NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
DIVISION OF HEALTH CARE FINANCING
BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT

A Request for Proposal for Development of Protocols and Procedures for Auditing the Minimum Data Set (MDS) Assessment Data

RFP No. 0802070924

Schedule of Key Events

RFP Release Date	June 9, 2008
Written Questions Due	June 25, 2008
Letter of Interest Due (optional)	July 7, 2008
Registration for Bidders Conference Required by	June 30, 2008
Bidders Conference (10:00 am – 1:00pm) Room C-125 Concourse Level Empire State Plaza, Albany NY	July 10, 2008
Response to Written Questions and Questions Received at Bidders Conference	July 21, 2008
Proposal Due Date by 2:00PM	August 1, 2008

Contacts Pursuant to State Finance Law § 139-j and 139-k

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k,the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

Jonathan P. Mahar
Grants and Procurement Unit
ESP Corning Tower, Room 1358
Albany, NY 12237-0676
(518) 473-8974, Fax (518) 474-8375
Email: jpm12@health.state.ny.us

Permissible Subject Matter Contacts:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health also identifies the following allowable contacts for communications related to the following subjects:

RFP Release Date:
Submission of written proposals or bids:
Submission of Written Questions:
Participation in the Pre-Bid Conference:
Debriefings:
Negotiation of Contract Terms after Award:

Mr. Terrence P. Cullen
Bureau of Financial Management & Information Support
ESP Corning Tower, Room 984
Albany New York 12237-0719
(518) 486-1371, Fax (518) 473-8825
Email: tpc03@health.state.ny.us

Mr. Robert Loftus
Bureau of Financial Management & Information Support
ESP Corning Tower, Room 984
Albany New York 12237-0719
(518) 486-1371, Fax (518) 473-8825
Email: rxl01@health.state.ny.us

Mr. Frank A. Czernicki
Bureau of Financial Management & Information Support
ESP Corning Tower, Room 984
Albany New York 12237-0719
(518) 486-1371, Fax (518) 473-8825
Email: fac01@health.state.ny.us

For further information regarding these statutory provisions, see the Lobbying Statute summary in Section E, 10 of this solicitation.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

June 9, 2008

Dear Potential Bidder:

Re: Request for Proposal for Development of Protocols and Procedures for Auditing the Minimum Data Set (MDS) Assessment Data

Pursuant to Chapter 109 of the Laws of 2006, as proposed to be amended by Senate Bill S6808a / Assembly Bill A9808a, a new case mix reimbursement system for residential health care facilities (RHCFs) will be implemented in New York State during 2009. Medicaid rates will be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the Federal Government for payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare), based on MDS assessment data. Such adjustments will be made semiannually on a calendar year basis. The reimbursement system will employ the MDS 2.0 or subsequent revisions as approved by the Center for Medicare & Medicaid Services (CMS). The reimbursement system will also employ the 53 Group RUG-III Classification System model version 5.20. Because of the direct connection that will exist between reported MDS data, the 53 Group RUG-III Classification System, and the Medicaid rate, it is vital that protocols and procedures are established to audit the MDS assessment data.

The New York State Department of Health is seeking a contractor with the necessary clinical and administrative expertise to develop protocols and procedures for auditing the MDS assessment data. The Request for Proposal (RFP), issued by the Bureau of Financial Management and Information Support, which details the required activities, will be posted on the Department of Health's website at www.health.state.ny.us/funding/ on June 9, 2008. Bidders wishing to receive these documents via mail must send a request, in writing, to the Department at the address provided at the bottom of this letter. Any qualified organization is invited to submit a proposal.

A bidder's conference will be held on July 10, 2008, from 10:00 a.m. to 1:00 p.m. in room C-125 on the Concourse level of the Empire State Plaza, Albany New York. Questions regarding this RFP will be answered only at this time, and may be submitted in writing prior to the date of the conference. To register, please call Ms. Lynne Ryan, at (518) 486-2487, by 4:00 p.m. EST, June 30, 2008.

Potential bidders that submit a letter of interest will automatically receive questions and answers, minutes of the bidder's conference, and any updates/amendments to the RFP. This letter should be received by July 7, 2008, and may be faxed to (518) 473-8825 in advance of the original letter.

Proposals in response to this RFP must be received at the address below by 2:00 p.m. on August 1, 2008. The successful bidder must be ready to assume all functions beginning on December 1, 2008.

Requests to receive the RFP via mail, questions for the bidder's conference, the letter of interest, and the proposal itself should be sent to:

Request for Proposal for Development of Protocols and Procedures for Auditing the MDS Assessment Data
Mr. Robert Loftus, Principal Health Care Fiscal Analyst
New York State Department of Health
Bureau of Financial Management and Information Support
Room 984, Corning Tower, Empire State Plaza
Albany, New York 12237-0719

Thank you in advance for your interest in this project. We look forward to seeing you at the bidder's conference and receiving your proposal.

Sincerely,

Richard Pellegrini
Director
Bureau of Financial Management
and Information Support

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Request for Proposal
Development of Protocols and Procedures for Auditing the Minimum Data Set (MDS) Assessment Data

A. Introduction

The New York State Department of Health, hereinafter referred to as DOH, is seeking a contractor to develop protocols and procedures for auditing the Minimum Data Set (MDS) assessment data that will be used for the Medicaid reimbursement system for Residential Health Care Facilities (RHCFs) in New York State during 2009. The contract awarded as a result of the Request for Proposal (RFP) will cover a 24-month period-anticipated running from December 1, 2008, through November 30, 2010.

This contract will be administered by DOH. The Bureau of Financial Management and Information Support (BFMIS), part of the Division of Health Care Financing in the Office of Health Insurance Programs, will be responsible for monitoring and approving the services provided under this contract.

The RFP has been prepared by BFMIS, and consists of seven sections: Introduction, Background, Detailed Specifications, Proposal Requirements, Administration, Appendices, and Attachments.

A copy of the MDS Version 2.0 is attached as Attachment 1. **Note:** The Department has submitted proposed changes of the MDS, Version 2.0 Section S – State Supplement, for review and approval to the Centers for Medicare & Medicaid Services (CMS). The Department has requested that these changes be effective with MDS submissions beginning October 1, 2008. A copy of proposed changes to Section S –New York State Supplement is included as Attachment 2. A copy of proposed changes to the Instructions for Section S – New York State Supplement is included as Attachment 3.

B. Background

During 2009, pursuant to Chapter 109 of the Laws of 2006, as proposed to be amended by Senate Bill S6808a/Assembly Bill A9808a, a new case mix reimbursement system for residential health care facilities (RHCFs) will be implemented in New York State. Medicaid rates will be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the Federal Government for payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare). Such adjustments will be made semiannually on a calendar year basis. The Department will collect resident identifying data from nursing facilities for designated dates in January and July in order to create a census roster. The census roster will be used to identify and extract, from the New York State MDS database, the MDSs required to set Medicaid reimbursement rates. Information from the MDS will be used to determine case mix classifications for RHCF Medicaid reimbursement. The reimbursement system will employ the MDS 2.0 or subsequent revisions as approved by the CMS. The reimbursement system will also employ the 53 Group

RUG-III Classification System model version 5.20. **Note:** CMS has announced that the MDS Version 3.0 is scheduled for implementation effective October 1, 2009. It is unclear at this time how the conversion to MDS Version 3.0 will affect the 53 Group RUG-III Classification System model version 5.20. A draft version of the MDS 3.0 is available from the CMS website at http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30Draft.pdf.

Because of the direct connection that will exist between reported MDS data, the 53 Group RUG –III Classification System, and the Medicaid rate it is vital that protocols are established to audit the MDS assessment data.

The Patient Review Instrument (PRI) is the State's current patient assessment tool used to establish nursing homes' case-mix for purposes of setting Medicaid reimbursement rates. Transitioning to the MDS for this purpose represents a major change. For example, there are 28 data items on a PRI assessment of a resident that determines a RUG, but the MDS results in 53 RUGs based on 108 data items. A copy of the PRI RUG-II Classification Sheet is included as Attachment 4. A copy of the RUG 53 Classification System Version 5.20 is included as Attachment 5.

MDS audit protocols must reflect the fact that audits will be conducted on-site at nursing facilities statewide based on complete medical records for particular timeframes. While it is not necessarily the Department's intention that the MDS protocols replicate the current PRI audit system, the following PRI information is provided for informational purposes.

The Department has an established protocol for auditing PRIs, which includes the following:

- Instruction manual for conducting PRI on-site reviews- included as Attachment 6
- PRI Instructions- included as Attachment 7
- PRI Clarification Sheet- included as Attachment 8
- Text of PRI audit worksheets- included as Attachment 9

The Department has an established protocol for selecting facilities for a PRI audit, which includes the following factors:

- The facility's previous audit results
- The number of months since the last audit
- The number of assessments since the last audit
- The case mix index (CMI) change from the previous assessment

The Department has an established protocol for selecting the number and type of residents to review, in part based on:

- Facility bed size (for example 40 audits for facilities less than 350 beds, 80 audits for larger facilities)
- Specialty residents (for example Traumatic Brain Injured – Extended Care, and Dementia)
- A resident's RUG Hierarchy and Activities of Daily Living (ADL) score

- A resident's ADL score

C. Detailed Specifications:

1. Project Manager

A project manager will be appointed by the contractor and approved by DOH. This manager will have the authority to speak for the contractor. The project manager will be the primary person with whom DOH conducts day-to-day business relating to the tasks to be performed under this contract. It is expected that the project manager will have the ability to resolve quickly any problems that arise during the contract period.

2. Minimum Requirements of Offerors - Details of Contract Deliverables

A qualified Offeror must demonstrate the relevant knowledge of, and experience with, directly and through any proposed subcontractors, the clinical documentation and criteria required for items on the MDS that are necessary to calculate Resource Utilization Groups (RUGs-III). This knowledge and experience must demonstrate the ability to develop an MDS audit system within the first four (4) months of the two-year contract period that includes, but is not limited to, the following contract deliverables:

2.1 Audit Selection Criteria

Offerors must demonstrate knowledge and experience relevant to making a proposal that includes:

- an algorithm(s) for selecting facilities for audit, including frequency. These criteria should, in part, be based on key aspects associated with each facility's MDS submissions. Offerors may choose to develop one algorithm for the initial year in which the State utilizes MDSs and another algorithm for subsequent years; and,

- two additional algorithms, one for selecting which specific residents' MDSs will be reviewed and another for selecting specific items on the MDS for audit. The number of residents/items selected for review must be broad enough in number and scope to provide a valid sampling of the MDSs at each selected facility.

Offerors must provide detailed approaches to meeting this deliverable, including a work plan for completion.

2.2 Audit Structure

Offerors must demonstrate knowledge and experience relevant to making a proposal that addresses:

- whether facility audits will be performed in a single stage and/or multiples stages and the circumstances that dictate these determinations.

- how many audit days will be required for each audit, which may vary among facilities based on bed size and/or other factors. This would include the Offeror's determination of the number of MDSs that could be audited in a 7.5-hour workday.

- the role of entrance conferences, exit conferences and facility participation during on-site reviews.

- the qualifications that must be met for personnel performing audits.

- the role of re-reviews of audit findings, if any, including what would trigger such a re-review, when it would be performed and by whom.

Offerors must provide detailed approaches to meeting this deliverable, including a workplan for completion.

2.3 The Audit Tool and Documentation

Offerors must demonstrate knowledge and experience relevant to making a proposal to develop:

- audit worksheets that delineate specified key criteria to be reviewed. Whether each criterion is met must be answerable by the auditor with a yes/no or similarly succinct notation. Related materials must also be developed that instruct auditors as to what specific medical record documentation must be in place and for what time periods required to complete each item on the audit worksheet.

- tools/instructions by which auditors will provide narrative documentation of the specific medical record documentation that led to their answers for each item on the audit worksheets.

- an algorithm that maps the effect of auditors' answers to audit worksheet questions, in all their combinations and permutations, on the reclassification of each resident within all the MDS RUGs.

Offerors must provide detailed approaches to meeting this deliverable, including a workplan for completion.

2.4 Implementation of Audit Results

Offerors must demonstrate knowledge and experience relevant to making a proposal that addresses whether audit results will be incorporated in rates only to the extent of the specific residents reviewed or extrapolated to the entire MDS submission of the

selected nursing home. If the latter, offerors must develop an algorithm for extrapolation.

Offerors must provide detailed approaches to meeting this deliverable, including a workplan for completion.

2.5 Changes to the Audit System for the Conversion to MDS Version 3.0

Offerors must demonstrate knowledge and experience relevant to making a proposal that addresses potential changes to the audit system as a result of CMS' announced conversion to MDS version 3.0, scheduled for implementation effective October 1, 2009. Specifically, how the conversion to MDS version 3.0 will affect the 53 Group RUG-III Classification System model version 5.20.

2.6 Consultation After Audit System Development

The offeror will continue to be available to the DOH until the contract end date of the two-year contract period to respond to any questions or concerns that arise after implementation of the MDS audit system.

D. Proposal Requirements

1. Proposal Format and Content

Proposals shall be prepared in the format described in Section D-2 Technical Proposal and Section D-3 Cost Proposal, below. The format of the proposals must follow, in sequence, each of the sections outlined below. Appendices should be similarly sequential. An official authorized to bind the Offeror to its provisions must sign proposals. Proposals that do not address all requirements of this RFP may be considered non-responsive, resulting in rejection of the proposal.

2. Technical Proposal

The Technical Proposal will contribute 75% toward the Offeror's overall score for each proposal submitted. No financial information is to be included in the Technical Proposal.

The Technical Proposal must be submitted separately from the Cost Proposal (see Section D-3) and consist of the following:

2.1 Transmittal Letter

An official authorized to bind the organization to the provisions of the RFP and Proposal must sign the transmittal letter in ink. Proposals that do not include all the requirements listed below will be considered non-responsive, resulting in rejection of the Proposal.

The transmittal letter must include:

- Identification of the person who will serve as primary contact for the State's Issuing Officer and that person's mailing address, e-mail address, telephone and fax numbers.

- Disclosure of any relationships and/or ownership interest that may represent a conflict of interest for the Offeror and/or subcontractor OR a statement that no such relationship exists. In cases where such a relationship does exist, describe how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided.

- The name, title and responsibilities of all officers, identifying those who are authorized to negotiate a contract with the Department and who will have ultimate responsibility and accountability for this contract.

- A description of any relevant litigation, charges, convictions, or disciplinary actions in which the Offeror is presently involved that may affect the Offeror's ability to perform with regard to this project OR a statement that no such actions exist.

2.2 Required Forms

In addition to the Transmittal Letter, the Offeror must complete the following Required Forms, which can be found in the Attachments referenced below:

- Attachment 10- Offeror's Questionnaire
- Attachment 12- Vendor Responsibility Attestation

Proposals that do not include these completed forms may be determined non-responsive, resulting in rejection of the Proposal.

2.3 Subcontractors

For each proposed subcontractor:

- Provide the full name and address of any organization with which the Offeror will subcontract for any services under this project. Describe the services the subcontractor will provide and how such services will be coordinated and managed by the Offeror. Describe the existing business relationship between the Offeror and the proposed subcontractor(s), including a brief description of the projects on which the Offeror and subcontractor are currently working.

- List responsible officers of each subcontractor, including those individuals authorized to negotiate for subcontractors.

- List any financial interest the Offeror has in proposed subcontractors, or provide a statement that no such interest exists.

- Provide evidence of all potential subcontractors' willingness to participate or enter into sub-contractual arrangements.

- Provide a description of any relevant litigation (pending or final), judgments, convictions and pending or final disciplinary actions for the subcontractor that may affect the ability to perform with regard to this project, or provide a statement that no such actions exist.

- Provide a Vendor Responsibility Attestation for any subcontractor that is known at the time of proposal submission and whose subcontract will equal or exceed $100,000 in any year during the contract period (see Attachment 12).

Proposals that do not include all of the above information may be determined non-responsive, resulting in rejection of the Proposal.

2.4 New York State Contract Work

List any New York State contract work within the previous five years for the Offeror and any of its proposed subcontractors. Including the following:

- State contracting agency
- Contact person
- Telephone number of contact person
- Project dollar amount
- Time frame
- Brief statement of the work performed

2.5 Response to Offeror's Questionnaire

Provide a response to all sections of the Offeror's questionnaire included in Attachment 10 to this RFP.

3. Cost Proposal

This is a competitive procurement, which will result in a fixed price contract.

In addition to the Technical proposal, Offerors must submit a separate Cost Proposal. The Cost Proposal will contribute 25% toward the Offeror's overall score. The Cost Proposal must consist of the following:

3.1 Cost Transmittal Letter

The Cost Transmittal Letter must be signed in ink by an individual authorized to bind the Offeror to its provisions. It must include a statement of assurance that the offer will remain valid and not subject to change for a minimum of 270 days from the proposal due date shown in the Schedule of Key events on page 1 of this RFP.

3.2 Cost Proposal Form

This RFP will result in a fixed price contract. Offerors must complete the Cost Proposal Form, Attachment 15, based on the following:

- A fixed price amount for each deliverable category as described in Section C-2 must be submitted.
- The fixed price amounts must be inclusive of all costs, including but not limited to salaries, fringe benefits, administrative costs, overhead, travel, and presentation costs.
- The sum of the fixed price amounts for each deliverable category will be the total fixed price bid amount.
- The total fixed price bid amount must reflect all costs for the full term of the contract, including the cost of consultation after audit system development through the end of the contract period.

In addition to the Cost Proposal Form, the Offeror must complete the following required forms, which can be found in the Attachments referenced below:

- Attachment 11- Bid Form
- Attachment 13 - State Consultant Services Form A, Contractor's Planned Employment from Contract Start Date through End of Contract Term
- Attachment 14 – NYS Taxation and Finance Form ST-220-CA

Proposals that do not include these completed forms may be determined non-responsive, resulting in rejection of the Proposal.

4. Method of Award

4.1 Vendor Selection

All complete and responsive proposals will be evaluated by DOH with the assistance of other State agencies as appropriate. At the discretion of the DOH, all bids may be rejected. The evaluation of the bids will include the following considerations:

- **Evaluation and Selection Committees**

  The Technical and Cost Proposals will be evaluated separately by a Technical Evaluation Committee and a Financial Evaluation Committee, respectively. These committees will report to a Selection Committee who will select the proposal that best meets the requirements of the Department.

- **Evaluation Criteria for Technical Proposals**

  The following general criteria will be used to evaluate the technical proposal. The three members of the Technical Evaluation Committee will independently evaluate each proposal.

  - Proposal organization
  - Proposal completeness
  - Proposal clarity and conciseness
  - Offeror's knowledge and experience specific to contract deliverables
  - Offeror's Organization Chart and Resumes
  - Offeror's References
  - Offeror's proposed overall approach and workplan

  The maximum points available for the technical proposal is 75. The following formula will be used when assigning a final score to technical proposals.

  Technical Proposal Points = (X/Y) x Z
  X = Technical proposal being scored
  Y = Highest scored technical proposal
  Z = Number of technical points available (75)

- **Evaluation Criteria for Financial (Cost) Proposals**

  The Financial proposals will be evaluated separately and independently from the technical proposals. The Offeror with the lowest total price, as determined by the Department, will receive the maximum score. Other Offerors will receive a proportionally lower score.

  The maximum points available for the cost proposal is 25. The following formula will be used when assigning a final score to cost proposal.

  Cost Proposal Points = (A/B) x C
  A = Lowest Cost Proposal
  B = Cost of proposal being scored
  C = Number of cost points available (25)

- **Total Combined Score**

  The Technical Score and the Cost Score will be combined into a Total combined Score, using the following formula:

  Technical Score
  + Cost Score

  Total Combined Score

- **Selection**

  The Department will select the proposal with the highest total combined score submitted by an Offeror that is deemed responsible.

4.2 Notification of Award

After evaluation and selection of the proposal, all Offerors will be notified in writing of the acceptance or rejection of their proposals. The name of the successful Offeror may be disclosed. Press releases pertaining to this project shall not be made without prior written approval by the Department and then only in conjunction with the Issuing Agency identified in this RFP.

4.3 Contract Process

Upon selection, the successful Offeror will be invited to enter into an agreement with the Department. The appendices contained in Section F (including the Standard Clauses for NYS Contracts, Appendix A), will form the basis of the agreement. Additionally, the contents of the selected Offeror's proposal, together with this RFP (including all Appendices), and any questions and answers passed during the procurement process will be made part of the final agreement. The provision of Section F, particularly Appendix A (Standard Clauses for NYS Contracts) will control.

New York State Finance Law Section 163(10)(e) (see also http://www.ogs.state.ny.us/procureounc/pgbguidelines.asp) allows the Commissioner of the New York State Office of General Services to consent to the use of this contract by other New York State agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

4.4 Acceptance of Deliverables and Payments

Payments will be made for satisfactory performance of the services described, based on the contractual fixed price, as agreed upon by the Contractor and the Department, up to the maximum amount payable under the contract.

All claims for payment will be submitted on a New York State Standard Voucher with backup information in a form satisfactory to the Department and the Comptroller of the State of New York.

E. Administrative

1. Issuing Agency

This RFP is a solicitation issued by the New York State DOH. The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

2. Inquiries

Any questions concerning this solicitation must be directed to:

Robert Loftus
Bureau of Financial Management & Information Support
ESP Corning Tower, Room 984
Albany, New York 12237-0719
(518) 486-1371, Fax (518) 473-8825
Email rxl01@health.state.ny.us

Questions and answers as well as any updates and/or modifications, will be posted on the Department of Health's website at www.health.state.ny.us/funding by the date listed on the schedule of key events on page 1 of this RFP. Bidders that submit a Letter of Interest will automatically receive these documents via mail.

3. Bidders' Conference

A bidders' conference will be held on the date and at the location specified in the Schedule of Key Events, page 1 of this RFP. At the conference, the Department will answer bidders' questions regarding the RFP. Questions may either be submitted in advance, as explained below, or be raised during the Bidders' Conference.

Information given in oral response to Bidders' Conference questions will be for general information only. Official binding responses will be provided by DOH in writing after the Bidders' Conference. A written summary of information presented at the Bidders' Conference will be provided to all attendees and to those Offerors who submitted a Letter of Interest and will also be posted on the DOH web site http:/www.health.state.ny.us/funding.

4. Letter of Interest

Offerors interested in responding to this RFP may submit a non-binding Letter of Interest by the date set forth in the Schedule of Key Events, page 1 of this RFP, indicating whether or not they intend to bid. The letter should specify a contact person and provide his or her mailing address, e-mail address, telephone and fax numbers.

Submission of the Letter of Interest is NOT mandatory, but it will ensure automatic receipt of any subsequent communications/addenda to the RFP.

Letters of Interest may be mailed, faxed or hand delivered to the attention of Robert Loftus at the address indicated above.

5. Submission of Proposals

5.1 Submission Summary

Interested vendors should submit an original and five signed copies plus one unbound copy of their Bid proposal not later than 2:00 p.m. on the Proposal Due Date listed on the Schedule of Key Events on page 1 of this RFP. For further details regarding the submission, see Section E-5.2, Requirements for Submission of Proposal, below.

Response to this RFP should be clearly marked as described in Section E-5.2, Requirements for Submission of Proposal, below and directed to:

Mr. Robert Loftus, Principal Health Care Fiscal Analyst
New York State Department of Health
Bureau of Financial Management and Information Support
Room 984, Corning Tower Building
Empire State Plaza
Albany, New York 12237-0719

It is the Offerors' responsibility to ensure that bids are delivered to Room 984, Corning Tower Building, prior to the date and time of the bid due date. Late bids due to delay by the carrier or not received in the Department's mail room in time for transmission to Room 984 will not be considered.

