Program
717 Delaware St. SE, PO Box 9441
Minneapolis, MN 55440
(612) 623-5312

MEDICAL PLAN OF CARE

Facility Name	City
Resident Name	M.A. No./Private Pay Number
Date of Admission/Readmission	
Physician Name	
Primary Diagnosis:	
Secondary Diagnosis:	
Medications:	Dose:
Treatments:	Frequency:
What Clinical Monitoring Procedures are Needed?	
What Rehabilitation Procedures are Needed?	
Rehabilitation Potential:	
Discharge Potential:	
Other Comments:	

Signature_____, M.D. Date_____

(To be attached to QA&R Assessment Forms)

COMMONLY USED PSYCHOTROPIC DRUGS AND SEDATIVE/HYPNOTICS

ANTI PSYCHOTIC TRANQUILIZERS

Compazine (Prochlorperazine)
Haldol (Haloperidol)
Lidone (Molindone Hyprochloride)
Lithobid (Lithium Carbonate)
Lithonate (Lithium Carbonate)
Lithane (Lithium Carbonate)
Lithotabs (Lithium Carbonate)
Loxithane (Loxapine Succinate)
Mellaril (Thioridazine)
Moban (Molindone Hyprochloride)
Navane (Thiothizene)
Prolixin (Fluphenazine)
Proketazine (Pheno Carphenezine)
Quide (Piperacetazine)
Repoise (Butaperazine)
Serentil (Mesoridazine)
Sparine (Promazine)
Solazine (Trifluoperazine)
Stelazine (Trifluoperazine)
Taractan (Chrlorprothixene)
Thoraziine (Chlorpromazine)
Trilafon (Perphenazine)

ANTI ANXIETY TRANQUILIZERS

Atarax (Hydroxyzine Hydrochloride)
Ativan (Lorazepam)
Azene (Clorazepate)
Centrax (Prazepam)
Equanil (Meprobamate)
Librax (Combination of Chlordiazepoxide and Clinidium Bromide)
Limbitrol (Combination of Chlordiazepoxide and Clinidium Bromide)
Librium (Chlordiazepoxide)
Miltown (Meprobromate)
Noludar (Methyprylon)
Serax (Oxazepam)
Trancopal (Chlormeazanone)
Tranxene (Clorazepata Dipotassium)
Tybatran (Typamate)
Valium (Diazepam)
Valmid (Ethinamate)
Verstran (Prazepam)
Vistaril (Hydroxyzine Hydrochloride)
Xanax (Alprazolam)

ANTI DEPRESANTS

Amitid (Amitriptyline HCE)
Aventyl (Nortriptyline)
Ascendin (Amoxapine)
Desyrel (Trazodone HCL)
Elavil (Amitriptyline HCE)
Endep (Amitriptlyine HCE)
Etrafon (Perphenazine, N.F. and Amitriptyline Hydrochloride)
Limbitrol (Combination of Chlordiazepoxide and Amitriptyline)
Ludiomil (Maprotiline HCE)
Marplan (Isocarboxazid)
Nardil (Phenelzine Dithydrogen Sulfate)
Niamid (Nialamide)
Norpramine (Desipramine)
Pamelor (Nortriptyline)
Parnate (Tranylcypromine)
Pertofrane (Desipramine)
Ritalin (Methylphenidate)
Sinequan (Doxepin) Adapin
Surmontil (Triminpramine Maleate)
Tofranil (Imipramine)
Triavil (Combination of Perphenazine and Amitriptyline Hydrochloride)
Vivactil (Protriptyline)

SEDATIVES/HYPNOTICS

Butisol Sodium (Sodium Butabarbital)
Dalmane (Flurazepam Hydrochloride)
Doriden (Glutethimide)
Halcion (Triazolam)
Luminal (Phenobarbital)
Nembutal (Pentobarbital)
Noctec (Chloral Hydrate)
Noludar (Methyprylon)
Placidyl (Ethchlorvynol)
Plexonal (Barbital Sodium and Butalbital Sodium)
Seconal (Secobarbital)
Restoril (Temazepam)
Somnos (Chloral Hydrate)
Tuinal (Secobarbital and Amobarbital)

ATTACHMENT VI

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street S.E.,
Minneapolis, Minnesota 55440
(612)623-5312

REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION

You may use this form, along with documentation, to support a requested reclassification reconsideration. The request and documentation must be submitted within ten working days of the receipt of the notice of classification.

RESIDENT'S NAME _____

MEDICAID OR PRIVATE PAY IDENTIFICATION NUMBER _____

FACILITY NAME _____

FACILITY ADDRESS _____

DATE OF RECEIPT OF NOTIFICATION OF RESIDENT CLASSIFICATION _____

In order to establish a basis for reconsidering the original classification we suggest:

1. **Enclose a copy of the resident assessment form. The facility must provide a copy of the assessment to the resident or their representative within one working day of request.**
2. **Circle the incorrect items in black ink.**
3. **Write a brief description of the basis for your disagreement with the items on the assessment form. (Use back of this form.)**
4. **Attach documentation establishing that the needs of the resident at the time of the assessment justify a change of classification.**

REQUEST SUBMITTED BY:

AUTHORIZED REPRESENTATIVE OF FACILITY ☐ RESIDENT ☐

RESIDENT'S AUTHORIZED REPRESENTATIVE ☐

SIGNATURE _____

DATE _____

I signify by my signature that these statements are correct and factual to the best of my knowledge.

HE-01279-01

INSPECTION OF CARE
INSTRUCTION MANUAL:
WITH PROCEDURES FOR COMPLETING CASE MIX REQUESTS FOR CLASSIFICATIONS



QUALITY ASSURANCE AND REVIEW PROGRAM



MINNESOTA DEPARTMENT OF HEALTH
717 SOUTHEAST DELAWARE STREET
MINNEAPOLIS, MINNESOTA 55440

612/623-5312

MAY 1986

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QUALITY ASSURANCE

REVIEW FORM GUIDELINE

The Quality Assurance Review form is to be completed for each resident of the facility at the time of the review.

DHS provides a list of MA recipients prior to the review. The facility is asked to update the list, to delete the names of recipients no longer in the facility and to add the names of recipients not on the list. For residents no longer in the facility, record on the printout the date expired, discharged or transferred and to where transferred. The facility will provide a list of private paying residents to be reviewed, identified by name, primary source of payment, social security number and level of care.