The Bid Form, included as Attachment 11, must be filled out in its entirety.

The responsible corporate officer for contract negotiation must be listed.
The responsible corporate officer must sign this document.

All evidence and documentation requested under Section D, Proposal Requirements must be provided at the time the proposal is submitted.

5.2 Requirements for Submission of Proposal

The following are general requirements to which an Offeror must adhere in submitting a proposal in response to this RFP:

- The Offeror must submit its proposal in two parts: Technical and Cost. Information required from Offerors and a detailed explanation of the required format for the Technical and Cost proposals are contained in Section D, Proposal Requirements;

- To facilitate the evaluation process, the offeror is required to submit one original, 5 bound copies, and one unbound copy of both the Technical and Cost Proposals (7 complete signed sets in all);

- The Technical and Cost portions of the proposal must be separately bound and placed in separately sealed envelopes labeled as either Technical or Cost. No cost information should be contained in the Technical Proposal. Both parts, however, should be submitted in the same package. The package(s) must indicate the following on the outside:

  - Offeror's name and address

  - NYS DOH Response to Development of Protocols and Procedures for Auditing the MDS Assessment Data

  - Proposal Due Date

- All copies of the proposal must be properly identified and mailed or hand delivered to the person and address listed in Section E-5.1 above.

- Proposals must be received by the Department on or before 2:00 p.m., on the Proposal Due Date at the mailing address set forth in the Schedule of Key Events on page 1 of the RFP. Any Offeror's proposal made in response to this RFP not received by 2:00 p.m. on the closing date for receipt of proposals will not be accepted.

- The Offeror must allow sufficient time for mail delivery to ensure receipt of its proposal by the specified time and should utilize certified or registered mail with return receipt requested. NO FAX COPIES WILL BE ACCEPTED.

6. Department of Health Rights

The Department of Health reserves the right to:

- reject any or all proposals received in response to this RFP.

- waive or modify minor irregularities in proposals received after prior notification to the Offeror.

- adjust or correct cost figures with the concurrence of Offeror if errors exist and can be documented to the satisfaction of DOH, and the State Comptroller.

- negotiate with Offerors responding to this RFP within the requirements to serve the best interests of the State.

- eliminate mandatory requirements unmet by all Offerors.

If the Department of Health is unsuccessful in negotiating a contract with the selected Offeror within an acceptable time frame, the Department of Health may begin contract

negotiations with next qualified Offeror(s) in order to serve and realize the best interests of the State.

7. Payment

If awarded a contract, the contractor shall submit invoices to the State's designated payment office:

New York State Department of Health
Bureau of Financial Management & Information Support
Room 984
Corning Tower, Empire State Plaza
Albany, New York 12237-0719

Payment of such invoices by the Department of Health shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

- In consideration of the Contractor's satisfactory performance of the services described in the Agreement, the Department agrees to pay the Contractor up to the contracted fixed price. Total reimbursement will not exceed the value shown on the face page of the Contract.

- The Department will issue payments to the Contractor at the percentages shown in the following schedules, provided that the Contractor has provided the corresponding deliverables to the Department's satisfaction:

Deliverable	Description of Deliverable	Percentage Payment
Audit selection criteria	Draft of audit selection criteria submitted to DOH Final audit selection criteria acceptable to DOH	50% 50%
Audit structure	Draft of audit structure submitted to DOH Final audit structure acceptable to DOH	50% 50%
Audit tool and documentation	Draft of audit tool and documentation submitted to DOH Final audit tool and documentation acceptable to DOH	50% 50%
Implementation of audit results	Draft of audit results implementation submitted to DOH Final audit results implementation acceptable to DOH	50% 50%
Changes to audit system as a result of the implementation of MDS 3.0	Assessment of the implications of CMS's implementation of MDS 3.0 on the 53-Group Rug III Classification System Model and the audit system Changes to audit system, if necessary, acceptable to DOH, as a result of the assessment above regarding the implementation of MDS 3.0	20% 80%
Consultation after audit system development through end of contract period	Contractor will continue to be available to the DOH until the contract end date to respond to any questions or concerns that arise after implementation of the MDS audit system.	0%

- The contractor represents and agrees to submit all claims for payment in a form satisfactory to the Department and the Comptroller of the State of New York.

- The Department shall not be liable for the payment of any taxes under the agreement, however designated, levied or imposed.

8. Term of Contract

The agreement shall be effective upon approval of the New York State Office of the State Comptroller. The contract awarded as a result of the RFP will cover a 24-month period anticipated to run from December 1, 2008, through November 30, 2010.

This agreement may be canceled at any time by the Department of Health giving to the contractor not less than thirty (30) days written notice that on or after a date therein specified this agreement shall be deemed terminated and canceled.

9. Debriefing

Once an award has been made, Offerors may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the Offeror's proposal, and will not include any discussion of other proposals. Requests must be received no later than three months from date of award announcement.

10. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep System online at https://portal.osc.state.ny.us. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us. Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Bidders must also complete and submit the Vendor Responsibility Attestation (Attachment 12).

11. State Consultant Services Reporting

Chapter 10 of the Laws of 2006 amended certain sections of State Finance Law and Civil Service Law to require disclosure of information regarding contracts for consulting services in New York State.

Winning bidders for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

Winning bidders must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

Both of these forms are included as Attachment 13 to this RFP.

12. Lobbying Statute

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as it pertains to development of procurement contracts with governmental entities:

a) makes the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;

b) requires the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;

c) requires governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;

d) authorizes the Temporary State Commission on Lobbying to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;

e) directs the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;

f) requires the timely disclosure of accurate and complete information from offerors with respect to determinations of non-responsibility and debarment;

g) expands the definition of lobbying to include attempts to influence gubernatorial or local Executive Orders, Tribal–State Agreements, and procurement contracts;

h) modifies the governance of the Temporary State Commission on lobbying;

i) provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;

j) increases the monetary threshold which triggers a lobbyists obligations under the Lobbying Act from $2,000 to $5,000; and

k) establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerors. Sections 139-j and 139-k are collectively referred to as "new State Finance Law."

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York Temporary State Commission on Lobbying (Lobbying Commission) regarding procurement lobbying, the Lobbying Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the Lobbying Commission.

13. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with NYS Office of Technology Policy P04-002, "Accessibility of New York State Web-based Intranet and Internet Information and Applications", and NYS Mandatory Technology Standard S04-001, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to NYS Mandatory Technology Standard S04-00, as determined by quality assurance testing. Such quality assurance testing will be conducted by Department of Health before web content will be considered a qualified deliverable under the contract or procurement.

14. Information Security Breach and Notification Act

Section 208 of the State Technology Law (STL) and Section 899-aa of the General Business Law (GBL) require that State entities and persons or businesses conducting

business in New York who own or license computerized data which includes private information including an individual's unencrypted personal information plus one or more of the following: social security number, driver's license number or non-driver ID account number, credit or debit card number plus security code, access code or password which permits access to an individual's financial account, must disclose to a New York resident when their private information was, or is reasonably believed to have been, acquired by a person without valid authorization. Notification of breach of that private information to all individuals affected or potentially affected must occur in the most expedient time possible without unreasonable delay, after measures are taken to determine the scope of the breach and to restore integrity; provided, however, that notification may be delayed if law enforcement determines that expedient notification would impede a criminal investigation. When notification is necessary, the State entity or person or business conducting business in New York must also notify the following New York State agencies: the Attorney General, the Office of Cyber Security & Critical Infrastructure Coordination (CSCIC), and the Consumer Protection Board (CPB). Information relative to the law and the notification process is available at: http:/www.cscic.state.ny.us/security/securitybreach/

15. New York State Tax Law Section 5-a

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors award state contracts for commodities, services and technology valued at more than $100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DFT to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offeror meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD attached hereto. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must complete and submit to the Department of health the form ST-220-CA attached hereto, certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offeror non-responsive and non-responsible. Offerors shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

16. Additional Terms and Conditions

16.1 Cost Liability

DOH assumes no responsibility and no liability for any costs incurred by bidders for proposal preparation or activities related to the review of this RFP.

16.2 Acceptance of Proposal Content

The contents of the proposal of the successful bidder will become a part of any contract awarded as a result of this RFP.

16.3 Prime Contractor Responsibilities

The selected contractor will be required to assume sole responsibility for the complete effort as required by this RFP. DOH will consider the selected contractor to be the sole point of contact with regard to contractual matters. All subcontracts entered into by the contractor for any part of this RFP are subject to review and approval by DOH.

16.4 Press Releases

The contractor may not issue a news release regarding this project without prior approval from DOH.

16.5 Ownership of Products

All contractor activities to be performed and all materials to be produced under this contract will be accomplished in consultation with and under the direction of DOH, and are subject to final approval by DOH, and remain the property of DOH.

16.6 Meetings Between Contractor and DOH

All meetings between the contractor and DOH will be held in Albany, New York unless otherwise agreed to in advance by DOH. The contractor agrees to meet with DOH to discuss contractual and programmatic issues at least on a semi-annual basis during the term of this contract, unless otherwise agreed to by DOH.

16.7 Confidentiality

All proposals submitted in response to this RFP will be kept in strict confidence to the extent permitted by law. Proposals and resulting contracts with the DOH are subject to disclosure under the Freedom of Information Law (FOIL). Confidential, trade secret or proprietary materials as defined by the laws of the State of New York must be clearly marked and identified as such upon submission. Bidders/Contractors intending to seek an exemption from disclosure of these materials under FOIL must request the exemption in writing, setting forth the reasons for the claimed exemption, at the time of submission. Acceptance of the claimed material does not constitute a determination on the exemption request; such determination will be made in accordance with statutory procedures.

16.8 Changes in Scope of Contract

The contractor agrees that, in the event the State through change in policy, regulation or law, alters the scope or level of required work or reallocates functions, which the State in its sole discretion may do at any time during the term of this agreement, and thereby causes a substantial increase or decrease in the required effort of the contractor, the parties will enter into good faith negotiations in order to reach agreement on the actions, if any, to be taken in order to achieve an equitable adjustment to the agreement terms that will promote the parties' expectations and objectives in entering into this agreement and not alter its fundamental purpose. It is further agreed that both parties will use best efforts to finalize negotiations on these matters within sixty (60) days of notification.

The contractor shall implement changes within the scope of work of this agreement, in accordance with a State approved schedule, including changes in policy, regulation, statute, or judicial interpretation.

The contractor shall recognize and agree that any and all work performed outside the scope of this agreement or without consent of the State shall be deemed by the State to be gratuitous and not subject to charge by the contractor.

Upon approval of the OSC, the State may agree to additional payment for unanticipated changes in the scope of the program. The changes must be approved via a formal amendment to this agreement. The contractor shall not be reimbursed for any unauthorized changes in the scope of this agreement. Verbal agreements regarding changes are not binding. To request a change, the contractor must define the need and the requirements of the change and any associated costs. The contractor shall provide a written explanation concerning how the cost increase was calculated. In addition, the request for change in scope of this agreement must include a discussion of the impact on the project if such change is not approved.

F. Appendices

The following will be incorporated as appendices into any contracts resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

- APPENDIX A – Standard Clauses for All New York State Contracts
- APPENDIX B – Request for Proposal
- APPENDIX C **–** Proposal. The bidder's proposal (if selected for award), including the Bid Form and all proposal requirements.
- APPENDIX D **–** General Specifications
- APPENDIX E – Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or Workers' Compensation Board, of coverage for:
  - Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:
    - WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
    - C-105.2 – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the U-26.3;OR
    - SI-12 - Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 **–** Certificate of Participation in Workers' Compensation Group Self-Insurance.
  - Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:
    - WC/DB-100, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
    - DB-120.1 – Certificate of Disability benefits Insurance OR the DB-820/829 Certificate/Cancellation of Insurance; OR
    - DB-155 – Certificate of Disability Benefits self-Insurance
- APPENDIX H – Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
- APPENDIX X – Modification Agreement Form

G. Attachments

Attachment 1	MDS Version 2.0
Attachment 2	Proposed changes to Section S- NYS Supplement
Attachment 3	Proposed changes to Instructions for Section S- NYS Supplement
Attachment 4	PRI RUG-II Classification Sheet
Attachment 5	RUG 53 Classification System Version 5.20
Attachment 6	Instruction Manual for Conducting PRI On-Site Reviews
Attachment7	PRI Instructions
Attachment 8	PRI Clarification Sheet
Attachment 9	Text of PRI Audit Worksheets
Attachment 10	Offeror's Questionnaire
Attachment 11	New York State Bid Form
Attachment 12	Vendor Responsibility Attestation
Attachment 13	State Consultant Services Form A - Contractor's Planned Employment from Contract Start Date through End of Contract Term and State Consultant Services Form B - Contractor's Annual Employment Report
Attachment 14	NYS Taxation and Finance Form ST-220-CA and ST-220-TD
Attachment 15	Cost Proposal Form

Appendix A

STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor

within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION**.** (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
http://www.empire.state.ny.us

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
http://www.empire.state.ny.us

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

Appendix D

APPENDIX D
GENERAL SPECIFICATIONS

A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:

All specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specification, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.

B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, telegram, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.

C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety be liable to the State of New York for any excess cost on account thereof.

D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.

E. The Department of Health will make no allowances or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.

F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.

G. The successful bidder will be required to complete the entire work, or any part thereof as the case may be, to the satisfaction of the Department of

Health in strict accordance with the specifications and pursuant to a contract therefore.

H. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

I. Non-Collusive Bidding

By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:

a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;

b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;

c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its or its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.

L. Work for Hire Contract
Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed or included in the application software provided to the Department as a part of this contract.

M. Technology Purchases Notification -- The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"

1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over $20,000, or of other technology over $50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.

3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.

4. The responses to this RFP must include a solution to effectively handle the turn of the century issues related to the change from the year 1999 to 2000.

N. YEAR 2000 WARRANTY

1. Definitions

For purposes of this warranty, the following definitions shall apply:

a. Product shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data conversion or data entry, the term Product shall include resulting deliverables.

b. Vendor's Product shall include all Product delivered under this Agreement by Vendor other than Third Party Product.

c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: a) corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Warranty Disclosure

At the time of bid, Product order or Product quote, Vendor is required to disclose the following information in writing to Authorized User:

a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's Installed Product) which have been specified to perform as a system: Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and

b. For Third Party Product Not Specified as Part of a System: Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's Year 2000 Warranty, Vendor shall pass through said third party warranty from the third party manufacturer to the Authorized User but shall not be liable for the testing or verification of Third Party's compliance statement. .

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the product(s) or system(s) in question with the year 2000 warranty statement set forth below.

3. Warranty Statement

Year 2000 warranty compliance shall be defined in accordance with the following warranty statement:

Vendor warrants that Product(s) furnished pursuant to this Agreement shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, Vendor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to Authorized User's ongoing business processes, time being of the essence, at Vendor's sole cost and

expense. This warranty does not extend to correction of Authorized User's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Agreement.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Agreement.

O. No Subcontracting
Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health.

P. Superintendence by Contractor
The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the Contractor.

Q. Sufficiency of Personnel and Equipment
If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.

R. Experience Requirements
The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.

S. Contract Amendments
This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor

2. If, in the judgement of the Department of Health, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

U. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and

2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

V. Conflicts

If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT

The New York State Department of Health recognizes the need to take

affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department.

X. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:

    a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the

contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than $500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than $1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than $500,000 for damages arising out of damage to or destruction or property during any single occurrence and not less than $1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.

ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

Y. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and

benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

   Instructions for Certification

   a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

   b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

   c. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

   d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of

those regulations.

e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.

g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non-procurement Programs.

h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

i. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

   a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.

   b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Z. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.

2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.

4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.

5. The CONTRACTOR , its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

6. All subcontracts shall contain provisions specifying:

   a. that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and

   b. that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

AA. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:

   a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and

b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and

c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

BB. Provisions Related to New York State Procurement Lobbying Law

1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

CC. Provisions Related to New York State Information Security Breach and Notification Act

1. CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

Appendix H

Appendix H

Federal Health Insurance Portability and Accountability Act ("HIPAA")
Business Associate Agreement ("Agreement") Governing Privacy and Security

I. Definitions:

(a) Business Associate shall mean the CONTRACTOR.

(b) Covered Program shall mean the STATE.

(c) Other terms used, but not otherwise defined, in this agreement shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including those at 45 CFR Parts 160 and 164.

II. Obligations and Activities of the Business Associate:

(a) The Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law.

(b) The Business Associate agrees to use the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates receives, maintains or transmits on behalf of the Covered Entity pursuant to this Agreement.

(c) The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Agreement.

(d) The Business Associate agrees to report to the Covered Program, any use or disclosure of the Protected Health Information not provided for by this Agreement, as soon as reasonably practicable of which it becomes aware. The Business Associate also agrees to report to the Covered Entity any security incident of which it becomes aware.

(e) The Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from,

or created or received by the Business Associate on behalf of the Covered Program agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.

(f) The Business Associate agrees to provide access, at the request of the Covered Program, and in the time and manner designated by the Covered Program, to Protected Health Information in a Designated Record Set, to the Covered Program or, as directed by the Covered Program, to an Individual in order to meet the requirements under 45 CFR 164.524, if the business associate has protected health information in a designated record set.

(g) The Business Associate agrees to make any amendment(s) to Protected Health Information in a designated record set that the Covered Program directs or agrees to pursuant to 45 CFR 164.526 at the request of the Covered Program or an Individual, and in the time and manner designated by Covered Program, if the business associate has protected health information in a designated record set.

(h) The Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Covered Program available to the Covered Program, or to the Secretary of Health and Human Services, in a time and manner designated by the Covered Program or the Secretary, for purposes of the Secretary determining the Covered Program's compliance with the Privacy Rule.

(i) The Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(j) The Business Associate agrees to provide to the Covered Program or an Individual, in time and manner designated by Covered Program, information collected in accordance with this Agreement, to permit Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

III. <u>Permitted Uses and Disclosures by Business Associate</u>

(a) General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Program as specified in the Agreement to which this is an addendum, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Program.

(b) Specific Use and Disclosure Provisions:

(1) Except as otherwise limited in this Agreement, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(2) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the business associate or to carry out its legal responsibilities and to provide Data Aggregation services to Covered Program as permitted by 45 CFR 164.504(e)(2)(i)(B). Data Aggregation includes the combining of protected information created or received by a business associate through its activities under this contract with other information gained from other sources.

(3) The Business Associate may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR §164.502(j)(1).

IV. Obligations of Covered Program

Provisions for the Covered Program To Inform the Business Associate of Privacy Practices and Restrictions

(a) The Covered Program shall notify the Business Associate of any limitation(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.

(b) The Covered Program shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.

(c) The Covered Program shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Program has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction

may affect the Business Associate's use or disclosure of Protected Health Information.

V. Permissible Requests by Covered Program

The Covered Program shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Program, except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate.

VI. Term and Termination

(a) ***Term.*** **The Term of this Agreement shall be effective during the dates noted on page one of this agreement, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in The Agreement.**

(b) ***Termination for Cause.*** **Upon the Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for the Business Associate to cure the breach and end the violation or may terminate this Agreement and the master Agreement if the Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or the Covered Program may immediately terminate this Agreement and the master Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible.**

(c) ***Effect of Termination.***

(1) Except as provided in paragraph (c)(2) below, upon termination of this Agreement, for any reason, the Business Associate shall return or destroy all Protected Health Information received from the Covered Program, or created or received by the Business Associate on behalf of the Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the

Parties that return or destruction of Protected Health Information is infeasible, the Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VII. <u>Violations</u>

(a) It is further agreed that any violation of this agreement may cause irreparable harm to the State, therefore the State may seek any other remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.

(b) The business associate shall indemnify and hold the State harmless against all claims and costs resulting from acts/omissions of the business associate in connection with the business associate's obligations under this agreement.

Miscellaneous

(a) ***Regulatory References*****. A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended, and for which compliance is required.**

(b) ***Amendment.*** **The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Program to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.**

(c) ***Survival.*** **The respective rights and obligations of the Business Associate under Section VI of this Agreement shall survive the termination of this Agreement.**

(d) ***Interpretation.*** **Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the Covered Program to comply with the HIPAA Privacy Rule.**

(e) If anything in this agreement conflicts with a provision of any other agreement on this matter, this agreement is controlling.

(f) HIV/AIDS. If HIV/AIDS information is to be disclosed under this agreement, the business associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

Attachment 1

Numeric Identifier _____

MINIMUM DATA SET (MDS) – *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ★	(Exactly as appears on Medicare Card) a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)
2.	GENDER ★	1. Male 2. Female
3.	BIRTHDATE ★	(Complete all four digits) Month — Day — Year
4.	RACE/ETHNICITY ★	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ★ [C in 1st box if non Med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ★	a. State No. *(Facility Medicaid Provider number)* b. Federal No. *(Facility Medicare Provider number)*
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ★	*(Resident Medicaid number)*
8.	REASONS FOR ASSESSMENT *Use 8a if NOT Medicare covered, leave 8b blank. Use 8a & b if Medicare covered*	[Note–Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** *Codes for assessments required for Medicare PPS or the State* *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

★ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Code "–" if information unavailable or unknown

Items shaded in pink are classified in the Medicare Prospective Payment System (PPS) RUG-III Version 5.20 for skilled nursing facilities.

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.).

RAP TRIGGER LEGEND

1 - Delirium	**10A** - Activities (Revise)
2 - Cognitive Loss/Dementia	**10B** - Activities (Review)
3 - Visual Function	**11** - Falls
4 - Communication	**12** - Nutritional Status
5A - ADL-Rehabilitation	**13** - Feeding Tubes
5B - ADL-Maintenance	**14** - Dehydration/Fluid Maintenance
6 - Urinary Incontinence and Indwelling Catheter	**15** - Dental Care
7 - Psychosocial Well-Being	**16** - Pressure Ulcers
8 - Mood State	**17** - Psychotropic Drug Use
9 - Behavioral Symptoms	**17*** - For this to trigger, O4a, b, or c must = 1-7
	18 - Physical Restraints

QUALITY INDICATORS (QI) / QUALITY MEASURES (QM) LEGEND: Chronic Care & Post-Acute

- QI 1.1 Incidence of new fractures
- QI 1.2 Prevalence of falls
- QM 2.1 Residents who have become more depressed or anxious
- QI 2.2 Prevalence of behavior symptoms affecting others
- QI 2.3 Prevalence of symptoms of depression w/o antidepressant therapy
- QI 3.1 Use of 9 or more medications
- QI 4.1 Incidence of cognitive impairment
- QI 5.1 Low-risk residents who lost control of their bowels or bladder
- QM 5.2 Residents who have/had a catheter inserted and left in their bladder
- QI 5.3 Prevalence of occasional or frequent bladder or bowel incontinence w/o a toileting plan
- QI 5.4 Prevalence of fecal impaction
- QM 6.1 Residents with a urinary tract infection
- QM 7.1 Residents who lose too much weight
- QI 7.2 Prevalence of tube feeding
- QI 7.3 Prevalence of dehydration
- QM 8.1 Residents who have moderate to severe pain
- QM 9.1 Residents whose need for help with daily activities has increased
- QM 9.2 Residents who spend most of their time in bed or in a chair
- QM 9.3 Residents whose ability to move in and around their room got worse
- QI 9.4 Incidence of decline in ROM
- QI 10.1 Prevalence of antipsychotic use, in the absence of psychotic or related conditions
- QI 10.2 Prevalence of antianxiety/hypnotic use
- QI 10.3 Prevalence of hypnotic use more than two times in last week
- QM 11.1 Residents who were physically restrained
- QI 11.2 Prevalence of little or no activity
- QM 12.1 High-risk residents with pressure ulcers
- QM 12.2 Low-risk residents with pressure ulcers
- QM 13.1 Short-stay residents with delirium = Post-Acute
- QM 13.2 Short-stay residents who had moderate to severe pain = Post-Acute
- QM 13.3 Short-stay residents with pressure ulcers = Post Acute

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) – *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note – Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.