The reviewer will check the pre-printed forms with the list of MA recipients updated by the facility. Review forms for those residents who do not have a pre-printed form will be hand printed by the reviewer using a ball point pen with black ink.

If the recipient information that is pre-printed on the review form is incorrect, corrections should be made as follows:

Line through the incorrect information and enter the correct data to the right of the entry, keeping inside the block.

No corrections will be made in Blocks 4, 5, 9 or 11.

The mark sense portion will be completed by marking a straight horizontal line in the center of the box using a number two lead pencil. Watch so the line does not extend into the next box. Do not make any stray marks in this portion.

Corrections can be made in the mark sense boxes, using white correction fluid on the original. Redraw the box in pencil over the whiteout. The facility (NCR) copy can be corrected by crossing out and re-marking.

The CURRENT/ACTIVE DIAGNOSES portion should be completed with a ball point pen with black ink.

The EXPLANATIONS PORTION is for the written explanation for a recommendation for level of care or component of care.

Both copies of the review form (original and NCR copy) are returned to the central office.

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 to QAR and carbon copy to facility. Facility completes items needed for resident identification, records Medical diagnoses, and attaches Medical Plan of Care Transmittal Sheet	Assessment must be done within 10 working days prior to admission or 10 working days after admission. Forms mailed to QAR within 5 working days of completion.	Date of Admission
New Admission (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Same as above	Date of Admission
Transfer from another facility (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Same as above	Date of Admission
Move between licensure levels within facility (Assessed by Facility)	Assessment form Resident's Plan of Care Transmittal Sheet	Same as above	Date of Admission
Readmission from the hospital (Assessed by Facility)	Assessment form Medical Plan of Care Transmittal Sheet	Assessment completed and mailed to QAR within 5 working days	Date of Admission
Annual Inspection of Care (QAR Team Visit)	Assessment Form	Annually as scheduled by MDH	First day of the month following the day of the team exit
Semi Annual Assessment (Assessed by Facility)	Assessment form Resident's Plan of Care Transmittal Sheet with census on day assessments were completed. (Include explanation of any discrepancy between the daily census and number of assessments submitted.)	No earlier than 170 days and no later than 190 days after the most recent QAR 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

KEY DEFINITIONS

The following definitions are from Minnesota Rules, parts 4656.0010 to 4656.0100 and 4549.0050 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 diagnoses, 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 homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents in boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Resident record. "Resident record" means the entire record of a resident compiled by the nursing home or boarding care home. The resident 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, consultation, and other services;

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, MN 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 Ford Law Library, 117 University Avenue, Saint Paul, MN 55155, and through the minitex interlibrary loan system.

I. INSTRUCTIONS FOR RESIDENT INFORMATION PORTION

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street, S.E., P.O. Box 9441
Minneapolis, Minnesota 55440
(612) 623-5312

1. CLAIMS PROCESSING DOCUMENT NO.

QA REVIEW

▶ SEE INSTRUCTIONS IN QA REVIEW MANUAL FOR COMPLETING THIS REVIEW.

Except for summary data, the information requested on this form is classified private and shall not be disclosed except in accordance with Minn. Statutes sections 144.0721 and 13.46.

USE A # 2 PENCIL



MARK BOXES THIS WAY

2. FACILITY NAME	3. FACILITY NO.	4. RECIPIENT'S NAME	
5. MEDICAL ASSISTANCE NUMBER	6. BIRTHDATE	7. SEX	8. LEVEL OF CARE
9. PROVIDER NO.	10. DATE ORIGINALLY ENTERED FACILITY	11. CASE OPEN DATE	

Block 1. CLAIMS PROCESSING DOCUMENT NUMBER
Enter the QA&R Location Code Number.

Block 2. Facility Name
Enter facility name as listed on current license. Nursing Home (NH) or Health Care Center (HCC) may be abbreviated.

Block 3. FACILITY NUMBER
Enter the Minnesota Department of Health facility identification number.

Block 4. RESIDENT'S NAME
Enter last name first, then first name and middle initial.

Block 5. MEDICAL ASSISTANCE NUMBER AND PRIVATE PAY CODES

MEDICAID RECIPIENTS

Enter 16 digit Medical Assistance Number for Medicaid residents.

Medicaid recipients from other states may have less than a 16 digit code. Enter the first three digits; enter the remainder of the number at the end of the digit field preceded by as many zeros as needed to complete the field.

Example: ND8464646464
ND8000046464646464

PRIVATE PAY RESIDENT

To arrive at a 16 digit number:

DIRECTION	EXAMPLE
Digits 1-3 Enter PSP (Primary Source of Payment)	PSP
Digit 4 Enter the appropriate code to indicate the type of PSP 1. Personal income or family support: includes personal income and savings, health insurance, retirement funds, and social security. 2. Medicare: includes money received under the Medicare program of health insurance for elderly and/or disabled persons (Title XVIII of the Social Security Act). 3. Other Government Assistance, includes sources of government assistance (federal, state or local) other than Medicare or Medicaid. 4. All other sources: includes religious organizations, foundations, volunteer agencies, Veterans Administration contracts, initial payment arrangements, life care arrangements, miscellaneous sources, and no-charge arrangements. 9. Unknown	PSP1 Personal income (could also be 2, 3,4 or 9) check guidelines for options.
Digits 5-7 Enter "SSA" when the resident has a social security number. Enter "XXX" when the resident does not have a social security number, including situations where a resident is receiving benefits and using their spouse's social security number.	EXAMPLE PSP1SSA Resident has a social security number. PSP1XXX Resident has no social security number or is receiving benefits from spouse's account.

Digits 8-16

Enter social security number for all residents who have social security numbers. When a resident does not have a social security number, but receives benefits from their spouse's number, enter their spouse's social security number if available. In all other situations, enter the resident's case number at the end of the 16 digit field, preceded by as many zeros as necessary to complete the field.

EXAMPLE

PSP1SSA501606464
Enter social security number

PSP1XXX501606464
Enter social security number. Resident is receiving benefits from spouse's account.

PSP1XXX000000437
Enter medical record number preceded by enough zeros to total 16 digits for the resident who is private pay and has no social security number.

(It is suggested that the facility record the Private Pay Code for use on subsequent RFC's (Request for Classification). This number will change only if the primary source of payment changes.)