Do NOT change this date on readmission

Month ___ Day ___ Year ___

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital *(Not SNF unit of acute care hospital)*
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No 1. Yes 2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above.)

Prior stay at this nursing home	a.
Stay in other nursing home	b.
Other residential facility – board and care home, assisted living, group home	c.
MH/psychiatric setting	d.
MR/DD setting	e.
NONE OF ABOVE	f.

6. LIFETIME OCCUPATION(S) (Put "/" between two occupations)

7. EDUCATION *(Highest level completed)*

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(Code for correct response)

a. Primary Language
0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?
0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)

Not applicable – no MR/DD (Skip to AB11)	a.
MR/DD with organic condition	
Down's syndrome	b.
Autism	c.
Epilepsy	d.
Other organic condition related to MR/DD	e.
MR/DD with no organic condition	f.

11. DATE BACKGROUND INFORMATION COMPLETED

(This date must NOT be earlier than date of entry)

Month ___ Day ___ Year ___

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE

(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)

Review for possible care plan approaches

(Check all that apply. If all information UNKNOWN, check last box only.)

CYCLE OF DAILY EVENTS	
Stays up late at night (e.g., after 9 pm)	a.
Naps regularly during day (at least 1 hour)	b.
Goes out 1+ days a week	c.
Stays busy with hobbies, reading, or fixed daily routine	d.
Spends most of time alone or watching TV	e.
Moves independently indoors (with appliances, if used)	f.
Use of tobacco products at least daily	g.
NONE OF ABOVE	h.
EATING PATTERNS	
Distinct food preferences	i.
Eats between meals all or most days	j.
Use of alcoholic beverage(s) at least weekly	k.
NONE OF ABOVE	l.
ADL PATTERNS	
In bedclothes much of day	m.
Wakens to toilet all or most nights	n.
Has irregular bowel movement pattern	o.
Showers for bathing	p.
Bathing in PM	q.
NONE OF ABOVE	r.
INVOLVEMENT PATTERNS	
Daily contact with relatives/close friends	s.
Usually attends church, temple, synagogue (etc.)	t.
Finds strength in faith	u.
Daily animal companion/presence	v.
Involved in group activities	w.
NONE OF ABOVE	x.
UNKNOWN – Resident/family unable to provide information	y.

END

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
b.		
c.		
d.		
e.		
f.		
g.		

= When box blank, must enter number or letter

a. = When letter in box, check if condition applies

Code "–" if information unavailable or unknown

NOTE: Normally, the MDS Face Sheet is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is readmitted to the facility after a discharge where return had not previously been expected. It is not completed following temporary discharges to hospitals or after therapeutic leaves/home visits.

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) – *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — **(Exactly as appears on Medicare Card)**
a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period*
Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month — Day — Year

5. MARITAL STATUS
1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(Billing Office to indicate; ***check all that apply in last 30 days)***
a. Medicaid per diem
b. Medicare per diem
c. Medicare ancillary part A
d. Medicare ancillary part B
e. CHAMPUS per diem
f. VA per diem
g. Self or family pays for full per diem
h. Medicaid resident liability or Medicare co-payment
i. Private insurance per diem (including co-payment)
j. Other per diem

8. REASONS FOR ASSESSMENT
[Note–If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]
See Section AA8 for explanation
a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged–return not anticipated
7. Discharged–return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*
b. ***Codes for assessments required for Medicare PPS or the State***
1. Medicare 5 day assessment
2. Medicare 30 day assessment
3. Medicare 60 day assessment
4. Medicare 90 day assessment
5. Medicare readmission/return assessment
6. Other state required assessment
7. Medicare 14 day assessment
8. Other Medicare required assessment

9. RESPONSIBILITY/ LEGAL GUARDIAN
(Check all that apply)
a. Legal guardian
b. Other legal oversight
c. Durable power of attorney/health care
d. Durable power of attorney/ financial
e. Family member responsible
f. Patient responsible for self
g. *NONE OF ABOVE*

10. ADVANCED DIRECTIVES
(For those items with supporting documentation in the medical record, ***check all that apply)***
a. Living will
b. Do not resuscitate
c. Do not hospitalize
d. Organ donation
e. Autopsy request
f. Feeding restrictions
g. Medication restrictions
h. Other treatment restrictions
i. *NONE OF ABOVE*

SECTION B. COGNITIVE PATTERNS

1. COMATOSE — *(Persistent vegetative state/no discernible consciousness)*
0. No QI 1. Yes ***(If yes, skip to Section G)***

2. MEMORY — a1 = QI
(Recall of what was learned or known)
a. Short-term memory OK–seems/appears to recall after 5 minutes
0. Memory OK **1.** Memory problem **2**
b. Long-term memory OK–seems/appears to recall long past
0. Memory OK **1.** Memory problem **2**

3. MEMORY/ RECALL ABILITY
(Check all *that resident was* ***normally able to recall during last 7 days)***
Current season a.
Location of own room b.
Staff names/faces c.
That he/she is in a nursing home d.
NONE OF ABOVE are recalled e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(Made decisions regarding tasks of daily life) 1,2,3 = QI
0. *INDEPENDENT*–decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*–some difficulty in new situations only **2**
2. *MODERATELY IMPAIRED*–decisions poor; cues/ supervision required **2**
3. *SEVERELY IMPAIRED*–never/rarely made decisions **2, 5B**

5. INDICATORS OF DELIRIUM–PERIODIC DISORDERED THINKING/ AWARENESS — a-f = 2 QM
(Code for behavior in the ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.]***
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED–(e.g., difficulty paying attention; gets sidetracked) 2 = **1, 17***
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS–(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) 2 = **1, 17***
c. EPISODES OF DISORGANIZED SPEECH–(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) 2 = **1, 17***
d. PERIODS OF RESTLESSNESS–(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) 2 = **1, 17***
e. PERIODS OF LETHARGY–(e.g., sluggishness; staring into space; difficult to arouse; little body movement) 2 = **1, 17***
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY–(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) 2 = **1, 17***

6. CHANGE IN COGNITIVE STATUS
Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since assessment if less than 90 days)
0. No change **1.** Improved **2.** Deteriorated **1, 17***

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING
(With hearing appliance, if used)
0. *HEARS ADEQUATELY*–normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting **4**
2. *HEARS IN SPECIAL SITUATIONS ONLY*–speaker has to adjust tonal quality and speak distinctly **4**
3. *HIGHLY IMPAIRED*/absence of useful hearing **4**

2. COMMUNICATION DEVICES/ TECHNIQUES
(Check all that apply *during last 7 days)*
Hearing aid, present and used a.
Hearing aid, present and not used regularly b.
Other receptive comm. techniques used (e.g., lip reading) c.
NONE OF ABOVE d.

3. MODES OF EXPRESSION
(Check all used by *resident to make needs known)*
Speech a.
Writing messages to express or clarify needs b.
American sign language or Braille c.
Signs/gestures/sounds d.
Communication board e.
Other f.
NONE OF ABOVE g.

4. MAKING SELF UNDERSTOOD
(Expressing information content–however able)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*–difficulty finding words or finishing thoughts **4**
2. *SOMETIMES UNDERSTOOD*–ability is limited to making concrete requests **4**
3. *RARELY/NEVER UNDERSTOOD* **4**

5. SPEECH CLARITY
(Code for speech in the ***last 7 days)***
0. *CLEAR SPEECH*–distinct, intelligible words
1. *UNCLEAR SPEECH*–slurred, mumbled words
2. *NO SPEECH*–absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS
(Understanding verbal information content–however able)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*–may miss some part/ intent of message **2, 4**
2. *SOMETIMES UNDERSTANDS*–responds adequately to simple, direct communication **2, 4**
3. *RARELY/NEVER UNDERSTANDS* **2, 4**

7. CHANGE IN COMMUNICATION/ HEARING
Resident's ability to express, understand, or hear information has changed as compared to status of ***90 days ago*** *(or since last assessment if less than 90 days)*
0. No change **1.** Improved **2.** Deteriorated **17***

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*–sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*–sees large print, but not regular print in newspapers/books **3** 2. *MODERATELY IMPAIRED*–limited vision; not able to see newspaper headlines, but can identify objects **3** 3. *HIGHLY IMPAIRED*–object identification in question, but eyes appear to follow objects **3** 4. *SEVERELY IMPAIRED*–no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems–decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) **3**	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass **0.** No **1.** Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(Code for indicators observed in last 30 days, irrespective of the assumed cause)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements–e.g., *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"* QI QM 1 or 2 = **8**

b. Repetitive questions–e.g., *"Where do I go; What do I do?"* 1 or 2 = **8**

c. Repetitive verbalizations– e.g., calling out for help *("God help me")* QM **1 or 2 = 8**

d. Persistent anger with self or others–e.g., easily annoyed, anger at placement in nursing home; anger at care received 1 or 2 = **8**

e. Self deprecation–e.g., *"I am nothing; I am of no use to anyone"* QM 1 or 2 = **8**

f. Expressions of what appear to be unrealistic fears–e.g., fear of being abandoned, left alone, being with others QM 1 or 2 = **8**

g. Recurrent statements that something terrible is about to happen–e.g., believes he or she is about to die, have a heart attack QM QI 1 or 2 = **8**

h. Repetitive health complaints–e.g., persistently seeks medical attention, obsessive concern with body functions QM 1 or 2 = **8**

i. Repetitive anxious complaints/concerns (non–health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry/clothing, relationship issues 1 or 2 = **8**

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning QI 1 or 2 = **8**

k. Insomnia/change in usual sleep pattern 1 or 2 = **8**

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions–e.g., furrowed brows 1 or 2 = **8**

m. Crying, tearfulness QM 1 or 2 = **8**

n. Repetitive physical movements–e.g., pacing, hand wringing, restlessness, fidgeting, picking QI QM 1 or 2 = **8, 17***

LOSS OF INTEREST

o. Withdrawal from activities of interest–e.g., no interest in longstanding activities or being with family/friends QI 1 or 2 = **7, 8**

p. Reduced social interaction QI 1 or 2 = **8**

2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 1,2 = QI
0. No mood indicators **1.** Indicators present, easily altered **8** **2.** Indicators present, not easily altered QM **8**

3. CHANGE IN MOOD

Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if **less than 90 days)**
0. No change **1.** Improved **2.** Deteriorated **1, 17***

4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral** symptom **frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral** symptom **alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

		(A)	(B)
	a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) A = 1, 2, or 3 = **9, 11**		
E4b,c,d Box A = 1,2,3 = QI	b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) A = 1, 2, or 3 = **9**		
	c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) A = 1, 2, or 3 = **9**		
	d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self–abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) A = 1, 2, or 3 = **9**		
E4e Box A = 1,2,3 = QI	e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating) A = 1, 2, or 3 = **9**		

★ ADL INDEX used to calculate all RUG-III categories except default

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change **1.** Improved **9** **2.** Deteriorated **1, 17***	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals **7**	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff **7**	a.
		Unhappy with roommate **7**	b.
		Unhappy with residents other than roommate **7**	c.
		Openly expresses conflict/anger with family/friends **7**	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status **7**	a.
		Expresses sadness/anger/empty feeling over lost roles/status **7**	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community **7**	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE–***(Code** for resident's **PERFORMANCE OVER ALL SHIFTS during last 7 days**–Not including setup)*
0. *INDEPENDENT*–No help or oversight–OR–Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION*–Oversight, encouragement or cueing provided 3 or more times during last 7 days–OR–Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*–Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times–OR–More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*–While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
–Weight-bearing support
–Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*–Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED–***(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless** of resident's self-performance classification)*
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY*	How resident moves to and from lying position, turns side to side, and positions body while in bed A = 1 = **5A**; A = 2, 3, or 4 = **5A, 16**; A = 8 = **16** A = QM		
b.	TRANSFER*	How resident moves between surfaces–to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) A = 1, 2, 3, or 4 = **5A** A = QM		
c.	WALK IN ROOM	How resident walks between locations in his/her room A = 1, 2, 3, or 4 = **5A**		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit A = 1, 2, 3, or 4 = **5A**		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair A = 1, 2, 3, or 4 = **5A** A = QM		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor,** how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair A = 1, 2, 3, or 4 = **5A**		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing,** including donning/removing prosthesis A = 1, 2, 3, or 4 = **5A**		
h.	EATING*	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) A = 1, 2, 3, or 4 = **5A** A = QM		
i.	TOILET USE*	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes A = 1, 2, 3, or 4 = **5A** A = QM		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) A = 1, 2, 3, or 4 = **5A**		

Resident _____ Numeric Identifier _____

2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). ***Code for most dependent*** *in self-performance and support.* A = 1, 2, 3 or 4 = **5A**
(A) BATHING SELF-PERFORMANCE codes appear below.

	(A)	(B)
0. Independent–No help provided		
1. Supervision–Oversight help only		
2. Physical help limited to transfer only		
3. Physical help in part of bathing activity		
4. Total dependence		
8. Activity itself did not occur during entire 7 days		

(Bathing support codes are as defined in ***Item 1, code B above)***

3. TEST FOR BALANCE (See training manual)

(Code for ability during test in the ***last 7 days)***
0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	
b. Balance while sitting–position, trunk control 1, 2, or 3 = **17***	

4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)

a-f > 0 but sum of a-f is < 12 = QI

(Code for limitations during ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury)*
(A) *RANGE OF MOTION*: **0.** No limitation; **1.** Limitation on one side; **2.** Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: **0.** No loss; **1.** Partial loss; **2.** Full loss

	(A)	(B)
a. Neck		
b. Arm–Including shoulder or elbow		
c. Hand–Including wrist or fingers		
d. Leg–Including hip or knee		
e. Foot–Including ankle or toes		
f. Other limitation or loss		

5. MODES OF LOCOMOTION

(Check all that apply during ***last 7 days)***

Cane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.
Wheeled self	b.	*NONE OF ABOVE*	e.
Other person wheeled	c.		

6. MODES OF TRANSFER

a = QM

Transfer included in ADL Index

(Check all that apply during ***last 7 days)***

Bedfast all or most of time **16**	a.	Lifted mechanically	d.
Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
Lifted manually	c.	*NONE OF ABOVE*	f.

7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No **1.** Yes

8. ADL FUNCTIONAL REHABILITATION POTENTIAL

Resident believes he/she is capable of increased independence in at least some ADLs **5A**	a.
Direct care staff believe resident is capable of increased independence in at least some ADLs **5A**	b.
Resident able to perform tasks/activity but is very slow	c.
Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
NONE OF ABOVE	e.

9. CHANGE IN ADL FUNCTION

Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change **1.** Improved **2.** Deteriorated

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)
0. *CONTINENT*–Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)*
1. *USUALLY CONTINENT*–BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*–BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*–BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*–Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE

Control of bowel movement, with appliance or bowel continence programs, if employed 1, 2, 3 or 4 = **16**
3,4 = QM 2,3 = QI

b. BLADDER CONTINENCE

Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed 2, 3 or 4 = **6**
3,4 = QM 2,3 = QI

2. BOWEL ELIMINATION PATTERN

Bowel elimination pattern regular–at least one movement every three days	a.	Diarrhea	c.
		Fecal impaction **17*** QI	d.
Constipation **17***	b.	*NONE OF ABOVE*	e.

3. APPLIANCES AND PROGRAMS

a,b not √'d = QI

Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
Bladder retraining program	b.	Pads/briefs used **6**	g.
External (condom) catheter **6**	c.	Enemas/irrigation	h.
Indwelling catheter **6** QM	d.	Ostomy present	i.
Intermittent catheter **6**	e.	*NONE OF ABOVE*	j.

4. CHANGE IN URINARY CONTINENCE

Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change **1.** Improved **2.** Deteriorated

SECTION I. DISEASE DIAGNOSES

Check only **those diseases that have a relationship** to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1. DISEASES ***(If none apply, CHECK the NONE OF ABOVE box)***

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
Diabetes mellitus	a.	Multiple sclerosis	w.
Hyperthyroidism	b.	Paraplegia	x.
Hypothyroidism	c.	Parkinson's disease	y.
HEART/CIRCULATION		Quadriplegia	z.
Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
Congestive heart failure	f.	Traumatic brain injury	cc.
Deep vein thrombosis	g.	**PSYCHIATRIC/MOOD**	
Hypertension	h.	Anxiety disorder	dd.
Hypotension **17***	i.	Depression **17***	ee.
Peripheral vascular disease **16**	j.	Manic depression (bipolar disease)	ff.
Other cardiovascular disease	k.	Schizophrenia	gg.
MUSCULOSKELETAL		**PULMONARY**	
Arthritis	l.	Asthma	hh.
Hip fracture	m.	Emphysema/COPD	ii.
Missing limb (e.g., amputation)	n.	**SENSORY**	
Osteoporosis	o.	Cataracts **3**	jj.
Pathological bone fracture	p.	Diabetic retinopathy	kk.
NEUROLOGICAL		Glaucoma **3**	ll.
Alzheimer's disease	q.	Macular degeneration	mm.
Aphasia	r.	**OTHER**	
Cerebral palsy	s.	Allergies	nn.
Cerebrovascular accident (stroke)	t.	Anemia	oo.
Dementia other than Alzheimer's disease	u.	Cancer	pp.
		Renal failure	qq.
		NONE OF ABOVE	rr.

2. INFECTIONS ***(If none apply, CHECK the NONE OF ABOVE box)***

Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Sexually transmitted diseases	h.
Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
Conjunctivitis	c.	Urinary tract infection **in last 30 days 14** QM	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
Respiratory infection	f.	*NONE OF ABOVE*	m.

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

Dehydration 276.5 = **14** QI Decubitus Ulcer 707.0 = QM

a. _____ •
b. _____ •
c. _____ •
d. _____ •
e. _____ •

SECTION J. HEALTH CONDITIONS

1. PROBLEM CONDITIONS ***(Check all problems present in last 7 days*** *unless other time frame is indicated)*

INDICATORS OF FLUID STATUS

Weight gain or loss of 3 or more pounds within a 7 day period **14**	a.	Dizziness/Vertigo **11, 17***	f.
		Edema	g.
Inability to lie flat due to shortness of breath	b.	Fever **14**	h.
		Hallucinations **17***	i.
Dehydrated; output exceeds input **14** QI	c.	Internal bleeding **14**	j.
		Recurrent lung aspirations in **last 90 days 17***	k.
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days 14**	d.	Shortness of breath	l.
		Syncope (fainting) **17***	m.
		Unsteady gait **17***	n.
OTHER		Vomiting	o.
Delusions	e.	*NONE OF ABOVE*	p.

Resident _____ Numeric Identifier _____

2. PAIN SYMPTOMS (a & b = 2 or b = 3) QM

*(Code the **highest level of pain** present in **the last 7 days**)*

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain ***(skip to J4)***
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excruciating

3. PAIN SITE

*(If pain present, **check all sites** that apply in **last 7 days**)*

Back pain	a.	Incisional pain	f.
Bone pain	b.	Joint pain (other than hip)	g.
Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
Headache	d.	Stomach pain	i.
Hip pain	e.	Other	j.

4. ACCIDENTS (a = QI, c,d = QI)

(Check all that apply)

Fell in past 30 days **11, 17***	a.	Hip fracture in **last 180 days 17***	c.
Fell in past 31-180 days **11, 17***	b.	**Other fracture in last 180 days**	d.
		NONE OF ABOVE	e.

5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable–(fluctuating, precarious, or deteriorating)	a.
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
End-stage disease, 6 or fewer months to live	c.
NONE OF ABOVE	d.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS

Chewing problem	a.
Swallowing problem **17***	b.
Mouth pain **15**	c.
NONE OF ABOVE	d.

2. HEIGHT AND WEIGHT

*Record **(a.) height in inches** and **(b.) weight in pounds.** Base weight on most recent measure in **last 30 days;** measure weight consistently in accord with standard facility practice –e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.*

a. HT (in.) ____ **b.** WT (lb.) ____

3. WEIGHT CHANGE

a. Weight loss–5% or more in **last 30 days;** or 10% or more in **last 180 days** QI QM
0. No **1.** Yes **12**

b. Weight gain–5% or more in **last 30 days;** or 10% or more in **last 180 days**
0. No **1.** Yes

4. NUTRITIONAL PROBLEMS

Complains about the taste of many foods **12**	a.	Leaves 25% or more of food uneaten at most meals **12** QM	c.
Regular or repetitive complaints of hunger	b.	*NONE OF ABOVE*	d.

5. NUTRITIONAL APPROACHES

(Check all that apply in last 7 days)

Parenteral/IV **12, 14**	a.	Dietary supplement between meals	f.
Feeding tube **13, 14** QI	b.	Plate guard, stabilized built-up utensil, etc.	g.
Mechanically altered diet **12**	c.	On a planned weight change program	h.
Syringe (oral feeding) **12**	d.	*NONE OF ABOVE*	i.
Therapeutic diet **12**	e.		

6. PARENTERAL OR ENTERAL INTAKE

(Skip to Section L if neither 5a nor 5b is checked)

a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days**
0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

b. Code the average **fluid intake** per day by IV or tube in **last 7 days**
0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION

Debris (soft, easily movable substances) present in mouth prior to going to bed at night **15**	a.
Has dentures or removable bridge	b.
Some/all natural teeth lost–does not have or does not use dentures (or partial plates) **15**	c.
Broken, loose, or carious teeth **15**	d.
Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes **15**	e.
Daily cleaning of teeth/dentures or daily mouth care–by resident or staff Not ✓ = **15**	f.
NONE OF ABOVE	g.

SECTION M. SKIN CONDITION

1. ULCERS (Due to any cause)

*(Record the number of ulcers at each ulcer stage–regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days.** Code 9 = 9 or more.) **[Requires full body exam.]***

		Number at Stage
a. Stage 1.	A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2.	A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3.	A full thickness of skin is lost, exposing the subcutaneous tissues–presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4.	A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

2. TYPE OF ULCER (a>o = QM)

*(For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1–i.e., 0=none; stages 1, 2, 3, 4)*

a. Pressure ulcer–any lesion caused by pressure resulting in damage of underlying tissue 1 = **16**; 2, 3, or 4 = **12, 16**
b. Stasis ulcer–open lesion caused by poor circulation in the lower extremities

3. HISTORY OF RESOLVED ULCERS

Resident had an ulcer that was resolved or cured in **LAST 90 DAYS**
0. No **1.** Yes **16**

4. OTHER SKIN PROBLEMS OR LESIONS PRESENT

(Check all that apply during last 7 days)

Abrasions, bruises	a.
Burns (second or third degree)	b.
Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
Rashes–e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
Skin desensitized to pain or pressure **16**	e.
Skin tears or cuts (other than surgery)	f.
Surgical wounds	g.
NONE OF ABOVE	h.

5. SKIN TREATMENTS

(Check all that apply during last 7 days)

Pressure relieving device(s) for chair	a.
Pressure relieving device(s) for bed	b.
Turning/repositioning program	c.
Nutrition or hydration intervention to manage skin problems	d.
Ulcer care	e.
Surgical wound care	f.
Application of dressings (with or without topical medications) other than to feet	g.
Application of ointments/medications (other than to feet)	h.
Other preventative or protective skin care (other than to feet)	i.
NONE OF ABOVE	j.

6. FOOT PROBLEMS AND CARE

(Check all that apply during last 7 days)

Resident has one or more foot problems–e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
Infection of the foot–e.g., cellulitis, purulent drainage	b.
Open lesions on the foot	c.
Nails/calluses trimmed during **last 90 days**	d.
Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
Application of dressings (with or without topical medications)	f.
NONE OF ABOVE	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE

10B only if BOTH N1a = ✓ and N2 = 0

(Check appropriate time periods over last 7 days)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

Morning QI **10B**	a.	Evening QI	c.
Afternoon QI	b.	*NONE OF ABOVE*	d.

(IF RESIDENT IS COMATOSE, SKIP TO SECTION O)

2. AVERAGE TIME INVOLVED IN ACTIVITIES

(When awake and not receiving treatments or ADL care)
0. Most–more than 2/3 of time **10B**
1. Some–from 1/3 to 2/3 of time
2. Little–less than 1/3 of time **10A** QI
3. None **10A** QI

3. PREFERRED ACTIVITY SETTINGS

(Check all settings in which activities are preferred)

Own room	a.		
Day/activity room	b.	Outside facility	d.
Inside NH/off unit	c.	*NONE OF ABOVE*	e.

4. GENERAL ACTIVITY PREFERENCES (Adapted to resident's current abilities)

*(Check all **PREFERENCES** whether or not activity is currently available to resident)*

Cards/other games	a.	Trips/shopping	g.
Crafts/arts	b.	Walking/wheeling outdoors	h.
Exercise/sports	c.	Watching TV	i.
Music	d.	Gardening or plants	j.
Reading/writing	e.	Talking or conversing	k.
Spiritual/religious activities	f.	Helping others	l.
		NONE OF ABOVE	m.

Resident _____ Numeric Identifier _____

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* **0.** No change **1.** Slight change **2.** Major change **a.** Type of activities in which resident is currently involved 1 or 2 = **10A** **b.** Extent of resident involvement in activities 1 or 2 = **10A**

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	***(Record the number of different** medications used in the **last 7 days;** enter "0" if none used)* 9+ = QI
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the **last 90 days**)* **0.** No **1.** Yes
3.	INJECTIONS	***(Record the number of DAYS** injections of any type received during the **last 7 days;** enter "0" if none used)*
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	***(Record the number of DAYS** during **last 7 days;** enter "0" if not used. Note–enter "1" for long-acting meds used less than weekly)* **(NOTE:** For **17** to actually be triggered, O4a, b, or c MUST = 1–7 AND at least one additional item marked **17*** must be indicated. See sections B, C, E, G, H, I, J, and K.)

a. Antipsychotic ≥ 1 = QI
1-7 = **17**

b. Antianxiety ≥ 1 = QI
1-7 = **11, 17**

c. Antidepressant 0 = QI
1-7 = **11, 17**

d. Hypnotic ≥ 1 = QI
2+ = QI

e. Diuretic 1-7 = **14**

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE–*Check treatments or programs received during the **last 14 days***

TREATMENTS

Chemotherapy	a.	Ventilator or respirator	l.
Dialysis	b.	**PROGRAMS**	
IV medication	c.	Alcohol/drug treatment program	m.
Intake/output	d.	Alzheimer's/dementia special care unit	n.
Monitoring acute medical condition	e.	Hospice care	o.
Ostomy care	f.	Pediatric unit	p.
Oxygen therapy	g.	Respite care	q.
Radiation	h.	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
Suctioning	i.		
Tracheostomy care	j.		
Transfusions	k.	*NONE OF ABOVE*	s.

b. THERAPIES–*Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)* [**Note–count only post admission therapies**]

(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

	DAYS (A)	MIN (B)
a. Speech-language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in **last 7 days**–no matter where received)

Special behavior symptom evaluation program	a.
Evaluation by a licensed mental health specialist in **last 90 days**	b.
Group therapy	c.
Resident-specific deliberate changes in the environment to address mood/behavior patterns–e.g., providing bureau in which to rummage	d.
Reorientation–e.g., cueing	e.
NONE OF ABOVE	f.

3. NURSING REHABILITATION/ RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes** per day in the **last 7 days** (Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)		**f.** Walking	
b. Range of motion (active)		**g.** Dressing or grooming	
c. Splint or brace assistance		**h.** Eating or swallowing	
TRAINING AND SKILL PRACTICE IN:		**i.** Amputation/ prosthesis care	
d. Bed mobility		**j.** Communication	
e. Transfer		**k.** Other	

4.	DEVICES AND RESTRAINTS *If c,d,e = 2* QM	*(Use the following codes for **last 7 days:**)* **0.** Not used **1.** Used less than daily **2.** Used daily Bed rails **a.** –Full bed rails on all open sides of bed **b.** –Other types of side rails used (e.g., half rail, one side) **c.** Trunk restraint 1 = **11, 18**; 2 = **11, 16, 18** **d.** Limb restraint 1 or 2 = **18** **e.** Chair prevents rising 1 or 2 = **18**
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in **last 90 days** (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in **last 90 days** (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? **0.** No **1.** Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	**a.** Resident expresses/indicates preference to return to the community **0.** No **1.** Yes
		b. Resident has a support person who is positive toward discharge **0.** No **1.** Yes
		c. Stay projected to be of a short duration–discharge projected **within 90 days** (do not include expected discharge due to death) **0.** No **2.** Within 31-90 days **1.** Within 30 days **3.** Discharge status uncertain
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) **0.** No change **1.** Improved–receives fewer supports, needs less restrictive level of care **2.** Deteriorated–receives more support

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	**a.** Resident: **0.** No **1.** Yes **b.** Family: **0.** No **1.** Yes **2.** No family **c.** Significant other: **0.** No **1.** Yes **2.** None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — **completion date for full and quarterly assessments**

Month — Day — Year

Must NOT be dated before A3a (Assessment reference date)

SECTION S. STATE SUPPLEMENT - MDS 2.0

1. UNIT NUMBER

Enter current unit number. Follow instructions in manual. [ ][ ]

2. PRESSURE ULCERS

Record the appropriate response. Stage 3 or 4 pressure ulcer sites present upon admission or readmission.

1. All currently reported sites were present on admission or readmission.
2. Some of the currently reported sites were present on admission or readmission.
3. None of the currently reported sites were present on admission or readmission.
4. No Stage 3 or 4 sites currently reported. [ ]

3. SUBSTANCE ABUSE

Substance Abuse History. Has the resident with HIV engaged in substance abuse behaviors more than one month ago which continue to influence care currently given to the resident? Record the appropriate response.

0. No
1. Yes
2. Resident does not have HIV [ ]

4. DISEASE DIAGNOSES

Record only those disease diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death *during the last 30 days.* (Do not list inactive diagnoses)

- **a.** HIV Dementia [a]
- **b.** HIV Wasting Syndrome [b]
- **c.** Non-psychotic disorder following organic brain damage [c]
- **d.** Psychotic disorder following organic brain damage [d]
- **e.** Spinal cord injury [e]
- **f.** Hemiplegia [f]
- **g.** Hemipareses [g]
- **h.** Huntington's Disease [h]
- **i.** Dementia Registry Reporting [i]
  - 1. County (FIPS) code of prior residence **4i 1** [ ][ ][ ]
  - 2. Physician license number **4i 2** [ ][ ][ ][ ][ ][ ]
- **j.** None of the above [j]

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. **RECREATION THERAPY**–*Enter number of days and total minutes of recreation therapy administered* ***(for at least 15 minutes a day)*** *in the* ***last 7 days*** *(Enter 0 if none)*

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. **ORDERED THERAPIES**–*Has physician ordered any of following therapies to begin in FIRST 14 days of stay–physical therapy, occupational therapy, or speech pathology service?*
0. No **1.** Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) than can be expected to be delivered.

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self–performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (**P.1.b.c**)
- Physical therapy was ordered for the resident involving gait training (**T.1.b**)
- Resident received nursing rehabilitation for walking (**P.3.f**)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. **Furthest distance walked** without sitting down during this episode.
0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.
0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode.
0. *INDEPENDENT*–No help or oversight
1. *SUPERVISION*–Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*–Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*–Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.
0. No **1.** Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

Web Link For More Information:
Nursing Home Quality Initiative
http://www.cms.hhs.gov/quality/nhqi

Required for Comprehensive Assessments

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier_____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     –Nature of the condition (may include presence or lack of objective data and subjective complaints).
     –Complications and risk factors that affect your decision to proceed to care planning.
     –Factors that must be considered in developing individualized care plan interventions.
     –Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP Problem Area	(a) Check if Triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision–check if addressed in care plan
1. DELIRIUM			
2. COGNITIVE LOSS			
3. VISUAL FUNCTION			
4. COMMUNICATION			
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL			
6. URINARY INCONTINENCE AND INDWELLING CATHETER			
7. PSYCHOSOCIAL WELL-BEING			
8. MOOD STATE			
9. BEHAVIORAL SYMPTOMS			
10. ACTIVITIES			
11. FALLS			
12. NUTRITIONAL STATUS			
13. FEEDING TUBES			
14. DEHYDRATION/FLUID MAINTENANCE			
15. ORAL/DENTAL CARE			
16. PRESSURE ULCERS			
17. PSYCHOTROPIC DRUG USE			
18. PHYSICAL RESTRAINTS			

B._____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

MINIMUM DATA SET (MDS) – VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	NATIONAL PROVIDER ID	Enter for all assessments and tracking forms, if available.	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	INFLUENZA VACCINE	**a.** Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)? **0.** No (If No, go to item W2b) **1.** Yes (If Yes, go to item W3) **b.** If influenza vaccine not received, state reason: **1.** Not in facility during this year's flu season **2.** Received outside of this facility **3.** Not eligible **4.** Offered and declined **5.** Not offered **6.** Inability to obtain vaccine	
3.	PNEUMOCOCCAL VACCINE	**a.** Is the resident's PPV status up to date? **0.** No (If No, go to item W3b) **1.** Yes (If Yes, skip item W3b) **b.** If PPV not received, state reason: **1.** Not eligible **2.** Offered and declined **3.** Not offered	

Attachment 2

Resident _____ Numeric Indicator _____

Section S. Supplement-MDS 2.0 (New York State) (2008)

1	UNIT NUMBER	Enter current number. Follow instructions in the manual.	
2	PRESSURE ULCERS	Record the appropriate response. Stage 3 or 4 pressure ulcer sites present upon admission or readmission. 1. All currently reported sites were present on admission or readmission. 2. Some of the currently reported sites were present on admission or readmission. 3. None of the currently reported sites were present on admission or readmission. 4. No stage 3 or 4 sites currently reported.	
3	SUBSTANCE ABUSE	Substance abuse history. Has the resident with HIV engaged in substance abuse behaviors more than one month ago which continue to influence care currently given to the resident? Record the appropriate response. 0. No 1. Yes 2. Resident does not have HIV	
4	DISEASE DIAGNOSES	Record only those disease diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death during the last 30 days. (Do not list inactive diagnoses). *(Check all that apply)*	
	a.	HIV dementia	a.
	b.	HIV wasting syndrome	b.
	c.	Non-psychotic disorder following organic brain damage.	c.
	d.	Psychotic disorder following organic brain damage	d.
	e.	Spinal cord injury	e.
	f.	Hemiplegia	f.
	g.	Hemipareses	g.
	h.	Huntington's disease	h.
	i.	Dementia Registry Reporting	i.
		1. County (FIPS code of prior residence)	
		2. Physician license number	
	j.	NONE OF ABOVE	j.
5	SPECIALTY UNIT / FACILITY REIMBURSEMENT	Record the appropriate approved specialty unit/facility applicable for the resident. 1. Discrete AIDS Unit 2. Ventilator Dependent Unit 3. Traumatic Brain Injured Unit (TBI) 4. Behavioral Intervention Unit 5. Behavioral Intervention Step Down Unit 6. Pediatric Specialty Unit/Facility 7. None of the above.	
6	RESIDENT ELIGIBLE FOR ENHANCED MEDICAID REIMBURSEMENT (ADD-ON) FOR THE FOLLOWING CONDITION(S):	Record the appropriate approved specialty unit/facility applicable for the resident. 1. AIDS Scatter Beds 2. Traumatic Brain-Injury (TBI)- Extended Care 3. None of the above.	
7	PRIMARY PAYOR	Report the payor: 1. Medicaid 2. Medicare 3. Other 4. Medicaid Pending	

Instructions: Complete Section S with assessment types including: comprehensive, full, correction, MPAF and quarterly reviews. (AA8a = 01, 02, 03, 04, 05, 10, 0; AA8b = 1, 2, 3, 4, 5, 7, 8, blank)

Attachment 3

New York State – Department of Health
Minimum Data Set, Version 2.0 (MDS 2.0)
Section S – NEW YORK STATE SUPPLEMENT (2008)
Item-by-Item Instructions

S0. Operating Certificate Number

Definition: The state assigned operating certificate number assigned by Department of Health to the facility for purposes of identification of the facility ownership.

Process: Obtain this information from the facility administrative or business office.

Coding: The Operating Certificate number is required to be submitted to the MDS database at the state but does not need to be recorded on the MDS form stored in the nursing home. We suggest the Operating Certificate Number be coded into a facility set-up area of the MDS encoding software along with other facility identification information. Alternatively, the encoder will need to enter the Operating Certificate number for each MDS when preparing the assessment record for submission to the state.

S1. Unit Number

Definition: The unique two digit number assigned by the facility to each nursing unit for purposes of reimbursement data collection.

Process: Look at the clinical/medical record jacket or face sheet for this information.

Coding: Enter the correct designation.

S2. Pressure Ulcers

Record the appropriate response. Stage 3 or 4 pressure ulcer sites present upon admission or readmission.

Intent: To determine if Stage 3 or 4 pressure ulcers were present upon admission or readmission to the facility.

Definition: Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bed sores and decubitus ulcers.

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s). Refer to pressure ulcers in item M2a and determine if any are Stage 3 or 4. If so, were these Stage 3 or 4 pressure ulcers present upon admission or readmission to the facility?

Coding: Refer to the ulcers reported in item M2a to provide this response. Of the Stage 3 or 4 pressure ulcers reported, if any, were these same pressure ulcer sites present upon admission or readmission.

S3. Substance Abuse

Substance Abuse History. Has the resident with HIV engaged in substance abuse behaviors more than one month ago which continue to influence care currently given to the resident?

Intent: To determine if substance abuse which occurred more than one month ago continues to influence the care given to the resident with HIV.

Definition: Excessive use of drugs or alcohol on a regular or irregular basis to the point where it interferes with judgement and activities of daily living.

Process: Review clinical/medical record for substance abuse history. Validate findings with the resident and direct care staff on all shifts.

Coding: Enter the number corresponding to the correct response.

S4. Disease Diagnoses

Diagnoses. Check only those disease diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring or risk of death during the last 30 days. (Do not list inactive diagnoses)

Intent: To document the presence of diseases that have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Definition: Nursing Monitoring – Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

Diseases Definition:

a. HIV Dementia – HIV itself invades the central nervous system, starting out as HIV encephalopathy manifested by progressive loss or decline in cognitive, motor or behavioral function.

b. HIV Wasting Syndrome – Findings of profound involuntary weight loss (more than 10% or baseline body weight) **AND EITHER** chronic diarrhea (at least two loose stools per day for 30 or more days) **OR** chronic weakness with documented fever (for 30 or more days, intermittent or constant) in the presence of HIV infection.

c. Non-psychotic disorder following organic brain damage - The organic factor may be a primary disease of the brain, a systemic illness that secondarily affects the brain, or a substance such as a toxic agent. This factor is either currently disturbing brain function or has left some long lasting effect (e.g., encephalitic syndrome).

d. Psychotic disorder following organic brain damage – A massive disintegration of integrated ego functioning, causing the person to be unable to deal effectively with self, others and the environment caused by a primary disease of the brain, a systemic illness that secondarily affects the brain or a substance (e.g., epileptic psychosis).

e. Spinal Cord Injury – Damage to the spinal cord as a result of physical injury (e.g., C4 level with complete lesion of spinal cord).

f. Hemiplegia – TOTAL paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body, usually caused by cerebral hemorrhage, thrombosis, embolism or tumor. There must be a diagnosis of hemiplegia in the resident's record.

g. Hemipareses – PARTIAL paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body, usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemipareses in the resident's record.

h. Huntington's Disease – An inherited illness of the central nervous system mainfesting severe symptoms such as chorea and other motor adnormalities, dementia and disorders of mood. This condition often gives rise initially to disorders of character and behavior such as irritability, impulsiveness, and violence. Eventually patients suffer from chronic fatigue, apathy, poor memory and progressive dementia.

Process: Consult transfer documentation and medial record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Sections I and S at the time of visit closest to the scheduled MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry or help to confirm existing observations, or suggest the need for additional follow-up.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death.

Coding: Do NOT record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check NONE OF THE ABOVE.

S4i. Dementia Registry Reporting – *Alzheimer's Disease and Other Dementias Registry*

Intent: To report cases to the Alzheimer's Disease and Other Dementias Registry as required by Public Health Law, Article 20 in lieu of reporting on the Confidential Case Report form (DOH-1988 (4/97)).

For reporting cases, to identify the county or residence prior to nursing home placement, to report the license number of the resident's primary care physician when the admission diagnosis was determined or when the resident was diagnosed with dementia while a resident at the facility, and to report the ICD-9 code indicating the specific dementing illness.

Definition: Dementia reportable to the Alzheimer's Disease and Other Dementias registry – reportable dementias are previously unreported cases of chronic or progressive irreversible dementia, including but not limited to Alzheimer's disease.

Coding: Dementia Registry Reporting – Check if this resident is a new admission with a diagnosis of reportable dementia or if the resident is newly diagnosed with reportable dementia while a resident at this facility. If checked, record the ICD-9 code indicating the specific dementing illness in Section I, Item 3 and complete items 1 and 2 below.

Do NOT check if the resident does not have reportable dementia or if the resident's reportable dementia was previously submitted to the registry by this facility. If not checked, skip items 1 and 2 below.

1. **County (FIPS) Code of Prior Residence** – If item S41 is checked, enter the Federal Information Processing Standards Publication (FIPS) code that represents the resident's county of home address using the following codes for New York State.

County	Code	County	Code	County	Code
Albany	001	Jefferson	045	St. Lawrence	089
Allegheny	003	Kings	047	Saratoga	091
Bronx	005	Lewis	049	Schenectady	093
Broome	007	Livingston	051	Schoharie	095
Cattaragus	009	Madison	053	Schuyler	097
Cayuga	011	Monroe	055	Seneca	099
Chautauqua	013	Montgomery	057	Steuben	101
Chemung	015	Nassau	059	Suffolk	103
Chenango	017	New York	061	Sullivan	105
Clinton	019	Niagara	063	Tioga	107
Columbia	021	Oneida	065	Tompkins	109
Cortland	023	Onondaga	067	Ulster	111
Delaware	025	Ontario	069	Warren	113
Dutchess	027	Orange	071	Washington	115
Erie	029	Orleans	073	Wayne	117
Essex	031	Oswego	075	Westchester	119
Franklin	033	Otsego	077	Wyoming	121
Fulton	035	Putnam	079	Yates	123
Genesee	037	Queens	081	Out of State	800
Greene	039	Rennselaer	083	Homeless	897
Hamilton	041	Richmond	085	Unknown	899
Herkimer	043	Rockland	087		

2. **Physician License Number** – If item S41 is checked enter the physician license number, which is issued by the New York State Education Department. The number is a six digit number, or for physicians with a limited license, the license number is an "L" followed by a 5 digit number. Do NOT include preceding specialty codes or succeeding office site numbers in the physician license number.

S5. Specialty Unit/Facility Reimbursement:

Intent: To identify a resident residing in a discrete specialty unit (facility) that is eligible for a discrete specialty Medicaid reimbursement rate in accordance with the applicable regulation or statute.

Definition: To be eligible for a discrete specialty unit/facility rate the resident must reside in a unit/facility that is approved by the Commissioner of Health in accordance with the cited regulation(s) and/or statute(s).

1. **Discrete AIDS Unit/Facility** - Approved pursuant to 10-NYCRR Part 86-2.10 (p) and Part 710 or any successor regulation and/or statute. (Note: Cannot also be marked as 1 for Question 6 of Section S)

2. **Ventilator Dependent Unit** - Approved pursuant to 10-NYCRR Part 86-2.10 (q) and Section 415.38 or any successor regulation and/or statute.

3. **Traumatic Brain-Injured (TBI) Unit**- Approved pursuant to 10-NYCRR Part 86-2.10 (n) and Section 415.36 or any successor regulation and/or statute. (Note: Cannot also be marked as 2 for Question 6 of Section S)

4. **Behavioral Intervention Unit**- Approved pursuant to 10-NYCRR Part 86-2.10 (w) and Section 415.39 or any successor regulation and/or statute.

5. **Behavioral Intervention Step-Down Unit**- Approved pursuant to 10-NYCRR Part 86-2.10 (x) and Section 415.41 or any successor regulation and/or statute.

6. **Pediatric Specialty Unit/Facility**- Approved pursuant to 10-NYCRR Part 86-2.10(i) or any successor regulation and/or statute. Department of Health Policy ONLY recognizes pediatric residents up to age 21 for purposes of specialty reimbursement (see Dear Administrator Letter of July 12, 2006).

7. **None of the Above**

6. Resident Eligible for Enhanced Medicaid Reimbursement (Add-On) for the following condition(s):

Intent: To identify a resident eligible for enhanced Medicaid reimbursement (Add- On) for an approved specialty program in accordance with the applicable regulation.

Definition: To be eligible for an enhanced Medicaid reimbursement rate (Add-On) the resident must be in a specialty program that is approved by the Commissioner of Health in accordance with the cited regulations.

1. **AIDS- (Approved Scatter Beds)**- Approved pursuant to 10-NYCRR Part 86-2.10 (p) (3) and Part 710 or any successor regulation and/or statute. (Note: Cannot also be marked as 1 for Question 5 of Section S).