6. BIRTHDATE

Enter two digits for the month, two digits for the day, three digits for the century and year.

Examples: Code April 14, 1986 as 04 14 896 (seven digits)

7. SEX

Enter F for female, M for male

8. LEVEL OF CARE

Enter codes for current living arrangement for all residents as follows:

01 - Skilled nursing home

02 - Intermediate care facility I (licensed nursing home)

03 - Intermediate care facility II (licensed boarding care home)

05 - State Hospital

25 - ICF-MR (Community residential facility)

9. PROVIDER NUMBER

Enter the DHS (DPW) provider number.

10. DATE ORIGINALLY ENTERED FACILITY

Enter the first admission date to the present facility. Example: Code March 3, 1984 as 03 03 84 (six digits)

11. CASE OPEN DATE

Enter the date the current assistance program was effective. This date is the same as the date of admission in authorization block 11 on the 1503 (six digits)

Leave blank for all Private Paying residents and for MA residents if you cannot find the date.

II. INSTRUCTIONS FOR FILLING OUT MARK SENSE PORTION

12. ADMITTED FROM

0 = No record
1 = Home
2 = Hospital
3 = State MI-MR Facility
4 = Other Long Term Care Facility

13. PHYSICIAN'S STATEMENT OF GENERAL CONDITION

Interpret physician's current progress note and code as:

0 = No record

1 = Improving

2 = Stable

3 = Unstable

4 = Declining

5 = Terminal

14. SPECIAL TREATMENTS

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 (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.

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 resident 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

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 mean procedures in accordance with the "Guideline for Isolation Precautions in Hospitals", written by Julie S. Garner, R.N. Mn and Bryan P. Simmons, M.D., 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.

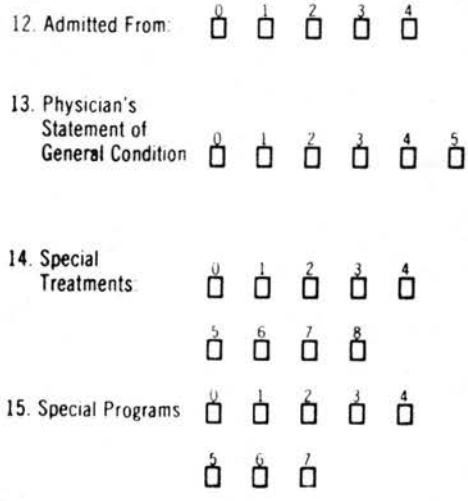
The medical record must establish that:

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.

If any of the above special treatments (9-15) are being done in the facility, draw a box(s) at the end of line 14. Place an X in the box. Number the box(s) with the appropriate number.



15. 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 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

Obtain information from the health records. Code the number that best describes the resident.

16. DRESSING

0 = Dresses without help of any kind

1 = Receives supervision or programming (MR). Record for resident who receives assistance to lay out clothes, fasten clothing, or monitor performance

2 = Receives help from another person to put on clothing (Resident participates)

3 = Is dressed (does not participate)

4 = Never dressed

17. GROOMING

0 = Grooms self without help of any kind

1 = Receives supervision or programming (MR)

2 = Receives help from another person in 2 or 3 areas

3 = Is groomed (does not participate)

18. BATHING

0 = Bathes without help of any kind

1 = Receives minimal supervision or programming (MR) in bathing

2 = Receives supervision only

3 = Receives help in and out of tub

4 = Receives personal help washing and/or drying body

5 = Is bathed (does not participate)

19. EATING

0 = Feeds self without help of any kind

1 = Receives minimal supervision (reminders) or programming in eating

2 = Receives personal help to cut meat, arrange food, butter bread, etc.

3= Receives partial feeding from another person. Include observation for choking or inappropriate behavior (taking food from others, throwing food)

4 = Receives total feeding from another person, tube feeding, or intravenous feeding

20. BED MOBILITY

0 = Moves self in bed without help

1 = Receives occasional help from another person to sit up

2 = Always receives help from another person to sit up

3 = Must be turned and positioned

21. TRANSFERRING

0 = Transfers without help of any kind

1 = Receives guidance only. Requires physical presence of another person during transfer

2 = Receives physical aid of one person

3 = Receives aid of two persons or mechanical device (Does not participate)

4 = Remains bedfast

22. WALKING

0 = Walks without help of any kind

1 = Receives the help of a device (cane, walker, crutch)

2 = Receives the personal help of one person

3 = Receives the personal help of two persons

4 = Does not walk
(Help with a few steps from bed to chair does not constitute walking.)

23. WHEELING

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

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

2 = Receives total help with wheeling

24. 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

25. HEARING

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

26. VISION

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

27. 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

For the mentally retarded, consider categories of community orientation.

0 = Oriented
Gets around the community with no problem

1 = Minor forgetfulness
Gets to a given destination with coaching, supervision

2 = Partial/intermittent periods of disorientation
Limited community orientation (e.g. recognizes house)

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

4 = Comatose

5 = Unknown

28. BEHAVIOR

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

0 = Behavior requires no intervention

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

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

4 = Behavior presents management problems and requires staff intervention because resident is physically abusive to self and others. Resident physically resists re-direction

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.

29. 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.

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

1 = 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

30. 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 2 and 3

MEDICATIONS

31. ORAL DOSES/DAY

Code "0" if the person does not receive oral medications. Code the range of doses administered as 1-2, 3-4, 5-9, 10-14, 15+.
Include food supplements ordered by physician. Include an average number of oral p.r.n. medications given per day within the last week.

Count total number of prescriptions including oral medications, injections and other medications given within the last week. Enter the number in the lower right hand corner of the Medication block, and circle. Use red ink.

32. INJECTIONS/WEEK

Code "0" if no injections are given
Code the range as 1-3, 4-7, or 8+, indicating the number of injections administered within the last week

33. OTHER MEDICATIONS/DAY

Code "0" if person does not receive other medications. Code the range of times administered as 1-3, 4-7, 8+. Include topicals, eye drops, irrigation fluids, medicated enemas or suppositories, etc. ordered by physician. Include an average number of p.r.n. (other) medications administered per day.

Count totalnumber of prescriptions including oral medications, injections and other medications given within the last week. Enter the number in the lower right hand corner of the Medication block, and circle. Use red ink.