2. **Traumatic Brain-Injury (TBI) Extended Care**- Approved pursuant to 10-NYCRR Part 86-2.10 (v) and Section 415.40 or any successor regulation and/or statute. (Note: Cannot also be marked as 3 for Question 5 of Section S)

3. **None of the Above**

7. Primary Payor:

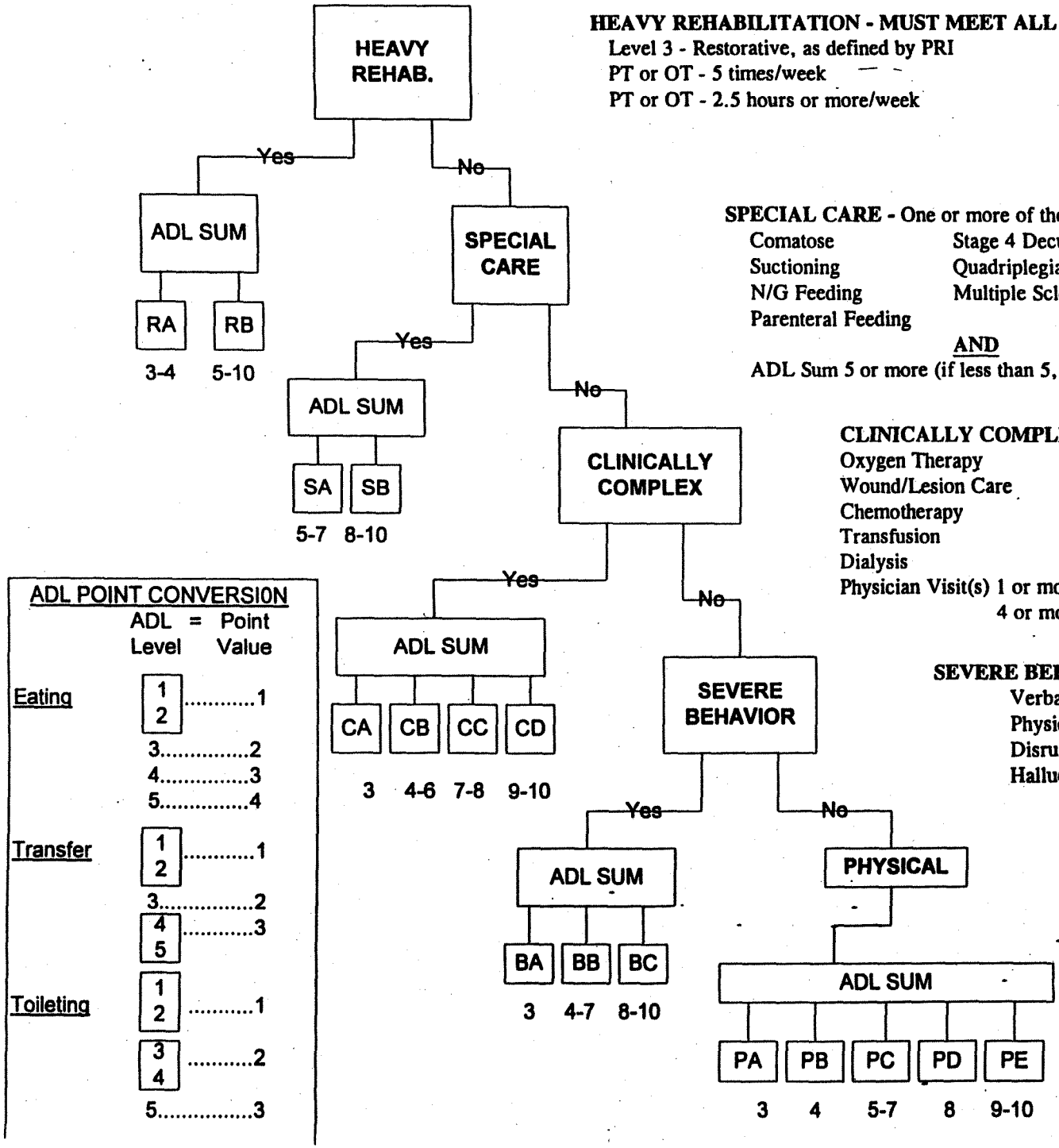
Intent: To determine if Medicaid is the payment source on the day of MDS completion.

Process: Check with the billing office to review current payment source. Do not rely exclusively on information recorded in the resident's clinical record.

Definition: Enter the one source of coverage that pays for most of the resident's current nursing home stay. Record "Other" only if the primary payor is not Medicaid or Medicare. For a patient with Medicaid coverage supplemented by Medicare Part B, record as "Medicaid". Record "Medicaid Pending" if there is no other primary coverage being used for the resident's present stay and the facility has sought or intends to seek establishment of Medicaid eligibility for the present stay.

Attachment 4

RUGS-II CLASSIFICATION



HEAVY REHABILITATION - MUST MEET ALL 3 CRITERIA

Level 3 - Restorative, as defined by PRI
PT or OT - 5 times/week
PT or OT - 2.5 hours or more/week

SPECIAL CARE - One or more of the following:

Comatose	Stage 4 Decubitus
Suctioning	Quadriplegia
N/G Feeding	Multiple Sclerosis
Parenteral Feeding	

AND

ADL Sum 5 or more (if less than 5, Clinically Complex).

CLINICALLY COMPLEX - One or more of the following:

Oxygen Therapy	Dehydration	Cerebral Palsy
Wound/Lesion Care	Internal Bleeding	UTI for Primary Problem
Chemotherapy	Terminally Ill	Hemiplegia/Hemiparesis
Transfusion	Stasis Ulcer	
Dialysis		

Physician Visit(s) 1 or more for H/C-PRI
4 or more for PRI (NF)

OR

Meets Special Care Criteria but ADL sum is less than 5

SEVERE BEHAVIORAL PROBLEMS - One or more of the following:

Verbal Disruption, Level 4
Physical Aggression, Level 4
Disruptive, Infantile/Inappropriate, Level 4
Hallucinations, Level 1

REDUCED PHYSICAL FUNCTIONING

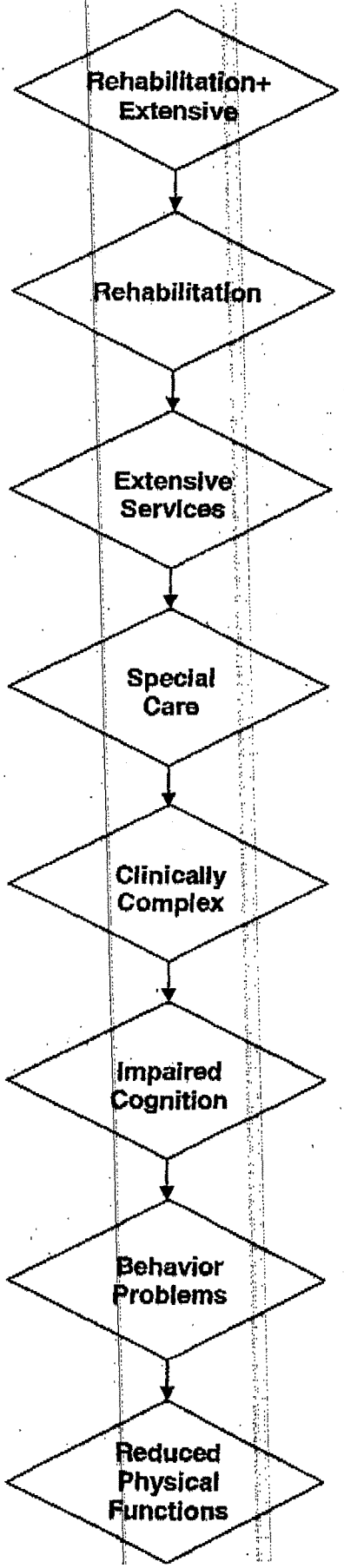
All Remaining Patients

ADL POINT CONVERSION

	ADL Level	= Point Value
Eating	1	1
	2	2
	3	2
	4	3
	5	4
Transfer	1	1
	2	2
	3	2
	4	3
	5	3
Toileting	1	1
	2	1
	3	2
	4	2
	5	3

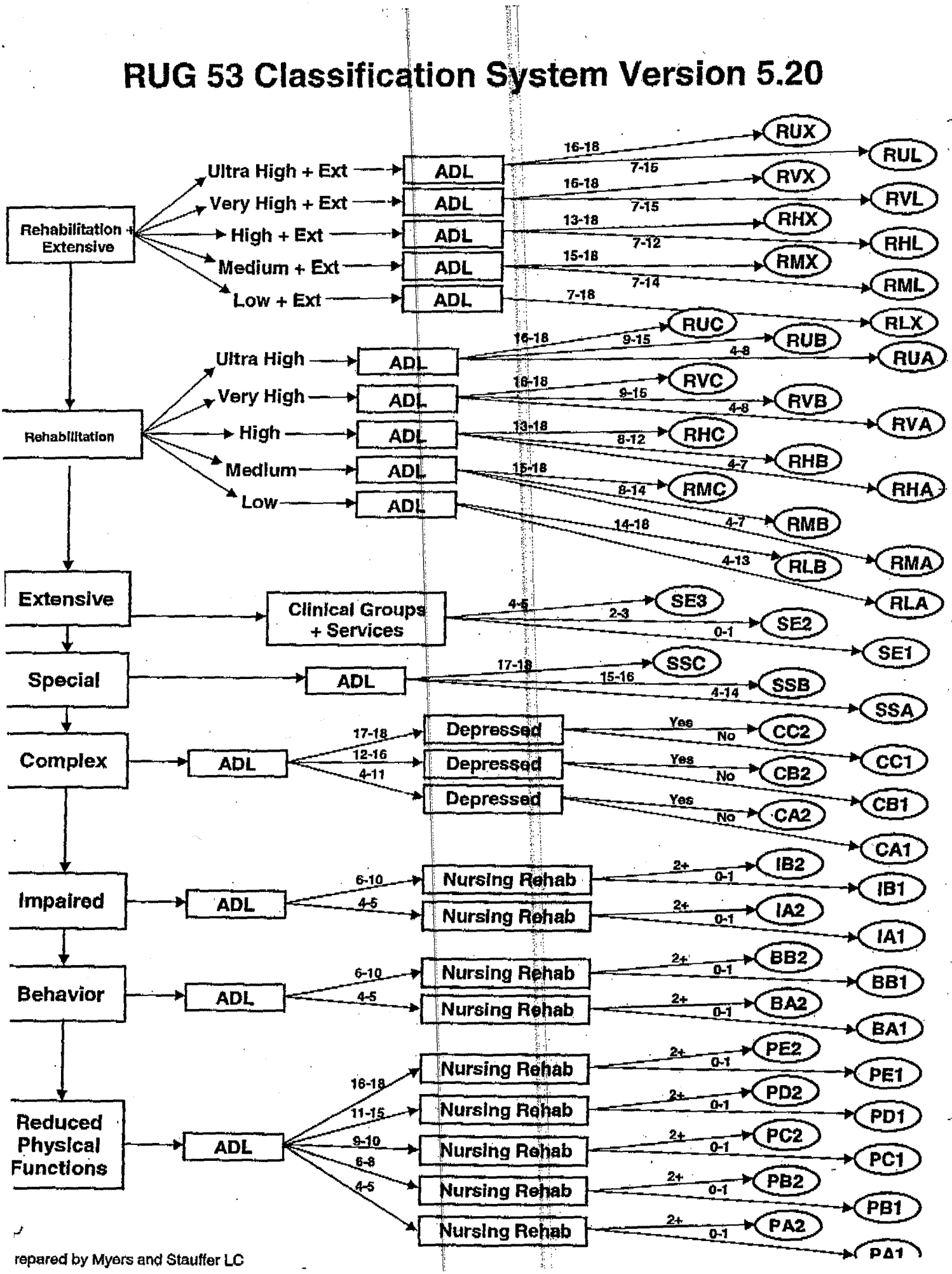
Attachment 5

RUG 53 Classification System Version 5.20



Prepared by Myers and Stauffer LC

RUG 53 Classification System Version 5.20



repared by Myers and Stauffer LC

RUG-III CLASSIFICATION SYSTEM (53 Group) WITH CASE MIX INDEXING

Major RUG Group	RUG Code	Hierarchical Classification	ADL Score	Case Mix Index (Rural)	Case Mix Index (Urban)
Rehab Plus Extensive	RUX	Ultra High Intensity	16-18	53	53
	RUL		7-15	52	52
	RVX	Very High Intensity	16-18	48	49
	RVL		7-15	46	46
	RHX	High Intensity	13-18	42	42
	RHL		7-12	41	41
	RMX	Medium Intensity	15-18	47	47
	RML		7-14	44	44
	RLX	Low Intensity	7-18	32	33
Rehab	RUC	Ultra High Intensity	16-18	51	51
	RUB		9-15	50	50
	RUA		4-8	49	48
	RVC	Very High Intensity	16-18	45	45
	RVB		9-15	43	43
	RVA		4-8	40	38
	RHC	High Intensity	13-18	39	39
	RHB		8-12	37	37
	RHA		4-7	35	34
	RMC	Medium Intensity	15-18	36	36
	RMB		8-14	34	35
	RMA		7-13	33	32
	RLB	Low Intensity	14-18	30	30
	RLA		4-13	26	24
Extensive Services	SE3	Extensive Count 4 or 5	7-18	38	40
	SE2	Extensive Count 2 or 3	7-18	31	31
	SE1	Extensive Count 0 or 1	7-18	29	29
Special Care	SSC	ADL Break Only	17-18	28	28
	SSB		15-16	25	26
	SSA		4-14	24	25
Clinically Complex	CC2	Depressed	17-18	27	27
	CC1	Not Depressed	17-18	23	23
	CB2	Depressed	12-16	22	22
	CB1	Not Depressed	12-16	21	21
	CA2	Depressed	4-11	20	20
	CA1	Not Depressed	4-11	17	17
Impaired Cognition	IB2	Nursing Rehab 2+	6-10	14	14
	IB1	Nursing Rehab 0 to 1	6-10	12	12
	IA2	Nursing Rehab 2+	4-5	8	8
	IA1	Nursing Rehab 0 to 1	4-5	6	6
Behavior Problems	BB2	Nursing Rehab 2+	6-10	13	13
	BB1	Nursing Rehab 0 to 1	6-10	10	10
	BA2	Nursing Rehab 2+	4-5	7	7
	BA1	Nursing Rehab 0 to 1	4-5	2	2
Reduced Physical Functioning	PE2	Nursing Rehab 2+	16-18	19	19
	PE1	Nursing Rehab 0 to 1	16-18	18	18
	PD2	Nursing Rehab 2+	11-15	16	16
	PD1	Nursing Rehab 0 to 1	11-15	15	15
	PC2	Nursing Rehab 2+	9-10	11	11
	PC1	Nursing Rehab 0 to 1	9-10	9	9
	PB2	Nursing Rehab 2+	6-8	5	5
	PB1	Nursing Rehab 0 to 1	6-8	4	4
	PA2	Nursing Rehab 2+	4-5	3	3
	PA1	Nursing Rehab 0 to 1	4-5	1	1

Instructions: Determine ALL of the RUG-III groups for which a resident qualifies (not just the first group for which the resident qualifies). Use the Hierarchical Classification Worksheet in Chapter 6 of the RAI Manual. Then from the qualifying groups, choose the RUG-III group that has the highest case mix index. The index maximizing method uses the case mix indices effective with RUG-III changes on January 1, 2006.

Crosswalk of MDS 2.0 Items and RUG-III Groups

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-III CODES
ULTRA HIGH REHABILITATION PLUS EXTENSIVE SERVICES Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline 3 days/week AND IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	16-18 7-15	Not Used Not Used	RUX RUL
VERY HIGH REHABILITATION PLUS EXTENSIVE SERVICES: Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	16-18 7-15	Not Used Not Used	RVX RVL
HIGH REHABILITATION PLUS EXTENSIVE SERVICES Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week; AND IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	13-18 7-12	Not Used Not Used	RHX RHL
MEDIUM REHABILITATION PLUS EXTENSIVE SERVICES Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines; AND IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	15-18 7-14	Not Used Not Used	RMX RML
LOW REHABILITATION PLUS EXTENSIVE SERVICES Rehabilitation Rx 45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines; AND Nursing rehabilitation 6 days/week, 2 services (see Reduced Physical Function (below) for nursing rehab services count); AND IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	7-18	Not Used	RLX
ULTRA HIGH REHABILITATION Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline 3 days/week	16-18 9-15 4-8	Not Used Not Used Not Used	RUC RUB RUA
VERY HIGH REHABILITATION Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	16-18 9-15 4-8	Not Used Not Used Not Used	RVC RVB RVA
HIGH REHABILITATION Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	13-18 8-12 4-7	Not Used Not Used Not Used	RHC RHB RHA

MEDIUM REHABILITATION Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines	15-18 8-14 4-7	Not Used Not Used Not Used	RMC RMB RMA
LOW REHABILITATION Rehabilitation Rx 45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines; AND Nursing rehabilitation 6 days/week, 2 services (see Reduced Physical Function (below) for nursing rehab services count)	14-18 4-13	Not Used Not Used	RLB RLA
EXTENSIVE SERVICES IV Feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or ventilator/respirator in the last 14 days AND ADL score of 7 or more	7-18	Count of other categories (special care, clinically complex, impaired cognition), plus IV medications, plus IV feeding	SE3 SE2 SE1
SPECIAL CARE Extensive Services (see above) and ADL score of 6 or less OR Special Care qualifier (any one): CP, MS, or Quad with ADL sum >=10, respiratory therapy = 7 days, feeding tube (calories >=51%, or calories =26%-50% and fluid >=501 cc) and aphasia, radiation tx, receiving tx for surgical wounds/open lesions or ulcers (2 sites, any stage; or 1 site stage 3 or 4), fever with dehydration, pneumonia, vomiting, weight loss, or feeding tube (calories >=51%, or calories =26%-50% and fluid >=501 cc) AND ADL score of 7 or more	17-18 15-16 4-14	Not Used Not Used Not Used	SSC SSB SSA
CLINICALLY COMPLEX Special Care qualifier (see above) and ADL score of 6 or less OR Clinically complex qualifier(any one): Burns, coma, septicemia, pneumonia, receiving treatment for foot lesion/infection, internal bleeding, dehydration, tube feeding (calories >=51%, or calories =26%-50% and fluid >=501 cc), oxygen, transfusions, hemiplegia with ADL score >=10, chemotherapy, dialysis, physician visits 1 or more days and order changes 4 or more days (last 14 days), physician visits 2 or more days and order changes 2 or more days (last 14 days), diabetes with injection 7 days/week and order change 2 or more days(last 14 days)	17-18 17-18 12-16 12-16 4-11 4-11	Signs of Depression No Signs Signs of Depression No Signs Signs of Depression No Signs	CC2 CC1 CB2 CB1 CA2 CA1
IMPAIRED COGNITION Score on MDS2.0 Cognitive Performance Scale (CPS) >=3 AND ADL score of 10 or less NOTES: No clinical variables used CPS Score of "6" will be assigned Clinically Complex or PE2-PD1) See Reduced Physical Function (below) for nursing rehab services count	6-10 6-10 4-5 4-5	2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab	IB2 IB1 IA2 IA1
BEHAVIOR PROBLEMS Wandering, physical abuse, verbal abuse, inappropriate behavior or resisted care on 4+ days/week OR hallucinations or delusions AND ADL score of 10 or less NOTES: See Reduced Physical Function (below) for nursing rehab services count	6-10 6-10 4-5 4-5	2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab	BB2 BB1 BA2 BA1
REDUCED PHYSICAL FUNCTION Nursing rehab service count: • passive and/or active ROM • amputation/prosthesis care training • splint or brace assistance • dressing or grooming training • eating or swallowing training • transfer training • bed mobility and/or walking training • communication training • scheduled toileting plan and/or bladder retraining program. NOTES: No clinical variables used	16-18 16-18 11-15 11-15 9-10 9-10 6-8 6-8 4-5 4-5	2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab 2 or more nursing rehab services on 6+ days/wk Less nursing rehab	PE2 PE1 PD2 PD1 PC2 PC1 PB2 PB1 PA2 PA1
Default			AAA

Attachment 6

Instruction Manual For Conducting Patient Review Instrument (PRI) On-Site Reviews

01/02/04

Table of Contents

Part A - Overview

Part B - Audit Process

Part A - Overview

1. Purpose of PRI On-site Reviews

On-site reviews (audits) are conducted to assure that PRI resident data submitted to the State Department of Health (SDOH) by nursing facilities is in compliance with established reporting standards contained in the Department's regulations and PRI clarification sheet. Compliance is necessary for the SDOH to establish appropriate Medicaid reimbursement, since PRI data is an integral component of the rate setting system.

2. Roles, Rights and Responsibilities of the On-Site Reviewer

- The on-site auditor's principle responsibility during the site visit is to validate the information submitted by the facility through use of a specific audit process.
- In performing audits, the on-site auditor should give no thought to the potential reimbursement implications of his/her determinations. Further, the on-site auditor should not attempt to answer questions of facility personnel on the reimbursement system. Facility personnel should direct such questions to the SDOH.
- The On-Site Reviewer is responsible for:
  - representing the SDOH in an impartial, positive, professional and ethical manner.
  - maintaining confidentiality of pertinent aspects of a resident's condition and care.
  - documenting findings appropriately.
  - accurately communicating audit findings to facilities.
  - identifying conflicts of interest. The reviewer must not accept an assignment to audit a facility in which s/he has previously been employed or has a personal relationship with facility employees.
  - reporting any observed indicators of egregious care or patient abuse.
- The On-Site Reviewer has the right to:
  - access resident medical records.
  - question facility staff regarding residents' conditions and care.
  - observe residents.
  - adequate and comfortable space to perform the audit.
  - conduct audits in a non-confrontational environment.

3. Roles, Rights and Responsibilities of Facility Personnel

- The role of facility personnel is to provide support to the auditor to assure an effective and accurate review.
- Facility staff has the responsibility to:
  - designate a contact person with whom the auditor may discuss issues or ask questions as they arise during the audit. The contact person should be knowledgeable regarding all aspects of the facility's units, medical records and PRI assessment system.
  - ensure the timely availability of complete medical records.
  - set aside adequate and appropriate space in which the reviewer may conduct the audit.
  - present a professional and non-confrontational outlook on the audit process.

- Facility staff has the right to:
  - discussion with the auditor concerning the scope of the audit.
  - produce documentation during the conduct of the review should the reviewer not be able to substantiate the facility's assessment.
  - an explanation of audit findings by the reviewer at an exit conference.
  - ask questions regarding PRI qualifiers.

4. Initiating Audits

- SDOH generates an audit through transmission of review materials to the contractor. The contractor then makes telephone contact with facility personnel to arrange the date(s) and time(s) of the audit, including the time of the entrance conference. If the audit is a later Stage review, the facility will have already been notified that an audit would be generated when SDOH transmitted the results of the previous Stage review.
- Auditors and facility personnel are expected to demonstrate flexibility and responsiveness in expeditiously scheduling audits.
- If a facility refuses to schedule an audit, the contractor must notify the SDOH. If the situation cannot be resolved, the SDOH will deem the data unavailable, resulting in denial of all the hierarchies that would have been reviewed and coding of all ADLs that would have been reviewed at level one.
- The contractor is instructed to transmit the resident list for audit, provided by SDOH, to the facility by facsimile copy between 3:30 PM and 4:00 PM on the last workday before the review. This list notifies the facility of which resident records are to be reviewed, so that the facility can make medical records available at the beginning of the audit. If the contractor is unsuccessful in sending a facsimile copy by 4:00 PM due to transmission problems, a call must be placed to the facility to resolve the problem.

5. Entrance Conferences

- This meeting is to be held at the beginning of the first day of each stage review and shall last approximately one-half hour. The meeting shall be attended, at a minimum, by the auditor and facility contact person (as designated by the administrator). The meeting is provided so the auditor can outline the purpose, scope and timetable of the particular stage audit to be conducted. **Note:** If the reviewer finds during the course of introductions that there is a conflict of interest (e.g., the Administrator or Director of Nursing (DON), etc., is a personal friend), the assignment should be refused and the review should be re-scheduled.
- The facility contact person should inform the auditor as to how s/he may be reached during the course of the audit.
- The reviewer should communicate the audit schedule to the facility contact person during the entrance conference.
- During the entrance conference, the auditor must secure the facility's written determination as to whether an exit conference is requested at the conclusion of that stage audit. The decision is binding. Facilities may have exit conferences at the conclusion of every stage audit if so requested at the applicable entrance conference. During the entrance conference, the auditor and facility personnel will set a planned time for the exit conference.
- At the entrance conference of a Stage I audit, facility staff must identify the census count for the last day of the PRI assessment period. The reviewer will enter this number on the On-Site Reviewer Cover Sheet. The PRI census date will be handwritten on this form. The census count is important in verifying that the number of PRIs submitted by the facility is accurate.
- At the entrance conference of a Stage II or Stage III audit, the auditor must secure the facility's written determination of which CIs from the immediately preceding stage audit the facility is requesting be re-reviewed. If the facility is requesting no CIs be re-reviewed, this also must be acknowledged in writing at the entrance conference. On rare occasions, the number of previous stage CIs to be re-reviewed may be so numerous that the auditor must contact the contractor's central office immediately after the entrance conference so that an additional day to conclude the audit and conduct an exit conference can be scheduled.
- At the conclusion of the entrance conference, the facility contact person will orient the reviewer to the work place from which the audit may be conducted and provide all necessary information regarding the facility's medical record documentation systems, facility layout and selected units, including introductions to other staff.

6. Exit Conferences

- The purpose of the exit conference is for the auditor to convey the provisional results of the review just conducted, as it relates to new CIs and any previous stage CIs re-reviewed at the written request of the facility. Further, the exit conference provides facility representatives the opportunity for discussion with the auditor regarding her/his findings. On occasion, this discussion may result in the auditor altering a decision, but this is not the actual purpose of the exit conference, which is largely a report-out by the auditor. The facility may not present additional medical record documentation for review during the exit conference, as opportunity for this will have been provided during the course of the audit.
- The exit conference will occur at the time established during the entrance conference, subject to revision based on mutual agreement of the auditor and facility personnel. The exit conference can last as long as 45 minutes, depending on necessity.
- Participants in the exit conference shall be limited to the facility administrator, the facility contact person, one other person not active as an assessor (who may be the director of nursing or other staff member), and an active facility assessor. Other persons may observe, but not participate, verbally, non-verbally or by written communication with participants. The auditor may ask any person to leave the exit conference if s/he determines the person's participation or presence is proving counter-productive.
- Exit conferences are not to be video taped, audio taped, or transcribed unless facility personnel secure approval of the SDOH prior to the first day of the particular Stage audit. Approval by SDOH requires the commitment of the facility to provide the auditor with a copy of the videotape, audiotape or transcribed record.
- The auditor will commence the exit conference with a short statement explaining its purpose, scope, limitations, time frame, and rules. The auditor will also inform attendees that they will receive a formal notification of audit outcomes from the SDOH.
- The auditor will next provide a review of his/her findings regarding the re-reviewed CIs from the immediately preceding stage review. The auditor will explain the reasons for his/her decisions. In instances where the auditor does not overturn a previous stage CI, facility staff will be afforded a single last opportunity to comment and make their case for overturn. The auditor has discretion to change his/her mind, or reserve the right to make a later decision.
- The auditor will then provide a review of his/her findings regarding the current stage audit, including the reasons for his/her CIs. Once again, the facility will be afforded an opportunity to make a case for the auditor to reverse these CIs and the auditor may or may not so decide, or reserve the right to make a later decision.
- In the course of presenting his/her findings, the auditor will have compiled resident specific examples of the documentation, or the lack thereof, which lead to each CI. The auditor will also note any instances in which PRI qualifiers appear to be consistently misapplied or misinterpreted by facility assessors.
- The tone of the exit conference is expected to be professional and neutral at all times. All parties must focus on the facts related to the qualifiers and attempt to be precise and concise in their discussions. Auditors have the authority to terminate discussion regarding a

particular CI upon determining that all the related facts have been thoroughly addressed and the discussion has digressed or become repetitive and counterproductive.
- The auditor has authority to terminate the exit conference after 45 minutes or at any time s/he determines it to be contentious, unprofessional or unproductive. In such instances, there will no re-scheduling of the exit conference.

Part B - Audit Process

1. Audit Framework: Stage I Reviews; Stages II & III Reviews; Exit Conference Visits; Expedited Audits

- For **Stage I audits**, SDOH provides audit forms for 40 residents (80 residents for a facility with over 350 total PRIs). For each of these residents, the reviewer completes an ADL Verification Form. Generally, for 16 of 40 residents, the reviewer is asked to also complete RUG category checklists, which address the qualifiers pertinent to specific questions on the PRI. The reviewer returns the completed audit forms to SDOH, which substitutes the **Stage I** audited PRIs for those originally reported. SDOH also compares the assessments resulting from the audit with those submitted by the facility to determine whether the extent of discrepancies is within parameters established by the SDOH, or warrants a Stage II audit.
- If a **Stage II audit** is required, SDOH enters into a fuller assessment of the appropriateness of the facility's PRI submission through the contractor's review of an additional 80 residents. If the facility has fewer than 80 remaining residents, the Stage II audit will involve all the remaining residents of the facility (except those in the Physical A (PA) RUG-II classification). A different reviewer is assigned to the Stage II audit, which is conducted similarly to the Stage I audit. The facility may discuss any CI from the Stage I audit with the Stage II reviewer, who will examine the medical records and agree with or overturn the previous reviewer's findings. The Stage II audit forms are returned to SDOH and a determination is made whether there is a need for a Stage III review.
- If a **Stage III audit** is required, it is performed by yet another reviewer and includes all remaining residents except those in the PA RUG-II classification. The facility may discuss any CI from the Stage II audit with the Stage II reviewer, who will examine the medical records and agree with or overturn the previous reviewer's findings. The results of Stage III audits (or Stage I and II audits for facilities with less than 40 or 120 residents, respectively) are utilized by the SDOH to make a determination regarding the appropriateness of delegating to the facility the right to perform its PRI assessment function with its own chosen staff/contractor for specified future periods.
- In instances where a facility has failed a Stage I or Stage II review but does not have any remaining residents yet to be reviewed (non-PAs), the facility will be offered a return visit solely to have the CIs from the immediately preceding audit re-reviewed by another auditor. These additional reviews are referred to as **"Exit Conference Reviews"**. The SDOH will contact the facility in writing to offer the return visit and the facility must respond in writing within six weeks as to whether it accepts or declines the offer.
- SDOH has entered into agreements on a one-time basis with certain facilities to perform some of their reviews in a manner where all their residents will be audited in a single Stage. These reviews are so designated to the audit contractor. These reviews are referred to as **"Expedited Audits;"**.
- The SDOH informs the facility in writing of the results of each of the above reviews.

2. Audit Principles

- Reviews are meant to ascertain the accuracy of PRIs prepared and submitted by nurse assessors employed by facilities. To do so, reviewers are to complete the computer audit forms exclusively through a review of medical record documentation, with assistance from facility staff as needed. Facility records must document conformance with the PRI qualifiers for each of the conditions/treatments/levels reported by the facility on its submissions.
- Whenever it appears that the record is incomplete, unclear, conflicting, or does not substantiate the PRI response provided by the facility, the auditor must consult with the Facility Contact Person to determine whether additional supporting documentation may be available elsewhere. Each facility will have its own way of keeping records. It is important that the auditor become familiar with the facility's record keeping system and where records are to be found so that supporting documentation is not missed. This is especially important if the entire record for a resident is not to be found in one place.
- Documentation found after the completion of the on-site visit will not impact the results of that stage review.
- Under no circumstances should an auditor recommend that the facility adopt a specific format for medical record documentation. If a facility asks for such advice, the reviewer should merely advise that documentation demonstrate conformance with the PRI qualifiers.
- Reviewers should bring to each audit the following reference materials: the PRI; PRI Instructions; PRI Clarification Sheet; a calendar for the audit time period; a description of how the RUG is assigned; and relevant correspondence from SDOH. All these documents should be utilized when performing the audit.
- Auditors will work independently but may require intermittent assistance from facility staff. The facility contact person and designated facility staff must be available to assist the reviewer.

3. Resident Observation and Discussion with Staff

- PRI audits are first and foremost a review of medical records to determine if documentation supports facility PRI submissions. Information secured through observation and staff discussion should not result in audit determinations that are unsupported by the medical record. However, these tools can be important in:
    - assisting the auditor in understanding the facility's documentation, especially when it is unclear or conflicting; and,
    - identifying patterns of inaccurate medical record documentation that should be reported to SDOH.
- PRI reviewers should observe approximately 20% of residents selected for audit. When possible, the auditor should observe residents during a meal, as well as residents with reported medical conditions and treatments, including but not limited to decubitus ulcer, stasis ulcer and wound care. Such observation may take place in residents' rooms and/or congregate areas, such as dining rooms. While observing residents, the reviewer may engage in discussion with staff regarding the resident's care and level of independence.
- While the PRI review is not a quality of care audit, the reviewer may encounter situations that represent poor quality (e.g., empty water pitchers, signs of dehydration such as dry, caked lips). In such instances, the reviewer should separately document these concerns as part of the narrative report of the audit visit. If potential patient abuse or neglect is ever noted, the reviewer is instructed to make a report to the SDOH by calling 1-888-201-4563 and completing the New York State Department of Health - Office Of Health Systems Management Health Care Facility Report Form.

4. Suggested Audit Schedule

- It is estimated that a reviewer will need to be on-site at the facility approximately 7.5 hours for every 40 residents to be reviewed. Reviewers have flexibility as to how they structure their work within the audit day, in consultation with facility personnel. However, for day one of each review, the reviewer should:

- determine whether s/he is in the correct facility by checking the posted operating certificate in the lobby to determine if the number on it matches the operating certificate number cited on the audit cover sheet. Discrepancies in operating certificate numbers may result from changes in ownership, changes in facility name and other reasons. Discrepancies must be resolved. If the facility cannot explain the reason for the difference, the reviewer should contact the contractor's central office, which will call SDOH.
- immediately follow with an entrance conference, which includes a check of census data if it is a Stage I review (see sections on Entrance Conferences and Checking Facility Census);
- immediately follow by having the facility contact person provide all necessary information regarding the facility's medical record documentation systems, facility layout and selected units, including introductions to other facility staff;
- for a Stage I review, immediately follow by completing the TBI checklists generated by SDOH for selected residents, if any. By doing these reviews first, you will be able to determine if the facility will need to provide medical records for additional TBI residents (see section on Instructions for Completing TBI Extended Care);

- After the above, the reviewer may complete the remaining individual computer audit forms, CI re-reviews and other relevant documents in any manner that is both efficient and amenable to all parties. For example, ADL, RUG, Dementia and CI checklists for various residents may be completed in any order. Further, reviews may be performed on nursing and other units in the facility or a centralized location. In evaluating how to structure the remainder of his/her workday, the auditor will consider the checklists to be completed and CIs to be re-reviewed.
- The auditor should inform the facility contact person whenever s/he is leaving the facility for lunch or other purposes. The facility contact person should do the same for the auditor.
- If the facility decided in writing during the entrance conference that an exit conference would occur, it must be conducted at the close of the audit. Note: If there are more previous stage CIs that must be re-reviewed than the reviewer can fit into the audit schedule, s/he should contact the contractor's central office after the entrance conference on the morning of the first day on-site so that a return visit can be scheduled to conclude the reviews and conduct an exit conference (see section on Exit Conferences).

5. Instructions for Completing/Interpreting Audit Forms and Related Materials

- When SDOH generates an audit, it forwards to the contractor the following materials:
  - On-Site Review Cover Sheet
  - Resident List for Audit
  - Audit Checklist Summary
  - Computerized Audit Forms For Specific Residents: ADL Verification Forms and RUG Category, TBI Extended Care and Dementia Checklists
  - Controverted Item Summary (Stage II, Stage III and Exit Conference Visits only)
  - Controverted Resident List for Previous Audit (Stage II, Stage III and Exit Conference Visits only)
- Additionally, it is the responsibility of the contractor to assure that auditors have the following materials in their possession with each audit, because the SDOH does not transmit them each time it generates an audit:
  - blank computerized audit forms for use in performing any re-reviews of previous Stage CIs and additional TBI extended care reviews;
  - blank copies of the On-Site Reviewer Report: Cover Sheet; Review Schedule; Record of Disagreements; Exit Conference - Summary of Disagreements
  - blank copies of the Controverted Items to be Reviewed form
  - Exit Conference Request Form
  - the PRI
  - PRI Instructions
  - PRI Clarification Sheet;
  - RUG "Spider Graph";
  - relevant correspondence from SDOH;
  - Health Care Facility Report Form; and,
  - a calendar for the audit time period.
- All notations on forms are required to be made in ink. If changes are made, the reviewer should cross out the original response, write the new response next to it and initial the change.
- **The On-Site Review Cover Sheet** provides facility specific identifiers, the audit stage, the number of PRIs the facility submitted for the period (Stage I only), and the number of residents selected for review. Also, the census date will be handwritten on this form. The auditor must enter on the sheet his/her four digit reviewer identification number and signature. Additionally, for a Stage I review, the auditor must enter the census number and date on this form.
- **The Resident List for Audit** is used by the contractor to notify the facility of the resident records to be reviewed. The contractor is instructed to transmit this list to the facility by facsimile copy between 3:30 PM and 4:00 PM on the last workday before the review. This list notifies the facility of which resident records are to be reviewed, so that the facility can make medical records available at the beginning of the audit. If the contractor is unsuccessful in sending a facsimile copy by 4:00 PM due to transmission problems, a call must be placed to the facility to resolve the problem. The reviewer is not required to fill out any information on this document or return it to SDOH with the audit.
- **The Audit Checklist Summary** provides a listing of the residents to be reviewed and whether each such resident record is subject to an ADL checklist review, specified RUG category checklist review(s), dementia checklist review, and/or a TBI Extended Care checklist review. The ADL checklist includes all three ADLs (eating, transfer & toileting). There may be more than one RUG/Hierarchy checklist for each resident. At the end of the resident listing is a summary showing the total number of required reviews, and the total number of residents subject to RUG/Hierarchy reviews. This information is helpful to the auditor in planning his/her audit schedule. Also provided is a listing of residents reported as TBI Extended Care by the facility but not selected for audit. This information is needed because if the auditor controverts TBI Extended Care classification for any resident that is selected for such a review, then the auditor is instructed to review all the TBI Extended Care residents that were not initially selected for review (see section on TBI Extended Care Reviews). The reviewer is not required to fill out any information on this document or return it to SDOH with the audit.
- **Computerized Audit Forms For Specific Residents** consist of ADL Verification Forms, RUGS Category (Hierarchy) Checklists, Traumatic Brain Injury (TBI) checklists and Dementia Checklists. Completion of these forms is the crux of the audit. For Stage I reviews there may be up to two checklists on one page for ADLs. For all other checklists, for any Stage review, there will be only one checklist per page, and a line under the checklist questions beneath which the auditor is expected to write notes. All these sheets provide the applicable time period (ATP), to identify the 28-day period that is subject to review. The ending date is the date of the PRI completion. The reviewer must enter her/his reviewer identification number on every sheet. Detailed instructions for completing these forms are provided in separate sections of this manual.
- **The On-Site Reviewer Report** consists of the following four pages, each of which must be completed by the reviewer and returned to SDOH with each audit:

- On **the cover page**, indicate the date(s) of the facility visit, the facility's name and operating certificate number and the audit stage. Enter the names of the facility contact person, other persons that assisted with the audit and those persons that attended the exit conference. If the review is a Stage II or Stage III, complete the section regarding the numbers of CIs from the immediate previous Stage that were re-reviewed. There may be more than one such CI requiring re-review for any given resident. Provide a description of the review. Was the facility fully prepared for the audit? Were there any particular problems? Was there one area that the facility did not seem to understand. Additional pages may be attached as needed.
- On the second page **(the On-Site Reviewer Report Review Schedule)**, indicate the amount of time spent at the facility overall and on each unit. Both a starting and ending time should be indicated for each unit, or for time in a specific department of the facility. For example, if therapy reviews were completed in the therapy department, then the therapy department would be listed as a separate unit. If all the review work was done in a conference room, it is still important to indicate how much time was spent reviewing records. Also identify the time and duration of the entrance and exit conferences.
- On the third page **(the On-Site Reviewer Report Record of Disagreements)**, provide a brief summary of each item controverted during the current stage. In each instance, the reviewer should provide the resident name, item controverted, the 28 day ATP associated with the PRI and a statement explicitly describing the reason for denial. For example, an entry might read 'Mary Jones, Oxygen, ATP 5/20/98-6/19/98, no physician order.' Multiple copies of this page may be submitted. Additional information may be provided, either on this report and/or on the computer audit form, but the summary reason should be clear.
- On the fourth page, **(the On-Site Reviewer Report Exit Conference Summary of Disagreements)**, list those CIs from the immediately preceding stage that were reviewed at the request of the facility but not overturned. The auditor should provide information in the same format as described immediately above for the record of disagreements form.

- **The Controverted Item Summary** is transmitted only with Stage II reviews, Stage III reviews and exit conference visits. This summary provides information from the previous stage(s), including a complete listing of all the facility residents reviewed on the previous stage(s) and all CIs. The facility received a copy of this form with the letter informing them that they would be contacted about another auditor visit. The reviewer is not required to fill out any information on this document or return it to SDOH with the audit.
- **The Controverted Resident List for Previous Audit** is transmitted only with Stage II reviews, Stage III reviews and exit conference visits. This summary provides much of the information contained on the Controverted Item Summary referenced immediately above, but in a more compact form. Of importance, this document contains information only for the immediately previous stage, as that is the only stage open for review, and provides the Applicable Time Period (ATP), allowing the auditor to know the PRI completion date. The reviewer is not required to fill out any information on this document or return it to SDOH with the audit.
- **The Controverted Items to be Reviewed** form is to be filled out at the entrance conference at the beginning of every Stage II review, Stage III review, and exit conference visit and must be returned to SDOH with the audit. This form provides the facility's official determination of the previous stage CIs that are to be re-reviewed. The facility is aware of which items were controverted on the previous stage review at the time it receives the Controverted Item Summary and letter indicating there will be a further review. Facility staff should, therefore, be prepared at the entrance conference to identify which items need to be re-reviewed. The reviewer will complete the information at the top of the page, identifying the facility and audit stage. The facility contact person will complete section I, identifying the residents and CIs to be reviewed. 'None' is to be written across the page if no CIs are to be reviewed. Both the facility contact person and the auditor must sign section II, even if no CIs will be reviewed.
- **The Exit Conference Request** form is used by the reviewer at the entrance conference for every Stage audit to secure the written determination of the facility as to whether an exit conference is requested. The form is to be completed and signed by facility staff whether the exit conference is requested or refused and must be returned to SDOH with the audit.

6. Instructions for Checking Facility Census

- On a Stage I review, the facility census for the date handwritten on the form must be checked and recorded. The census reflects the number of residents as of 4:00 PM, which may be different from the census at midnight. In the case of a discrepancy between the reviewer's determination and the number of PRIs the facility submitted, the reviewer must inform the facility contact person that s/he must resolve the issue. If the census discrepancy cannot be fully explained before the auditor leaves the facility, the reviewer should encourage the facility to continue its analysis because the SDOH will be contacting the facility directly about the problem until the census is resolved. If the census discrepancy is resolved while on-site, the reviewer should make an effort to secure and transmit to SDOH with the audit package the following:
  - a cover letter on facility letterhead explaining the reason(s) for the discrepancy;
  - the facility's submission of additional PRIs for any residents excluded in error from the original submission. The PRI must be based on a date within the original assessment period and include name, social security number and all other required data;
  - identification of residents whose PRIs were submitted in error in the original submission, including names and social security numbers. Audits that may have been generated for any of these residents are not to be reviewed. Instead, they are to be so marked and attached to the On-Site Reviewer Report. They should not be left with the other checklists. **Note:** The reviewer should be aware that this situation is different than when a resident is in the facility on the census date but not on the date of the PRI completion. In this later situation, the audit forms must be completed based on the date of completion, as submitted.
- Regardless of whether the census discrepancy is resolved prior to conclusion of the audit, the reviewer must note the discrepancy on the on-site reviewer report cover sheet and enter the correct census number on the on-site review cover sheet.
- If the facility asserts the reviewer is checking the incorrect date, s/he must call the contractor's central office, which will contact the SDOH to verify the date. If for some reason no response is available from SDOH before the audit is completed, the reviewer should obtain information for both dates so that the census can be entered on the audit cover sheet once the correct date is determined.

7. Instructions for Completing ADL Verification Forms

- Reviewers are verifying the findings of nurses in the facility as they relate to the PRI for the 28-day period ending the day of assessment (ascertained through the beginning and ending dates specific to each resident printed on each of the audit forms).
- Reviewers must enter their reviewer ID numbers on each resident specific ADL verification sheet transmitted by SDOH. The ADL verification form lists and defines all three of the ADLs used in calculating an ADL score (eating, transfer and toileting), each of which must be verified for a selected resident. For each ADL, the reviewer should choose the description on the form that most accurately describes the amount of assistance the resident actually received in performing the task in question (toileting, transfer, eating) and record the number preceding that description on the field "audit level". In general, this determination should reflect the assistance required at least 60% of the time the activity was performed. There are four such care descriptions from which to choose for eating and three for transfer and toileting. The numbers associated with these care descriptions represent the point value for the ADL score, not the "Level" on the PRI form.
- During a Stage I review, the auditor is said to be performing a "blind review", because s/he is not informed by SDOH as to how the facility answered the ADL questions.
- During Stage II and III reviews, the auditor is aware of how the facility answered the questions and must document the points of disagreement in the manner specified on the bottom of the audit worksheet.

- All ADL verification forms will indicate the resident's name as well as medical record, unit, and room numbers. It is important for the reviewer to assure that the medical record s/he is reviewing is for the correct resident.
- Occasionally, a facility is unable to locate the record for a given resident, or is able to locate only part of a record. If no ADL records are found, record a level '1' for all three ADLs and note on the audit form that no medical records were produced related to the item.

8. Instructions for Completing RUG Category (Hierarchy) and Dementia Checklists

- Reviewers are verifying the findings of nurses in the facility as they relate to the PRI for the 28-day period ending the day of assessment (ascertained through the beginning and ending dates specific to each resident printed on each of the audit forms).
- Reviewers must enter their reviewer ID numbers on each resident specific RUG category checklist transmitted by SDOH. In the verification of RUG categories, the auditor checks to ensure that each of several qualifiers was met. If a specified qualifier has been met, the reviewer enters a '1' to answer 'yes'. If the qualifier has not been met, the reviewer enters '2' to answer 'no'. The same methodology applies to the Dementia checklist.
- The transmission of a RUG category checklist or dementia checklist indicates the facility claimed the associated item when submitting its PRIs.
- Some resident records may be subject to no RUG category reviews, others resident records may be subject to multiple reviews for various PRI questions.
- All RUG category and dementia checklists will indicate the resident's name as well as medical record, unit, and room numbers. It is important for the reviewer to assure that the medical record s/he is reviewing is for the correct resident.
- Occasionally, a facility is unable to locate the record for a given resident, or is able to locate only part of a record. If no records are found relative to a RUG category or dementia checklist, mark '2' for all the questions and note on the audit form that no medical records were produced related to the item.