34. 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 = Once a day or less

1 = One or two shifts a day

2 = Monitoring on every shift

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)

RECOMMENDATIONS

39. LEVEL OF CARE

This is the judgment decision by the QA&R team as to the level of care needed by the resident (Guidelines for each level of care option (0-8) follow.)

Block 39 will be coded for Medicaid residents only. An explanation for recommending a change in level of care for Medicaid residents is to be written in Block 47.

Block 39 will be left blank for private paying residents. However, the team will make a conclusion (or judgment decision) as to the level of care required by the private paying resident based on the following guidelines (0-8). The conclusion will be recorded in the lower right hand corner of Block 47. Using red ink, record the level of care code used for Medicaid LOC'S, and circle the code number. (No explanation is written in Block 47 for conclusions.)

RECOMMENDATIONS FOR LEVEL OF CARE

0 = No change in level of care

(Current LOC is recorded in Block 8.)

1 = Skilled

If any one of the following is present, the Skilled level is indicated:

a. Restorative and Rehabilitative Treatment Group

- An active restorative treatment program is being carried out toward planned discharge or transfer to a lower level of dependency.

b. Unstable Disease Group

- episodes of active disease processes requiring immediate clinical judgements by licensed nurses - episodes come at unpredictable times of day or night.

- Medication requiring professional dosage adjustment or preadministrative monitoring; or licensed nurse observations for reactions, side effects or drug interaction. Requirements must include evening and night shifts.

c. Special Treatment Group

- Direct care services by licensed nurses are needed during evening and night shifts for:
- Injections
- Intravenous medications
- Sterile dressings
- Lamp treatments
- Complex topical therapy
- Catheter care (urinary or nasal)
- Ostomy care - colostomy, ileostomy, or tracheostomy
- Tube feeding
- Oxygen therapy or IPPB
- Suctioning
- Positioning and alignment
- Irrigations
- Behavior problems requiring some supervision for safety of self or others
- Severe communication problems

d. Complex Management Group (Heavy Care Residents)

- Total disability and dependency in four or more of the Activities of Daily Living areas
- Moderate disability (at least #2 on form) in seven of the fourteen Activities of Daily Living areas

2 = Intermediate 1

ICF residents are characterized as those not meeting any of the SNF criteria but requiring licensed nurses services or supervision during the day and an occasional on-call visit during the night. ICF residents have low levels of dependency in ADL's but are not capable of self medication. Disease processes, such as Psychosis, Diabetes, and ASHD may be fairly advanced, however, they should be relatively stable and well controlled. Direct services and supervision by licensed nurses during the daytime shift can provide all of the professional services needed.

3 = Intermediate 2

Intermediate 2 residents need or receive personal or maintenance care only. Examples of such services are: board, room, laundry and personal services; assistance with bathing, dressing and other items of personal hygiene, super-

vision and/or administration of medications, and a program of activities and supervision required by persons who are not capable of properly caring for themselves.

4 = ICF/MR Community Residential Facility

The Department of Human Services (DHS) issues a special program license for ICF/MR facilities and specifies that any Intermediate Long Term Care Facility with five or more MR residents should secure the special program licensure. DHS recommends that every MR under age 60 should be placed in a licensed ICF/MR facility unless concomitant illness requires the SNF level of care.

If a recipient is residing in a state hospital, consider recommending to a community residential facility if the person might function in a less restrictive alternative. This recommendation incorporates the concept of dignity of risk for the individual and the principle of normalization.

5 = ICF/MR State Hospital

The state hospitals are certified as ICF/MR facilities for purposes of federal reimbursement.

Considerations for recommending to (or remaining in) a large congregate facility may include the need for <u>daily</u> behavior management and/or medical management which cannot be provided in the community.

6 = Psychiatric Care

Considerations for determining the need for psychiatric care would include.

- The need for frequent assessment and revision of treatment by qualified personnel.

- The need for protection.

Regulation MDH 51 states: "Disturbed mental patients shall not be received or retained in a nursing home or boarding care home." A person for whom general use of restraints is necessary for his protection and the protection of others shall be considered disturbed mentally. The term "restraints" includes both physical and chemical (medication) measures. When behavior patterns in community facilities are markedly disruptive or injurious to self or others, recommendations are made for transfer to a psychiatric care unit.

7 = Acute Hospital Care

A recommendation for acute hospital care is made if the resident has an unstable or declining condition with an exacerbation of a medical problem and the staff may not have the resources or equipment to provide intervention. A declining condition would not necessarily be consideration for acute hospital stay if the family and the resident desire the supportive terminal care intended with the hospice concept.

8 = Semi-Independent Living or Independent Living

SILS: This category is intended for MR or MI persons who have demonstrated skills in self preservation, money management, shopping and domestic activities. Services such as training, counseling, instruction and supervision in accordance with the IPP would be provided regardless of where the resident lives. Twenty-four hour staff supervision would not be provided in a semi-independent living facility.

Criteria to be used in recommending SILS include:

1. Resident appears to have motivation to make decisions.
2. Zero or one in individual dependencies 16-29.
3. No medications required or is capable of self-administration of medications.
4. Attends sheltered workshop or is competitively employed.
5. Uses public transportation independently.

Independent Living: A recommendation to independent living can be made even if support services may be needed such as chore services, home delivered meals and homemaker service.

40. COMPONENT OF CARE

Recommendations for individual program strengthenings are based on the identification of patient problems. The process of identifying patient problems includes reviewing the health record, interviewing and/or observing the resident, and interviewing the staff. This process results in a professional judgment as to what may reasonably benefit the resident.

There must be documentation of assessments and the implementation of programs at the time of review. Verbal assurance that the problem will be dealt with is not sufficient reason for not making the recommendation.

Recommendations should focus on problems of the resident. These problems should be identified specifically in the explanation so that the facility can readily ascertain the problem and the suggested plan of action.

The following format should be used in writing specific recommendations in the EXPLANATION section;

1. The problem as it relates to the resident.

2. The source of the information (e.g. health record indicates, staff or resident states, resident observed to be . . .),

3. Suggested intervention by facility staff which may benefit the resident (phrased as a question).

0 = No recommendations

1 = Medical Services

Strengthen this area when patient problem requires assessment by the Physician.

Examples:

When patient problem may benefit from referral to a specialist (includes psychiatric or psychological)

When patient problem may benefit from re-assessment of medication regime.

When patient problem is a nutritional problem that is related to the diagnosis.