9. Instructions for Completing TBI Extended Care Reviews

- If the facility has reported any residents as qualifying for TBI extended care, there will be a verification process as part of Stage I.
- The Audit Checklist Summary lists individually **all** residents reported by the facility as meeting the qualifiers for TBI classification and differentiates those selected for audit from those not selected. At the end of this summary there are counts of the total number selected for review and the total not selected. For those selected, SDOH has transmitted TBI extended care checklists. The auditor must complete these checklists, following the same instructions as are provided above for RUG category and dementia checklists. All TBI extended care checklists will indicate the resident's name as well as medical record, unit, and room numbers. It is important for the reviewer to assure that the medical record s/he is reviewing is for the correct resident.
- **If the auditor controverts any TBI extended care classification for any resident selected for audit, defined as marking 2 for 'no' on any of the individual questions (qualifiers) on the checklist, the reviewer is additionally required to audit all the TBI residents not selected for audit.** The auditor must use the blank audit pages s/he brought to the facility for this purpose and must enter the facility name, operating certificate number, and patient name and identification number on each sheet in a legible manner in order to reduce errors in keying. For these TBI reviews, enter 2 for audit purpose.

10. Instructions for Re-Reviewing Previous Stage Controverted Items (CIs)

- When a facility is undergoing a Stage II or III review, the facility may request a re-review of CIs from the immediately previous Stage. In the case of a Stage III review, only items controverted on the Stage II review may be re-reviewed and all CIs resulting from the Stage I review are final. The audit packet provides a listing identifying those CIs from the immediately preceding stage that are open for review should the facility so request.
- While the auditor knows the previous auditor's CIs, s/he does not know which qualifier(s) were unmet. Therefore, the re-review is accomplished though a complete review of all the qualifiers for the applicable resident classification. All of the questions must be tested in the same way they would be for a resident being reviewed for the first time.
- Previous Stage CIs may relate to RUG categories, ADLs, dementia or TBI extended care. Keep in mind that, if there were TBI denials on the Stage I, other reported TBIs would have been reviewed. Any such denials will not be listed on the Controverted Resident List prepared for the auditor; these will be identified on the Controverted Item Summary sent to the facility with a room number of 'TBINO'. Such residents may have been selected for the Stage II, making it possible to do an initial review of ADLs and a re-review of the TBI.
- Reviewers are to use the blank audit forms they brought to the facility to complete these re-reviews and must enter the facility name, opcert, and patient name and identification number on each sheet in a legible manner in order to reduce errors in keying. For these CI re-reviews, list the audit purpose as a '1'.

11. Other Auditing Instructions

- The facility may claim that some information the reviewer seeks to audit is not what was submitted by the facility on the PRI. Among other reasons, this may happen in situations where the facility: completed a PRI based on a date after the census date; erroneously claimed the wrong type of therapy (e.g. PT/OT), or claimed a treatment not provided. To make its case, the facility may sometimes provide a hand written copy, or a computer printout, showing different information. Regardless, the auditor must answer the questions on the computer audit forms generated by SDOH for the cited ATP because they are based on the information actually submitted by the facility.
- Careful documentation is in the auditor's best interest. Documentation should always be adequate to allow the reviewer to recall the precise circumstances of the determination, even after the lapse of a significant period of time. Reviewers should include all the following information in their notes and reports to document the basis for their determinations:
    - Date(s): List all relevant dates in the record that support your findings. For example, resident absences from therapy in the 28 day ATP.
    - Time(s): Give exact time (or times) of discussion with staff, (e.g. 10:15 AM).
    - Place(s): Cite the place where discussion took place. (e.g., E wing nurse's station).
    - Record Type(s): Cite where medical record documentation was found or absent, including but not limited to: nurses' progress notes; weekly or monthly summaries; medication records; physician's notes; therapists' notes; dietician's notes; social worker's notes; decubitus sheet, etc.
    - Name(s): Give names of recorders whether nurse, physician, therapist, etc. If the signature is not legible, try to determine the correct spelling from the charge nurse. List names of any staff members with whom you discussed the patient's condition (e.g., Nancy White, RN; Donna Brown, RPT).
- If the reviewer discovers that the facility has entered the resident's social security number incorrectly, a note of this should be made on the audit sheet, but the pre-printed information on the sheet should not be changed.

- It is important that the facility have ample time to locate records and the reviewer should not appear to be rushing facility personnel in this regard. On the other hand, the facility did have the resident list before the audit began, so the auditor is not expected to stay beyond the normative and planned time for leaving.

12. Assembly of Audit Materials

- The following forms must be completed in accordance with the instructions in this manual, assembled and mailed to the Department of Health for processing:
  - On-Site Reviewer Report;
  - Exit Conference Request form;
  - Controverted Items to be Reviewed form (for other than Stage I reviews);
  - the On-Site Review Cover Sheet; and all ADL verification Forms, RUG Category Checklists, TBI Extended Care Checklists, and Dementia Checklists
- In preparing the audit to send to the Department, the auditor should staple together in the upper left hand corner all of the sheets pertaining to one resident. The ADL checklists should be on top of any other checklists and the cover sheet should be on top of the audit checklists.
- The reviewer must sign the first page of the on-site reviewer report and note the facility name and reviewer's name on all the following pages of the report.
- Mail all the required forms to:

  Mr. Robert Loftus
  Bureau of Financial Management and Information Support
  New York State Department of Health
  Room 984, Corning Tower Building
  Empire State Plaza
  Albany, New York 12237-0719

Revised: June 2008

Attachment 7

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

I. USING THESE INSTRUCTIONS: These instructions and the training manual should be read before completing the PRI. These instructions should be kept with the PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE PRI ACCURATELY.

2. ANSWER ALL QUESTIONS: Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number should be entered: / /9 /6 /2 /1 /0 /. If there are unused boxes, they should be on the left side of the number as shown in the example.

3. QUALIFIERS: Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered yes. These qualifiers take the following forms:

o TIME PERIOD - The time period for the questions is the past four weeks, unless stated otherwise. For patients who have been in the facility less than four weeks (that is, new admissions or readmissions), use the time from admission to PRI completion as the time frame.

o FREQUENCY - The frequency specifies how often something needs to occur to meet the qualifier. For example, respiratory care needs to occur daily for four weeks or the PRI cannot be checked for this patient as receiving this care.

o DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered Ayes@ for the patient.

o EXCLUSIONS - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from respiratory care.

4. ACTIVITIES OF DAILY LIVING: The approach to measuring ADLs is slightly different from the other PRI questions. Measure the ADLs according to how the activity was completed 60% or more of the time during the past four weeks. Read the specific instructions for ADLs to understand the CHANGED CONDITION RULE and other details. PERFORMANCE: Measure what the patient does, rather than what the patient might be capable of doing.

5. CORRECTIONS: Cross out any responses which you wish to change and re-enter clearly to the right of the original response. Example: /3/ 4.

6. Use pen, not pencil.

INSTRUCTIONS: PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the 8 character identifier (7 numbers followed by the letter "N") stated on the facility's operating certificate. The last character "N" indicates Nursing Facility.

2. SOCIAL SECURITY NUMBER: Your PRIs can not be processed unless this question is accurately entered. Do not leave this question blank, do not enter zero if there is no social security number. Only use the Social Security number that has been specifically designated for the patient and not the spouse of the patient. Only use the number that has been assigned by the federal Social Security Administration. If there is no such number for a patient, a NEW SYSTEM has been developed to enable all facilities in the State to assign a unique ID number to those patients without a Social Security number. If a patient was assigned a computer generated number by the Department, that number should no longer be used. If the patient has no Social Security number, use this method: Enter the first three (3) letters of the patient's last name (starting to the far left), and then enter the six digits of the patient's date of birth. Omit the century in the birth date, which will be either a "19" or "18" as in 1930 or 1896. As an example, if a patient named Cheryl Brant has no social security number and was born on May 8, 1913, you would enter:/B/R/A/0/5/0/8/1/3 on the PRI.

3. RESIDENT IS LOCATED: Former HRF Area or Former SNF Area. This question has been revised to reflect the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). It is imperative that nursing facilities formerly deemed "dual level" complete this section properly.

4. PATIENT NAME: Enter the patient's name, last name first, in the boxes provided. Enter up to the first 10 letters of the patient's last name.

6. MEDICAL RECORD NUMBER: Enter the unique number assigned by the facility to identify each patient. It is not the Medicaid, Medicare or Social Security number unless that is the number used by the facility to identify each of its patients.

7 ROOM NUMBER: Enter the numbers and/or letters which identify the patient's room in the facility.

8. UNIT NUMBER: Enter the one or the two digit number (01-12) assigned by your facility to each nursing unit for the purpose of this data collection.

11. DATE OF INITIAL ADMISSION: Enter the month, day and year the patient (1) entered the present nursing facility. Use the date of the patient's first admission and not the most recent. If the patient were transferred from another facility, it would be an initial admission to your facility. As another example, consider a patient that was admitted to a hospital from your facility and subsequently loses bed hold. If this patient is eventually readmitted to your facility at the original level of care, use the original admission date to complete this item.

12. MEDICAID NUMBER: Enter these numbers if patient has the coverage available, whether

13. MEDICARE NUMBER: or not the coverage is being used. If not, enter only one zero in the
far right box.

14. PRIMARY PAYOR: Enter the one source of coverage which pays for most of the patient's current nursing home stay. Code "Other" only if the primary payor is not Medicaid or Medicare. (Do not code "Other" for a patient with Medicaid coverage supplemented by Medicare Part B Code Medicaid.) Medicaid pending is to be coded as "Medicaid", if there is no other primary coverage being used for the patient's present stay.

15A. REASON FOR PRI COMPLETION: Select the one reason why the PRI is being completed. Responses 3, 4, and 5 under Utilization Review have been eliminated.

REIMBURSEMENT ASSESSMENT CYCLE:

Indicate whether this assessment is being completed as a part of a full facility assessment or as part of a quality assessment cycle for new admissions only.

1. Biannual Full Facility Cycle - The data collection during which all the patients residing in the facility are assessed. These PRI assessments include patients who were assessed during your previous PRI data collection and any new admissions.

2. Quarterly New Admission Cycle - The "new admission only data collection," involving only patients who were not assessed at their present level of care during your previous full facility data collection are reviewed. This specific PRI data collection occurs three months after your full facility PRI data collection. A new admission may be a new patient from the hospital, community or another nursing facility; or was hospitalized during your previous full facility assessment (regardless of bedhold).

15B. WAS A PRI SUBMITTED BY YOUR FACILITY FOR THIS PATIENT DURING A PREVIOUS FULL FACILITY AND/OR NEW ADMIT CYCLE: Review your facility's records to determine whether a PRI for reimbursement purposes was ever completed for this patient.

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

Documentation-	For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components: o A description of the patient's decubitus. o Circumstance or medical condition which led to the decubitus. o An active treatment plan.
Definition LEVELS:	#0 No reddened skin or breakdown. #1 Reddened skin, potential breakdown. #2 Blushed skin, dusty colored, superficial layer of broken or blistered skin. #3 Subcutaneous skin is broken down. #4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone. #5 Patient is a level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a AYES@ to be answered for any of these conditions, all of the following qualifiers must be met:	
Time Period-	Condition must have existed during the past four weeks. (The only exception is to use the past twelve weeks for question 17H, urinary tract infection.
Documentation-	Written support exists that the patient has the condition.
Definitions-	See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

	DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17A.	COMATOSE: Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days.	Brain insult Hepatic encephalopathy Cerebral vascular accident	Total ADL Care Intake and output Parenteral feeding
17B.	DEHYDRATION: Excessive loss of body fluids requiring	Fever Acute urinary tract	Intake & output Electrolyte lab tests

	immediate medical treatment and ADL care.	infections Pneumonia Vomiting Unstable diabetes	Parenteral hydration Nasal Feedings
17C.	INTERNAL BLEEDING: Blood loss stemming from a subacute or chronic condition (*e.g.*, gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood likely to be needed every 60 days
17D.	STASIS ULCER: Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.	Severe edema Diabetes PVD	Sterile dressing Compresses Whirlpool Leg elevation
17E.	TERMINALLY ILL: Professional prognosis (judgement) is that patient is rapidly deteriorating and will likely die within three months.	End stages of: Carcinoma, Renal disease, and Cardiac diseases	ADL Care Social/emotional support
17F.	CONTRACTURES: Shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to spasticity, paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.		
	To qualify as AYES@ on the PRI the following qualifiers must be met:		
	1. The contracture must be documented by a physician, physical therapist or occupational therapist.		

	2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis. There does not need to be an active treatment plan to enter AYES@ to contractures.		
17G.	DIABETES MELLITUS: A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.	Destruction/malfunction of the pancreas Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus	Special diet Oral agents Insulin Exercise
17H.	URINARY TRACT INFECTION: During the past twelve weeks symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q.29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (*e.g.*, mentally confused or incontinent patients).	Exclude if symptoms are present, but the lab values are negative	Antibiotics Fluids

17I.	HIV INFECTION SYMPTOMATIC: HIV (Human Immunodeficiency Virus) Infection, Symptomatic: Includes Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection AND a positive finding is documented AND the patient has had symptoms, documented by a physician, nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant as related to the HIV infection. Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.		
17J.	ACCIDENT: An event resulting in serious bodily harm, such as a fracture, a laceration which requires closure, a second or third degree burn or an injury requiring admission to a hospital.		
	To qualify as AYES@ on the PRI the following qualifier must be met: 1. During the past six months serious bodily harm occurred as the result of one or more		

	accidents.		
17K.	VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.		
	All services shall be Provided in accordance with Sections 416.13, 711.5 and 713.21 of Chapter V of Title 10 of the *Official Compilation of Codes Rules and Regulations* of the State of New York.		

18. MEDICAL TREATMENTS: For a AYES@ to be answered for any of these, the following qualifiers must be met:	
Time Period-	Treatment must have been given during the past four weeks in conformance with the frequency requirements cited below and still be required. For medical treatments having a daily frequency requirement, treatment must be provided every day of the four week period, except for residents newly admitted during the period. For residents newly admitted during the four week period, treatments required daily must have been provided each day from admission to the end of the four week period and documentation must support the seriousness of the condition and the probability that treatment will continue for at least four weeks.
Frequency-	As specified in the chart below. (The only exception is to

	use the past twelve weeks for question 18L, catheter.)
Documentation-	Physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order specifies that treatment should be given and includes frequency as cited below, where appropriate.
Exclusions-	See chart on next page.

	DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18A.	TRACHEOSTOMY CARE: Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.	Daily	Self-care patients
18B.	SUCTIONING: Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.	Daily	Any tracheostomy Suctioning
18C.	OXYGEN THERAPY: Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (*e.g.*, cardiopulmonary condition).	Daily	Inhalators Oxygen in room, but not in use
18D.	RESPIRATORY CARE: Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.	Daily	Suctioning
18E.	NASAL GASTRIC FEEDING: Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.	None	None Gastrostomy not applicable
18F.	PARENTERAL FEEDING: Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (*e.g.*, comatose, damaged stomach).	None	None Gastrostomy not applicable
18G.	WOUND CARE: Subcutaneous lesion(s) resulting from surgery, trauma,	Care has been provided or is	Decubiti Stasis ulcers

	or open cancerous ulcers.	professionally judged to be needed for at least 3 consecutive weeks	Skin tears Feeding tubes
18H.	CHEMOTHERAPY: Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician, nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant when the physician assistant's order is appropriately cosigned. (Patient may have to go to a hospital for treatment.)	None	None
18I.	TRANSFUSIONS: Introduction of whole blood or blood components directly into the blood stream. (Patients may have to go to a hospital for treatment.)	None	None
18J.	DIALYSIS: The process of separating components, as in kidney dialysis (*e.g.*, renal failures, leukemia, blood dyscrasia). Patient may have to go to a hospital for treatment.	None	None
18K.	BOWEL AND/OR BLADDER REHABILITATION: The goal of this treatment is to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (i.e., usually not longer than six weeks). NOT all patients at level 5 under Toileting Q.22 may be a "YES@ with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:	Very specific And unique for each patient	Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions

	Bladder rehabilitation: Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental and physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.		
	Bowl rehabilitation: A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (*e.g.*, bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.		Exclude a bowel maintenance program which controls bowel intinence by development of a routine bowel schedule
18L.	CATHETER: During the past twelve weeks, an indwelling or external catheter has been needed. Indwelling catheter has been used for any duration during the past twelve weeks. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past twelve weeks. A physician order is required for an indwelling catheter; for an external catheter a physician order is not required.		Exclude catheters used to empty the bladder once, secure a specimen or instill medication
18M.	PHYSICAL RESTRAINTS: A physical device used to restrict resident movement. Physical restraints include belts, vests, cuffs, mitts, jackets, harnesses and geriatric chairs.	At least two continuous Daytime hours for at least 14 days during the past four weeks.	Exclude all of following: o Medication use for the sole purpose of modifying residents behavior

			o Application only at night o Application for less than two continuous daytime hours for 14 days o Devices which residents can release/remove such as, velcro seatbelts on wheelchairs o Residents who are bed bound o Side rails, locked doors/gates, domes
	To Qualify as AYES@ on the PRI the following qualifiers must be met: 1. The restraint must have been applied for at least two continuous daytime hours for at least 14 days during the past four weeks. Daytime includes the time from when the resident gets up in the morning to when the resident goes to bed at night. 2. An assessment of need for the physical restraint must be written by an M.D. or R.N. 3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint.		
	NEW ADMISSIONS: If a patient is a new admission and will require the use of a physical restraint for at least two continuous daytime hours for at least 14 days as specified by the physician order, then enter AYES@ on the PRI.		
III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING Use the following qualifiers in answering			

each ADL question:	
Time Period-	Past four weeks.
Frequency-	Asses how the patient completed each ADL 60% or more of the time performed (since ADL status may fluctuate during the day or over the past four weeks.) CHANGED CONDITION RULE: When a patient's ADL has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.
Definitions-	SUPERVISION means verbal encouragement and observation, not physical hands-on care. ASSISTANCE means physical hands-on care. INTERMITTENT means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis. CONSTANT means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity. Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

CLARIFICATION OF ADL RESPONSES

19. EATING:

#3 ARequires continual help...@ means that the patient requires a staff person=s continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

#5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.

20. MOBILITY:

#3 AWalks with constant supervision and/or assistance...@ may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient needs the help of two people to transfer.

#5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 "Continent... Requires no or intermittent supervision" and #2 "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 "Continent...Requires constant supervision/total assistance... " refers to a patient who may not be able to balance him/herself and transfer, has contractures, has fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, as documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A Patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel

incontinence.

Example 2: The patient requires intermittent supervision for bowel function (level 2) and is taken to the toilet every two hours as part of a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

IV. BEHAVIORS - VERBAL DISRUPTION; PHYSICAL AGGRESSION; DISRUPTIVE, INFANTILE/SOCIALLY INAPPROPRIATE BEHAVIOR; AND HALLUCINATIONS

The following qualifiers must be met:

Time Period-	Past four weeks.
Frequency-	As stated in the responses to each behavioral question.
Documentation-	To qualify a patient as LEVEL 4 or to qualify the patient as a "YES" to HALLUCINATIONS, the following conditions must be met: o Active treatment plan for the behavioral problem must be in current use. o Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. The problem addressed by this assessment must still be exhibited by the patient.
Definitions-	The terms used on the PRI should be interpreted only as they are defined below: o PATIENT'S BEHAVIOR: Measure it as displayed with the behavior modification and treatment plan in effect during the past four weeks. o DISRUPTION: Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur. o NONDISRUPTION: Verbal outbursts and/or physical actions by the patient

	may be irritating, but do not create a need for immediate action by the staff. o UNPREDICTABLE BEHAVIOR: The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern. o PREDICTABLE BEHAVIOR: Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and can plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS

23. VERBAL DISRUPTION: Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.

24. PHYSICAL AGGRESSION: Note that the definition states "with intent for injury."

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: Note that the definition states this behavior is physical and creates disruption.
EXCLUDE the following behaviors:

o Verbal outbursts
o Social withdrawal
o Hoarding
o Paranoia

26. HALLUCINATIONS: For a "YES" response, the hallucinations must occur at least once per week during the past four weeks, in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment.

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

o For each therapy these three types of information will be entered on the PRI; "Level", "Days" and "Time" (hour and minutes).

o For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as #1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will be 0 (zero).

o Use the chart on the following page to understand the qualifiers for each of the three types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART THAT FOLLOWS FOR THE SPECIFIC QUALIFIERS.

27. *LEVEL QUESTION:	**QUALIFIERS (see level 4 below)	
QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY = LEVEL 2	RESTORATIVE THERAPY = LEVEL 3
DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL / ADL ABILITY	None. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement.	There is positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.
PHYSICIAN ORDER, NURSE PRACTITIONER ORDER (IN CONFORMANCE WITH A WRITTEN PRACTICE AGREEMENT WITH A PHYSICIAN), OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER	Yes	Yes, monthly
PROGRAM DESIGN AND EVALUATION QUALIFIER	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.

TIME PERIOD QUALIFIER	Treatments have been provided during the past four weeks.	Treatments have been provided during the past four weeks.
NEW ADMISSION QUALIFIER	Not Applicable	New admissions of less than four weeks can be marked for restorative therapy if: o There is a physician order, nurse practitioner order (in conformance with a written agreement with a physician), or appropriately cosigned physician assistant order for therapy and patient is receiving it. o The licensed therapist has documented in the care/plan that therapy is needed for at least 4 weeks. o A new admission includes readmission to a residential health care facility.
* After completion of the ALevel@ question, proceed to the separate ADays@ and ATime@ qualifiers on the next page. ** QUALIFIERS NOT MET = LEVEL 4 ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS FOR LEVELS 2 OR 3 IS NOT MET.		
27. DAYS AND TIME PER WEEK QUESTION: QUALIFIERS*		
QUALIFIERS FOR DAYS AND TIME*	MAINTENANCE THERAPY (i.e.,level 2 or 4 under ALevel@ question)	RESTORATIVE THERAPY (i.e., If level 3 or 4 under ALevel@ question)
TYPE OF THERAPY SESSION	Count only one-to-one care. Exclude group sessions (*e.g.*,	Count only one-to-one care. Exclude group sessions

	PT exercise session, OT cooking session).	(*e.g.*, PT exercise session, OT cooking session).
SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY)	A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.	A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides).
* QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THE QUALIFIERS UNDER EACH LEVEL OF THERAPY.		

28. NUMBER OF PHYSICIAN VISITS: Enter A0" (zero) unless the patient need qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits that meet the physician, nurse practitioner, or physician assistant visit qualifiers
o PATIENT TYPE/NEED QUALIFIERS: The patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).
o PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT VISIT QUALIFIER: If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits during the past four weeks that meet the following qualifications:
o A visit qualifies only if there is physician, nurse practitioner, or physician assistant documentation that she/he has personally examined the patient to address the pertinent medical problem. The physician, nurse practitioner, or physician assistant must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (*e.g.*, change medications, renew treatment orders, nursing orders, order lab tests). o Do not include phone calls as a visit nor visits which could have been accomplished over the phone. o A visit qualifies whether it is on-site or off-site, as long as the patient is not an inpatient in a hospital/other facility.

29. MEDICATIONS

A. Monthly average number of all medications ordered: Enter the monthly average number of different medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months determine the monthly average number of medications ordered based on the number of months since admission. The average should include the total number of ordered medications whether or not they were administered: (PRN medications; injectables, ointments, creams, ophthalmics, short-term antibiotic regimens and over-the-counter medications, etc.)