When patient's health problem may benefit from the physician's assessment.

2 = Nursing

Strengthen this area when patient problem would benefit from assessment by nursing.

Examples:

Patient problem of nutrition related to feeding.

Patient problem related to clinical monitoring.

Patient problem that might respond to nursing rehabilitation techniques.

Patient problem related to administration of medications and treatments.

Patient problem (change of condition) that needs to be communicated to the physician.

Patient problem that might benefit from a nursing assessment.

3 = Speech, Hearing, Vision

Strengthen this area if the resident appears to have a problem and may reasonably benefit from an assessment or treatment by a qualified specialist.

4 = Dental

Strengthen this area if the resident has dental problems that have been identified by the physician or nursing staff and there is no evaluation by a dentist or if correctable defects identified in the dental evaluation have not been followed up by the dentist.

5 = Psychological Services

Strengthen if a psychologist is presently involved in the resident's care and there appears to be a need for reassessment or revision of the plan.

Psychological evaluations for mentally retarded residents would also be strengthened in this category.

6 = Social Services

Strengthen this category if there appears to be a need and there is no assessment or plan of care to deal with identified needs. Investigation of and follow through on community resources as part of discharge planning would also fall in this area.

Strengthen social services if the plan outlined by Social Services is not being carried out.

7 = Activities

Strengthen this area when there appears to be a need and the resident's personal interests have not been identified or when a specific plan is not detailed to reflect the personal interests or there is no evidence of actual delivery of that plan.
If the facility provides only large group activities or art and craft type activities, it might be an indication that there would be a need for assessment for individualized activity programming.

8 = Direct Care Staff

This terminology is commonly used in facilities for the mentally retarded. It includes the individuals who conduct the resident living programs. The direct care staff interact with the residents in activities such as training, recreation, bathing, toileting, and also participate in the development of individual programming plans for residents. Components of the health care plan may also be assigned.
Strengthen this area if there are gaps in the programming for the resident that are the responsibility of direct care staff.

Gaps in communication to the doctor or nurse consultant about the person's health care status would be strengthened here.

9 = Dietary

Strengthen this area if the resident appears to have a problem related to nutrition.

Examples:

Patient problem of nutrition related to acceptance of diet
Patient problem with need for establishing ideal weight range

10 = Rehabilitation (O.T., P.T.)

Strengthen this area if the resident appears to have a problem which may reasonably benefit from an assessment, plan of care, and implementation by a qualified therapist.

Examples:

Patient problem of decreasing mobility
Patient problem of decreasing fine motor skills
Patient problem of decreasing sensory integration skills.

11 = Program of Care

This category is intended for nursing homes.

This is a written individualized plan of care for each nursing home resident that has been obtained through a multidisciplinary team approach. The written plan identifies problems/strengths, approaches, goals, time limitations and assigned responsibility.

Strengthen this area when there appears to be a need and it is unclear what the goals and approaches are for an identified need and it is not clear who should have responsibility for this need or problem.

12 = Developmental Services

This category is intended for ICF-MR facilities and corresponds to the guideline for Program of Care (11). Developmental Services refer to Plan of Care as an Individualized Program Plan (IPP).

Components of an IPP and background material for writing program strengthenings in an ICF-MR setting will be found in attachment I of this manual.

41-46. CURRENT/ACTIVE DIAGNOSES

Enter the physician's current active medical diagnoses as recorded in the medical record.
Include severity of retardation for MR's.
Diagnoses should not extend into coding boxes at the end of the line.

47. EXPLANATIONS

Enter explanation for LOC recommendations (Medicaid only).

Record recommendations for program strengthenings. (Refer to Paragraph 40 under Component of Care for correct format.)

Enter code for private pay conclusion in lower right hand corner. (Refer to Paragraph 39 for procedure.)

ICF/MR RESIDENTS ONLY

This section is designed to record specific areas of programming. This section is completed for any person who has an Individualized Program Plan. The person may be residing in an ICF/MR facility, psychiatric hospital or a nursing home. The majority of IPP's will be for the developmentally disabled.

When reviewing individualized program plans, it may be appropriate to have more than one category checked in the following sections:

A. Current Individualized Program

0 = No program emphasis

1 = Sensori-Motor Stimulation/Development
Stimulating sensory response, identifying sound patterns, defining body location

2 = Physical Mobility/Dexterity
Passive exercising, rolling, creeping, crawling, using hands purposefully, training for mobility, stair climbing, skipping, developing fine motor skills, learning skills for sports.

3 = Self-Care Development
Using utensils, behaving acceptably during meals, dressing skills, selecting clothing, handling soap and washcloth, caring for hair, using cosmetics and deodorants.

4 = Language/Communication
Encouraging vocalization, using gestures, following verbal directions, repeating messages, learning number concepts, understanding time concepts.

5 = Social Behavior/Self Direction
Recognizing familiar persons, occupying self for brief periods, using self protective skills, social skills for group interactions, money concepts, traveling with supervision, acquiring housekeeping skills, self medication programs, leisure time.

6 = Community Access/Work
Use of transportation, shopping, involvement in community groups, participating in work entry programs, preparation for semi-independent living.

B. Outside Facility Programs/Services

Outside facility programs will usually be found for the MR/DD in ICF/MR facilities.

0 = No outside facility program

1 = Developmental Achievement Center, Day Programs

Structured Programs designed to address specific behavioral objectives in a variety of formats. Some DAC programs have separate work components which could be considered work training. A professional judgement will be necessary to determine if both "1." DAC and "4" Work Training is scored.

2 = Schools

School age children in programs run by the local school district. The physical location may or may not be in a school building.

3 = Community Support Programs

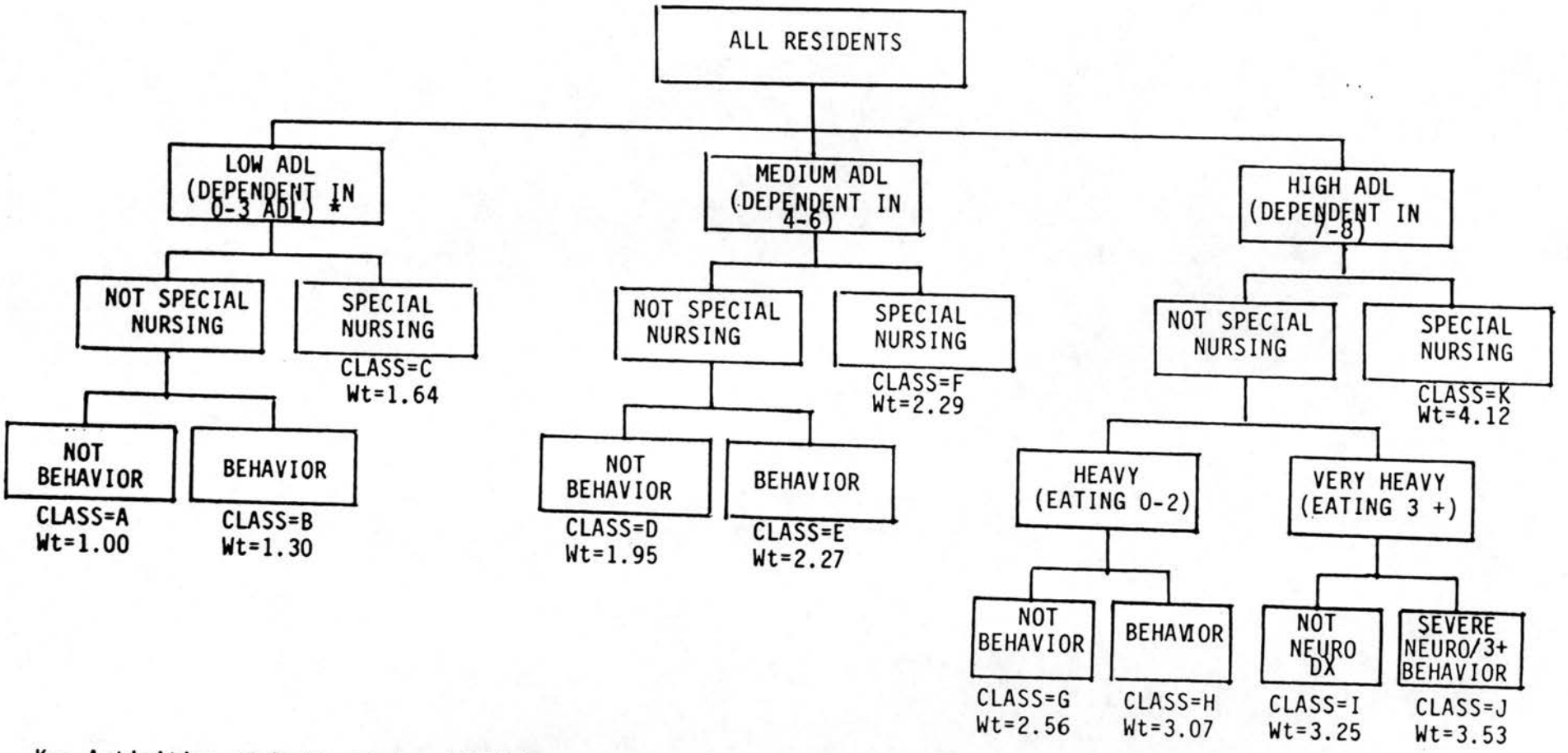
Residents may participate in community mental health services, socialization/recreation programs, drop in centers, therapeutic social club, alcholics anonymous, emotions anonymous, etc. Group may or may not have a trained professional leading or facilitating the group.

4 = Work/Skill Training, Sheltered Workshop

A structured setting designed to help persons develop skills that are needed in a work environment. Vocational/employment services and work adjustment programs would be included.

RESIDENT CLASSIFICATION SYSTEM

Decision Tree



Key Activities of Daily Living (ADL's)

		Not Dependent	Dependent
16	Dressing	0-1	2-4
17	Grooming	0-1	2-3
18	Bathing	0-3	4-5
19	Eating	0-1	2-4
20	Bed Mobility	0-1	2-3
21	Transferring	0-1	2-4
22	Walking	0-1	2-4
29	Toileting	0	1-6

Classification	Weight (Relative Resource Use)
A Low ADL	1.00
B Low ADL Behavior	1.30
C Low ADL Special Nursing	1.64
D Medium ADL	1.95
E Medium ADL Behavior	2.27
F Medium ADL Special Nursing	2.29
G High ADL	2.56
H High ADL Behavior	3.07
I Very High ADL (Eating 3-4)	3.25
J High ADL Severe Neurological Impairment	3.53
K High ADL Special Nursing	4.12

HOW TO ARRIVE AT A CASE MIX CLASSIFICATION

Introduction

The case mix classification is determined by applying criteria to each completed QA&R 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.

Step 1. 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:

QAR Form Item	ADL	Not Dependent	Dependent
16	Dressing	0-1	2-4
17	Grooming	0-1	2-3
18	Bathing	0-3	4-5
19	Eating	0-1	2-4
20	Bed Mobility	0-1	2-3
21	Transferring	0-1	2-4
22	Walking	0-1	2-4
29	Toileting	0	1-6

Step 2. 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

Step 3. Refer to the Resident Classification Decision Tree on page 32. Choose the branch of the tree which matches the residents ADL Category above, Low, Medium or High.

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:

14. 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 34, CLINICAL MONITORING, WHICH MUST BE SCORED 2.

2 = Oxygen and Respiratory Therapy
3 = Ostomies and Catheters
4 = Dressings
5 = Skin Care
9 = Hyperalimentation/Hickman Catheter
10 = Intravenous Fluids
11 = Intravenous Medications
12 = Blood Transfusions
13 = Drainage Tubes
14 = Symtom Control for the Terminally Ill
15 = Isolation Precautions

34. Clinical Monitoring

2 = Monitoring on every shift. (Monitoring must take place on all shifts including weekends.)

Case Mix Classification

If the assessment form fits these criteria, the classification is:

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 item 28, 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 ADL), if the items marked on the assessment form do not meet the Special Nursing criteria specified in step 4, proceed to the box marked Very Heavy Eating 3+. Review the score on the assessment form for item 19, Eating. If the score is 2 or less, skip steps 9-12 and proceed to step 13. 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 intercranial injury
Intercranial 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 assessment items 41-46 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 the assessment form for item 28, 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 item 19, Eating, is 2 or less, proceed to the box marked Behavior. If the score is 2 or more for item 28, 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

RESIDENT NOTIFICATION

The following procedures are from Minnesota Rule Parts 9549.0050 to 9549.0059 and Parts 4656.0010 to 4656.100 [Temporary].

The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Minnesota Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative.

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 department to reconsider the resident classification.

A reconsideration request must be in writing and submitted to the commissioner within ten working days of the receipt of the notice of resident classification. (See Attachment VI for sample form.) Requests must be accompanied by written documentation to support the claim that the resident's needs at the time of the assessment were different from those needs identified in the assessment, or that those needs identified in the assessment require a different resident classification than the classification assigned by the department. The nursing home or boarding care home shall provide a resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the department in support of the resident's assessment. This documentation must be provided within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. If a facility requests reconsideration of a resident's classification, the facility must provide a written notice to the resident or the person responsible for payment on the date the request is submitted to the department. The notice to the resident or the person responsible for payment must contain the information provided to the department supporting the request for reconsideration.

The department shall review the requests for reconsideration, affirm or modify the resident's classification, and notify the resident and the nursing home or boarding care home by letter of the classification within 20 working days.

The resident classification established by the department must be the classification that applies to the resident while the request for reconsideration is pending.
The department reserves the right to request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Any change in a resident classification due to a reconsideration must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

ATTACHMENT I

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street, S.E., P.O. Box 9441
Minneapolis, Minnesota 55440
(612) 623-5312

1. CLAIMS PROCESSING DOCUMENT NO.

Q'A REVIEW

▶ SEE INSTRUCTIONS IN QA REVIEW MANUAL FOR COMPLETING THIS REVIEW.

Except for summary data, the information requested on this form is classified private and shall not be disclosed except in accordance with Minn. Statutes sections 144.0721 and 13.46.

USE A # 2 PENCIL



MARK BOXES THIS WAY

2. FACILITY NAME	3. FACILITY NO.	4. RECIPIENT'S NAME	
5. MEDICAL ASSISTANCE NUMBER	6. BIRTHDATE	7. SEX	8. LEVEL OF CARE
9. PROVIDER NO.	10. DATE ORIGINALLY ENTERED FACILITY	11. CASE OPEN DATE	

12. Admitted From: 0 1 2 3 4

13. Physician's Statement of General Condition: 0 1 2 3 4 5

14. Special Treatments: 0 1 2 3 4 5 6 7 8

15. Special Programs: 0 1 2 3 4 5 6 7

ICF - MR RESIDENTS ONLY

INDIVIDUALIZED PROGRAM PLANS

A. Current Individualized Program: 0 1 2 3 4 5 6

B. Outside Facility Program/Services: 0 1 2 3 4

INDIVIDUAL DEPENDENCIES

16. Dressing: 0 1 2 3 4

17. Grooming: 0 1 2 3

18. Bathing: 0 1 2 3 4 5

19. Eating: 0 1 2 3 4

20. Bed Mobility: 0 1 2 3

21. Transferring: 0 1 2 3 4

22. Walking: 0 1 2 3 4

23. Wheeling: 0 1 2

24. Communication: 0 1 2 3 4

25. Hearing: 0 1 2 3 4

26. Vision: 0 1 2 3 4

27. Orientation: 0 1 2 3 4 5

28. Behavior: 0 1 2 3 4

29. Toileting: 0 1 2 3 4 5 6

30. Self Preservation Skills: 0 1 2 3 4

MEDICATIONS

31. Oral Doses/Day: 0 1-2 3-4 5-9 10-14 15+

32. Injections/Week: 0 1-3 4-7 8+

33. Other Meds/Day: 0 1-3 4-7 8+

34. Clinical Monitoring: 0 1 2

PSYCHOTHERAPEUTIC DRUG USE

35. Anti-psychotic Tranquilizers: 0 1 2

36. Anti-anxiety Tranquilizers: 0 1 2

37. Anti-depressants: 0 1 2

38. Sedatives/Hypnotics: 0 1 2

RECOMMENDATIONS

39. Level of Care: 0 1 2 3 4 5 6 7 8

40. Component of Care: 0 1 2 3 4 5 6 7 8 9 10 11 12

CURRENT/ACTIVE DIAGNOSIS

41.

42.

43.

44.

45.

46.

47. Explanations

R.N.'S SIGNATURE/DATE	SOCIAL WORKER'S SIGNATURE/DATE	M.D.'S SIGNATURE/DATE

ORIGINAL - QUALITY ASSURANCE AND REVIEW PROGRAM COPY: FACILITY

ATTACHMENT II

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street S.E.,
Minneapolis, Minnesota 55440
(612)623-5312

TRANSMITTAL OF REQUESTS FOR CLASSIFICATION

FACILITY NAME _____

ADDRESS _____

CITY _____

TELEPHONE NO. ( ) _____

DATE _____

TOTAL NO. OF REQUESTS FOR CLASSIFICATION _____

1. NEW ADMISSIONS _____
   SCREENED BY PAS _____
   ASSESSED BY FACILITY _____
2. READMISSION FROM HOSPITAL _____
3. RFC RETURNED WITH CORRECTIONS _____
4. REQUEST FOR RECONSIDERATION _____
5. SEMI-ANNUAL ASSESSMENTS _____

   FACILITY CENSUS ON DAY OF COMPLETION OF SEMI-ANNUAL ASSESSMENTS _____ DATE OF CENSUS _____

   (If total no. of assessments differs from census, use reverse side of form for explanation)

- - - -

ATTACHMENT III

minnesota department of health
717 s.e. delaware st. p.o. box 9441 minneapolis 55440
(612) 623-5000

To: 03/14/86

FROM: Quality Assurance and Review
(612) 623-5312

SUBJECT: Classification Notice

Minnesota Laws of 1984 establish a new reimbursement system for residents in nursing homes and boarding care homes certified to participate in the Medicaid Program. The new system establishes eleven payment classifications based on residents' care needs. Those needs will be identified by assessments conducted at different intervals by the facility, by the Department of Health, or by pre-admission screening.

A nurse employed by your facility completed an assessment form describing your care needs on 02/20/86. Based on the assessment your care needs show that your payment classification is -- B --. The payment rate which corresponds to this classification will be provided to you by the administration of your facility. This classification is effective as of 3/ 1/86.

If you want a copy of the assessment form, the Administrator or a designee must provide you a copy, as well as any other documents used for the assessment, and discuss it with you. If you need clarification of your payment classification, you may contact the Case Mix Coordinator of the Minnesota Department of Health by calling (612) 623-5312.

You, or a person you select, have the right to request a reconsideration of this payment classification if you disagree with it. If you do so, you will have up to ten (10) working days from the receipt of this letter to notify the Department of Health.

This notice to us must be in writing and must be accompanied by documentation which supports your request. A form has been provided to the facility for your convenience. With this form, include documentation such as a statement from your physician, or other documents to show that your care needs were different from those identified in the assessment form at the time the assessment was made.

Your may obtain assistance in making a reconsideration request by contacting your Nursing Home Ombudsman Program. The Ombudsman Program is designed to assist nursing home residents, and is independent of the Health Department and your nursing home. Their number in your area is 612/825-6861.

an equal opportunity employer

ATTACHMENT IV

Minnesota Department of Health
Quality Assurance and Review Program
717 Delaware St. SE, PO Box 9441
Minneapolis, MN 55440
(612) 623-5312

MEDICAL PLAN OF CARE

Facility Name	City
Resident Name	M.A. No./Private Pay Number
Date of Admission/Readmission	
Physician Name	
Primary Diagnosis:	
Secondary Diagnosis:	
Medications:	Dose:
Treatments:	Frequency:
What Clinical Monitoring Procedures are Needed?	
What Rehabilitation Procedures are Needed?	
Rehabilitation Potential:	
Discharge Potential:	
Other Comments:	

Signature_____, M.D. Date_____

(To be attached to QA&R Assessment Forms)

COMMONLY USED PSYCHOTROPIC DRUGS AND SEDATIVE/HYPNOTICS

ANTI PSYCHOTIC TRANQUILIZERS

Compazine (Prochlorperazine)
Haldol (Haloperidol)
Lidone (Molindone Hyprochloride)
Lithobid (Lithium Carbonate)
Lithonate (Lithium Carbonate)
Lithane (Lithium Carbonate)
Lithotabs (Lithium Carbonate)
Loxithane (Loxapine Succinate)
Mellaril (Thioridazine)
Moban (Molindone Hyprochloride)
Navane (Thiothizene)
Prolixin (Fluphenazine)
Proketazine (Pheno Carphenezine)
Quide (Piperacetazine)
Repoise (Butaperazine)
Serentil (Mesoridazine)
Sparine (Promazine)
Solazine (Trifluoperazine)
Stelazine (Trifluoperazine)
Taractan (Chrlorprothixene)
Thoraziine (Chlorpromazine)
Trilafon (Perphenazine)

ANTI ANXIETY TRANQUILIZERS

Atarax (Hydroxyzine Hydrochloride)
Ativan (Lorazepam)
Azene (Clorazepate)
Centrax (Prazepam)
Equanil (Meprobamate)
Librax (Combination of Chlordiazepoxide and Clinidium Bromide)
Limbitrol (Combination of Chlordiazepoxide and Clinidium Bromide)
Librium (Chlordiazepoxide)
Miltown (Meprobromate)
Noludar (Methyprylon)
Serax (Oxazepam)
Trancopal (Chlormeazanone)
Tranxene (Clorazepata Dipotassium)
Tybatran (Typamate)
Valium (Diazepam)
Valmid (Ethinamate)
Verstran (Prazepam)
Vistaril (Hydroxyzine Hydrochloride)
Xanax (Alprazolam)

ANTI DEPRESANTS

Amitid (Amitriptyline HCE)
Aventyl (Nortriptyline)
Ascendin (Amoxapine)
Desyrel (Trazodone HCL)
Elavil (Amitriptyline HCE)
Endep (Amitriptlyine HCE)
Etrafon (Perphenazine, N.F. and Amitriptyline Hydrochloride)
Limbitrol (Combination of Chlordiazepoxide and Amitriptyline)
Ludiomil (Maprotiline HCE)
Marplan (Isocarboxazid)
Nardil (Phenelzine Dithydrogen Sulfate)
Niamid (Nialamide)
Norpramine (Desipramine)
Pamelor (Nortriptyline)
Parnate (Tranylcypromine)
Pertofrane (Desipramine)
Ritalin (Methylphenidate)
Sinequan (Doxepin) Adapin
Surmontil (Triminpramine Maleate)
Tofranil (Imipramine)
Triavil (Combination of Perphenazine and Amitriptyline Hydrochloride)
Vivactil (Protriptyline)

SEDATIVES/HYPNOTICS

Butisol Sodium (Sodium Butabarbital)
Dalmane (Flurazepam Hydrochloride)
Doriden (Glutethimide)
Halcion (Triazolam)
Luminal (Phenobarbital)
Nembutal (Pentobarbital)
Noctec (Chloral Hydrate)
Noludar (Methyprylon)
Placidyl (Ethchlorvynol)
Plexonal (Barbital Sodium and Butalbital Sodium)
Seconal (Secobarbital)
Restoril (Temazepam)
Somnos (Chloral Hydrate)
Tuinal (Secobarbital and Amobarbital)

ATTACHMENT VI

MINNESOTA DEPARTMENT OF HEALTH
QUALITY ASSURANCE AND REVIEW PROGRAM
717 Delaware Street S.E.,
Minneapolis, Minnesota 55440
(612)623-5312

REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION

You may use this form, along with documentation, to support a requested reclassification reconsideration. The request and documentation must be submitted within ten working days of the receipt of the notice of classification.

RESIDENT'S NAME_____

MEDICAID OR PRIVATE PAY IDENTIFICATION NUMBER_____

FACILITY NAME_____

FACILITY ADDRESS_____

DATE OF RECEIPT OF NOTIFICATION OF RESIDENT CLASSIFICATION_____

In order to establish a basis for reconsidering the original classification we suggest:

1. **Enclose a copy of the resident assessment form. The facility must provide a copy of the assessment to the resident or their representative within one working day of request.**
2. **Circle the incorrect items in black ink.**
3. **Write a brief description of the basis for your disagreement with the items on the assessment form. (Use back of this form.)**
4. **Attach documentation establishing that the needs of the resident at the time of the assessment justify a change of classification.**

REQUEST SUBMITTED BY:

AUTHORIZED REPRESENTATIVE OF FACILITY ☐ RESIDENT ☐

RESIDENT'S AUTHORIZED REPRESENTATIVE ☐

SIGNATURE_____

DATE_____

I signify by my signature that these statements are correct and factual to the best of my knowledge.

HE-01279-01