B. Monthly average number of psychoactive medications ordered: Enter the monthly average number of psychoactive medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months, determine the monthly average of psychoactive medications ordered based on the number of months since admission. The average should include all ordered psychoactive medications whether or not they were actually administered.

A Apsychoactive@ mediation is defined as a medication that is intended to affect mental and/or physical processes, namely to sedate, stimulate, or otherwise change mood, thinking or behavior.

The following are classes of psychoactive medications with several examples listed in each:

o	Antidepressants-	Amitriptyline (Elavil); Imipramine (Tofranil); Doxepin (Sinequan); Tranylcpromine (Parnate); Phenelzine (Nardil)
o	Anticholinergics-	Benztropine (Cogentin); Trihexyphenidyl (Artane)
o	Antihistamines-	Diphenhydramine (Benadryl); Hydroxyzine (Atarax)
o	Anxiolytics-	Chlordiazepoxide (Librium); Diazepam (Valium)
o	Cerebral Stimulants-	Methylphenidate (Ritalin); Amphetamines (Benzedrine)
o	Neuroleptics-	Phenothiazines; Thiothixene (Navane); Haloperidol (Haldol); Chlorpromezine (Thorazine); Thioridazine (Mellaril)
o	Somnifacients-	Barbituates (Nembutal); Temazepam (Restoril); Glutethimide (Doriden); Flurazepam (Dalmane)

VI. DIAGNOSIS

30. PRIMARY MEDICAL PROBLEM: Follow the guideline stated below when answering this question.

o NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks. A review of the medical record for nursing and physician, nurse practitioner, or physician assistant notes during the past four weeks may be necessary.

o JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.

o ICD-9 Refer to the ICD-9 Codes for Common Diagnoses attached at the end of these instructions for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.

o NO ICD-9 NUMBER: Enter A0" (zero) in the far right box if no ICD-9 number can be found for the patient=s primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

o NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV infection.

31: QUALIFIED ASSESSOR NUMBER: The qualified assessor who is attesting to the accuracy of the assessment must sign the completed form and enter the assessor Identification Number which was assigned at an approved N.Y.S. Department of Health Training Program.

Since the PRI is completed and submitted for the purposes of a reimbursement assessment cycle, the certified assessor must have actually completed the patient assessment, utilizing medical records and/or observations or interviews of the patient. This should be indicated by checking the YES box.

38. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups:

1. WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

2. WHITE/HISPANIC: A person who meets the definition of both White and Hispanic

(See Hispanic Below)

3. BLACK: A person having origins in any of the Black racial groups of Africa.

4. BLACK/HISPANIC: A person who meets the definition of both Black and Hispanic (see below).

5. ASIAN OR PACIFIC ISLANDER: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

6. ASIAN or PACIFIC ISLAND/HISPANIC: A person who meets the definition of both Asian or
Pacific Islander and Hispanic (see below).

7. AMERICAN INDIAN or ALASKAN NATIVE: A person having origins in any of the original peoples of North American and who maintains tribal affiliation or community recognition.

8. AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. OTHER: Other groups not included in previous categories.

HISPANIC: A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.

Attachment 8

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

CLARIFICATION SHEET: PATIENT REVIEW INSTRUMENT

THIS SHEET ADDRESSES COMMON QUESTIONS ON THE PRI INSTRUCTIONS. IT SHOULD BE USED TO CLARIFY CERTAIN PRI QUESTIONS IN CONJUNCTION WITH THE INSTRUCTIONS, AND DOES NOT CONTAIN CHANGES TO THE INSTRUCTIONS. THE ANSWERS PROVIDED ARE FOR **NURSING HOMES** COMPLETING THE PRI FOR REIMBURSEMENT PURPOSES AND MAY NOT APPLY TO HOSPITALS AND HOME HEALTH AGENCIES.

PLEASE NOTE THAT ALL REFERENCES IN THIS CLARIFICATION SHEET TO THE APPLICABILITY OF PHYSICIAN ASSISTANT AND NURSE PRACTITIONER SERVICES FOR PRI PURPOSES (E.G.: COUNTING OF MEDICAL VISITS FOR UNSTABLE CONDITIONS AND ORDERING TREATMENTS) ARE EFFECTIVE SOLELY FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON AND AFTER JULY 1, 1999.

IN ADDITION, DUE TO AN AMENDMENT TO ARTICLE 37 OF THE PUBLIC HEALTH LAW, REFERENCES IN THE PRI CLARIFICATION SHEET REGARDING APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDERS HAVE BEEN AMENDED. EFFECTIVE WITH PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON OR AFTER NOVEMBER 23, 2005, PHYSICAN ASSISTANTS MAY WRITE INPATIENT MEDICAL ORDERS WITHOUT A SUPERVISING PHYSICIAN'S COUNTERSIGNATURE, IF PERMITTED BY THE PHYSICIAN AND THE FACILITY'S BY-LAWS, RULES, AND REGULATIONS.

FURTHER, FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON OR AFTER NOVEMBER 23, 2005, PHYSICIAN ASSISTANT'S INPATIENT MEDICAL ORDERS THAT ARE NOT COSIGNED BY A SUPERVISING PHYSICIAN ARE DEEMED TO MEET THE REQUIREMENTS IN THE PRI INSTRUCTIONS FOR "APPROPRIATELY COSIGNED" IF THE LACK OF SUCH A COSIGNATURE IS PERMITTED BY THE SUPERVISING PHYSICIAN AND THE FACILITY'S BYLAWS, RULES, AND REGULATIONS.

PLEASE NOTE THAT ALL REFERENCES IN THIS CLARIFICATION SHEET TO THE ALLOWABILITY OF NEW ADMISSION QUALIFIERS FOR MEDICAL TREATMENTS, INCLUDING OXYGEN THERAPY, ARE EFFECTIVE SOLELY FOR PRI SUBMISSIONS ATTRIBUTABLE TO ASSESSMENT PERIODS ON AND AFTER JULY 1, 1999.

SECTION I. ADMINISTRATIVE DATA

2. SOCIAL SECURITY NUMBER:

Q) *What can be entered for the social security number?*

A) Use only the number that has been specifically designated for the resident and not the spouse of the resident. Use only the number that has been assigned by the federal Social Security Administration. If there is no such number for a resident, a system has been developed to enable ALL FACILITIES in the state to assign a unique ID number to those residents without a social security number. To assign a resident ID number in lieu of a social security number, use the first three (3) letters of the resident's last name and the six number date of birth. Example: Mary Jones was born January 25, 1901. Her number would be JON012501.

Q) *If no social security number exists, can the railroad retirement number be used instead?*

A) NO. Enter the first three (3) letters of the last name and the six number date of birth. See example above.

Q) *If a social security number becomes available later, can it be used?*

A) Yes. Use the correct number when it becomes available. Be aware, however, that the social security number on a discharge must match that used on the full house PRI.

3. RESIDENT IS LOCATED:

Q) Does this question have to be answered?

A) YES. Former stand-alone Health Related Facilities (HRFs) must enter a '1' for all residents. All other facilities may use a '2'.

4. PATIENT NAME:

Q) *How should the resident name be entered?*

A) Begin entering the resident name on the left. Unused boxes should be on the right.

6. MEDICAL RECORD NUMBER:
AND
7. ROOM NUMBER:

Q) *Do these responses need to be accurate?*

A) Yes. Be accurate with these numbers and check whether they are updated. For example: if a resident has been re-admitted from the hospital (after loss of bed hold) there could be a new medical record number.

Q) *How is Traumatic Brain Injury - Extended Care entered under room number? What are the qualifiers?*

A) To record this type of resident, enter 'TBI99' in the five spaces of room number, question 7. A qualifying resident is one who is at least three months post-injury, and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage or anoxia. In addition, this person must have participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home, and have been assessed by a neurologist or physiatrist who determined that the person would no longer benefit from an intensive rehabilitation program. There must also be a classification system for measuring the physical, affective, behavioral, and cognitive level of functioning, as well as an active treatment plan.

8. UNIT NUMBER:

Q) Where is this number found and why can't the facility enter its actual unit number/name on the PRI?

A) Since the facilities use names, numbers, letters or any combination of these to label their units, it would be difficult to accommodate these differences for the PRI answer key. The Unit Identification Form serves to standardize the format of answers entered in this question. A copy of the Unit Identification Form should be returned with all PRI certification submissions. Use the unit number your facility has assigned to each unit on the Unit Identification Form of the RUG-II Project.

Q) *Do the unit numbers need to be assigned in a specific way?*

A) The assignment can be made in any way convenient to the facility. The Unit Identification Form serves to tie the assigned number to the facility name for the unit.

9. DATE OF BIRTH:

Q) *If the entire date of birth is unknown, that is, the date and/or month, can only the year be entered on the PRI?*

A) No. Enter at a minimum the correct birth year of the resident and estimate the month and day.

Q) *Several residents' birth dates have been discovered to be erroneous since our last submission. If the correct date is entered on the next PRI will the computer pick it up as an error?*

A) NO. An error will not occur if the date is changed during a full house submission. DO NOT change this type of information on quarterly admit and discharge submissions.

12. MEDICAID NUMBER:

Q) *Is the recipient or facility number used?*

A) Use the recipient number which is used for the purpose of billing the Medicaid Management Information System (MMIS). Check with your business office, if necessary, to determine which is the recipient's number.

13. MEDICARE NUMBER:

Q) *How are Medicare numbers entered?*

A) Enter the first ten (10) digits/letters of the Medicare number on the PRI and drop any additional digits/letters. The last box is for the Medicare suffix (letter). Not all Medicare numbers include this suffix.

14. PRIMARY PAYOR:

Q) *What should be entered if the resident is Medicaid pending?*

A) Enter the PRI response "Medicaid" if the resident is using no other primary source of coverage for the nursing home stay. Do NOT enter "Medicaid" for the resident who is using another source of coverage which is coming to an end, such as Medicare, private or self pay and are Medicaid pending.

SECTION II. MEDICAL EVENTS

16. DECUBITUS LEVEL:

Q) *If the decubitus level has changed during the past four weeks, is the present or previous level entered on the PRI?*

A) Enter the most severe level the resident has had anytime during the past four weeks.

Q) *Can the cause for a decubitus be other than a pressure point, such as a skin tear or other skin disorders?*

A) NO. Only an ulcer which has formed at a pressure point.

Q) *How detailed of an explanation in the medical record is needed to substantiate the level of decubitus, particularly level 4? Is diagnosis or hospitalization sufficient?*

A) Only level 4 has documentation qualifiers specific to the PRI as stated in the PRI Instructions. It must be evident from the medical record why the resident is at level 4; one of the useful pieces of information could be the diagnosis, but diagnosis in itself is not specific enough. For residents in a nursing home who developed the decubitus while in the hospital, hospitalization is an acceptable rationale for cause.

Q) *Who may document as the "Licensed Clinician" for level 4?*

A) The licensed clinician may be a physician, physician assistant, nurse practitioner, registered nurse, or a licensed practical nurse whose note is co-signed by a RN. The reason the LPN's note must be co-signed is because the documentation of a level 4

decubitus is in the nature of a clinical assessment rather than a description of care provided.

Q) *Must a Stage IV decubitus be necrotic?*

A) YES. According to the PRI definitions, a stage IV decubitus is a "necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia, and bone". Documentation must be present to substantiate the level and probable cause of the decubitus. It is not necessary, however, that necrotic tissue be present during the time frame of the PRI submission. Even if a level 4 decubitus is debrided, it remains a level 4 until it takes on the clinical profile of a level 3. Documentation must be present to substantiate that the necrosis did exist, and that the decubitus did have the clinical profile of a level 4 at some time during the 28-day period. Enter the most severe level the resident has had during the past four weeks.

17. MEDICAL CONDITIONS:

A. COMATOSE

Q) *What if the coma does not exist during the entire four-week period?*

A) The coma has to be present for any four (4) or more days during the time period. The four (4) days do not have to be consecutive.

B. DEHYDRATION

Q) *Can the dehydration occur in the hospital?*

A) The dehydration must occur in the nursing home. However, the care for the dehydration may be in the hospital. The resident must be back from the hospital during the PRI data collection period in the facility to substantiate the dehydration.

C. INTERNAL BLEEDING

Q) *Does monitoring a resident for possible drug side effects qualify here?*

A) No. There must be evidence of an active bleed. Monitoring for drug side effects does not meet this qualifier.

E. TERMINALLY ILL

Q) *Is a terminal diagnosis sufficient in and of itself to capture a resident as terminally ill for PRI purposes?*

A) No. There must also be evidence of a rapid decline in condition to capture the resident as terminally ill under the PRI. The medical record should provide evidence of the rapid deterioration.

F. CONTRACTURES

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore. please automatically enter a '2' for a negative response.

G. DIABETES MELLITUS

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore please automatically enter a '2' for a negative response.

H. URINARY TRACT INFECTION

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

Q) *If there is a 'YES' response to question 17H, UTI, will that put a resident in the clinically complex hierarchy?*

A) NO. The UTI ICD-9 code 599.0 must be entered in response to Question 30. In order to claim UTI for question 30, the condition must have existed during the past 28 days and must be the medical condition requiring the largest amount of nursing time.

J. ACCIDENT

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

K. VENTILATOR DEPENDENT

Q) *What is the time frame for this question?*

A) Answer 'YES' on the PRI for all the following: a resident who was admitted to the facility during the 28 day relevant period and was on a ventilator upon admission or was ventilator dependent within five days prior to admission; a resident who has been extubated for no more than one month at the close of the 28 day relevant period **if** he/she is receiving active respiratory rehabilitation services during the period; and a resident who decompensates and requires intubation.

18. MEDICAL TREATMENTS:

Q) *Can these treatments be claimed for a new admission?*

A) Effective for PRI submissions attributable to assessment periods on and after July 1,1999, a new admission qualifier will be instituted for medical treatments. For PRI submissions prior to July 1, 1999, there is no new admission qualifier for medical treatments.

Q) *The PRI instructions, which are in regulation, make a requirement for a physician order for medical treatments. Does the order of a physician assistant or nurse practitioner satisfy the requirement for a physician order?*

A) The Department is implementing a policy whereby nurse practitioners' and physician assistants' orders for medical treatments do count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on and after July 1, 1999. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of the SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

A. TRACHEOSTOMY CARE

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

C. OXYGEN (DAILY)

Q) *What does daily mean?*

A) Daily means seven days per week; it does not have to be given during the entire twenty-four hours of each day.

Q) *Does the resident need to be in the facility for the full 28 days to be captured as having received oxygen therapy?*

A) Effective for PRI submissions attributable to assessment periods on and after July 1, 1999, a new admission qualifier will be instituted for oxygen therapy. A resident will not need to have been in the facility for the full 28 days to be captured as having received oxygen therapy. For PRI submissions attributable to assessment periods prior to July 1, 1999, there is no new admission qualifier for oxygen therapy so residents must have been in the facility the full 28 days to be captured as having received oxygen therapy.

Q) *Are oxygen enrichers acceptable means of providing oxygen daily?*

A) YES.

D. RESPIRATORY CARE (DAILY)

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

Q) *Is suctioning included with "respiratory care"?*

A) NO. Suctioning is a separate treatment. Both "suctioning" and "respiratory care" can be checked on the PRI if the other respiratory treatments are being provided in addition to suctioning. If daily oxygen is being provided as well as daily respiratory care, check both on the PRI.

E. NASAL GASTRIC FEEDING

Q) *Is gastrostomy tube feeding captured here?*

A) No. Do not include gastrostomy feeding; this is captured under level 5 of the Eating question.

G. WOUND CARE

Q) *Must the wound care have already been provided for three weeks at the time of PRI completion for it to be entered? Does the "still required" qualifier apply to wound care?*

A) If the wound care has been provided for three consecutive weeks during the 28 day period, it does not have to be ‘still required’ at the close of the 28 day period. If the wound care has not been provided for three consecutive weeks by the close of the 28-day assessment period, it does need to be in progress at the close of the period and the condition of the wound (e.g., circumference, depth) must necessitate at least three

consecutive weeks of care. For example, if at the close of the period wound care has been in progress for two consecutive weeks and is anticipated to be needed for one more week, this would meet the qualifier.

Q) *Is there a specified frequency for wound care?*

A) Although there is no specified frequency for the provision of wound care, there must have been some wound care provided during each of three consecutive weeks during the 28 day period or, in the alternative, it must be evident that wound care which has commenced to be given by the end of the period will be needed for three consecutive weeks.

Q) *Are specific treatments required to capture wound care? Does it matter where the* treatments *are given?*

A) The qualifiers for wound care relate to the nature of the wound (subcutaneous lesion resulting from surgery, trauma, or open cancerous ulcers) and to the duration of treatment (at least three weeks). Any treatment is allowable if it is ordered by a physician, nurse practitioner or physician assistant (with physician cosign) and provided by appropriate clinical personnel. For example, whirlpool treatments given for wound care in the therapy department, by a therapist, would be allowable. It should be noted, however, that several types of lesions (e.g. decubiti), which may be treated with a whirlpool, are specifically excluded from wound care by the PRI instructions. In reference to physician assistant orders with physician cosign, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

H. CHEMOTHERAPY

Q) *Are radiation or cobalt treatments considered chemotherapy?*

A) NO.

Q) *What chemical agents are countable under the PRI system as Chemotherapy? How may these medications be administered?*

A) Any oral or intravenously administered chemical agent that a physician, nurse practitioner or physician assistant (with physician cosign) documents as being ordered to treat a carcinoma is acceptable for PRI purposes as chemotherapy. Medications administered intramuscularly cannot be counted as chemotherapy. In reference to physician assistant orders with physician cosign, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI

submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

I. TRANSFUSION

Q) *According to the PRI definition, how many transfusions have to be given during the past four weeks and does the "still required" qualifier apply to transfusions?*

A) One or more transfusions must have been given during the 28 day relevant period and there must be a likelihood that additional periodic transfusions will be required, based on the resident's condition. A resident who received a transfusion for a one-time acute medical episode would not meet the 'still required' qualifier because additional transfusions would not likely be needed.

K. BOWEL AND BLADDER REHABILITATION

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

L. CATHETER

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

M. PHYSICAL RESTRAINTS (DAYTIME ONLY)

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '2' for a negative response.

SECTION III. ACTIVITIES OF DAILY LIVING

19. EATING:

Q) *What level should be entered for a resident on "Do Not Feed" orders?*

A) Enter a level 1, because no staff involvement is required.

20. MOBILITY:

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information.

Therefore, please automatically enter a '1' for the lowest level.

21. TRANSFER:

Q) *Should transfers to bath or toilet be included?*

A) No. Exclude transfers to bath or toilet.

Q) *Assistance of one person is required but the resident does not participate in the transfer. Is this resident still a level 3?*

A) YES. The key issue is how many people assist in the transfer. The resident who is at level 3 may or may not participate in the transfer.

Q) *Since the resident is small and lightweight, the assistance of only one person is needed with the lifting equipment. However, in most cases, the assistance of two people would be required with this equipment. Which transfer level is correct?*

A) Level 3, "requires one person..." is the correct PRI level. The key issue is the amount of assistance the resident actually receives.

Q) *Should a resident who needs the assistance of two people to transfer rather than one person have documented why this additional staff assistance is needed?*

A) YES. If a 2 person transfer is required, there must be a logical reason why the resident needs the help of 2 people to transfer. Documentation must support this need.

22. TOILETING:

Q) What is meant by the 60 percent rule?

A) There are actually two 60 percent rules that apply to toileting. As with other ADL questions, assess how the resident completed the task 60 percent of the time. Additionally, the **incontinent** resident is defined as one who loses control of his/her bladder or bowel functions (with or without equipment) 60 percent or more of the time. Equally, the **continent** resident is one who has control of his/her bladder **and** bowel functions 60 percent or more of the time. This continence may be achieved through the use of equipment, such as a catheter. Keep in mind that for levels 1 and 2, this second 60 percent rule is irrelevant because it is immaterial for PRI classification purposes whether the resident is continent or incontinent. For level 3 the resident must be continent by the 60 percent rule, while for levels 4 and 5 the resident must be incontinent by the 60 percent rule.

Q) *What kinds of residents are included at level 3?*

A) Level 3 includes residents who are continent of both bowel and bladder function 60 percent of the time and require constant supervision and/or constant physical assistance with major/all parts of the task. This 'continence' may be due to the use of toileting appliances: e.g. colostomy, ileostomy and/or urinary catheter devices. If a resident is continent of both functions but does not require constant help, then this

resident is a level 1 or 2. Residents who are continent 60 percent of the time and are scheduled to be toileted just after meals are appropriately categorized as level 3, not level 5. Level 5 residents require a more individualized plan, as described in later questions.

Q) *What kinds of residents are included at level 5 and what are the associated care planning requirements?*

A) Level 5 requires that the resident is incontinent presently and is on a scheduled toileting program. If the resident *appears* continent *only* because he/she is on this formal toileting schedule, then this is applicable for level 5. The resident's care plan must establish a toileting assistance program that is based on an assessment of resident needs. The assessment should establish the needs of the resident which led to the development of the program. The program documented in the care plan must constitute more than taking the resident to the bathroom after meals. The goal of this program may be for restoration or maintenance; refer to the PRI Instructions for examples. The plan must establish either specific times or time intervals for toileting assistance to be provided. In no instance can the plan establish a toileting assistance schedule with any less frequency than every 2-4 hours during the day. The toileting intervals may vary during the day; for example, the resident may be toileted at two-hour intervals during the morning and at four-hour intervals during the afternoon and evening. The plan may provide for use of a bed pan at night as needed. The care plan document is separate and apart from the document used to record when toileting occurs and who provides toileting assistance.

Q) A resident has a diagnosis of CVA with a left hemiplegia. Although he is able to take himself to the bathroom and to complete his own toileting, he does require staff help to pull up his pants when he is finished voiding. What level is appropriate for PRI categorization of this resident?

A) This resident would be considered a level 2, as he requires only **minor** physical assistance.

Q) *Which level is the resident who needs 'constant assistance' with elimination devices/equipment (e.g. catheter)?*

A) Level 3. This level includes the continent resident who needs constant assistance with appliances such as a catheter or ileostomy.

Q) *If a resident needs constant assistance with his/her catheter (level 3) and is on a formal bowel program (level 5) which level is entered on the PRI.?*

A) Level 5. A person can not be both level 3 and level 5 since level 3 requires 60 percent **continence of *both* bowel and bladder function** while level 5 pertains to a resident **incontinent of *at least one*** of these functions

Q) *If the resident cannot transfer onto a toilet, is this assistance considered level 2 'minor physical assistance' or level 3 'major physical assistance'?*

A) Level 3, major physical assistance

Q) *What documentation is needed at level 5 to adequately demonstrate that the resident has been toileted in conformance with the care plan?*

A) The facility MUST have a mechanism in place to substantiate that the resident is taken to the bathroom in conformance with the schedule established in the care plan. This mechanism for documentation could be in the form of a checklist or flowsheet. The name or initials of the health care worker performing the toileting assistance and the specific time the toileting assistance was provided must be present in each instance assistance is provided. In instances where use of a bedpan is documented on the toileting record, this must be distinguished from taking the resident to the toilet. The document used to record when toileting occurs and who provides toileting assistance is separate and apart from the care plan.

Q) *Can the resident at level 5 routinely be taken to a toilet during the day but use a bedpan at night?*

A) YES. The PRI states 'as needed at night'.

Q) *If a resident is on a toileting schedule but a commode is used, does this person qualify for a level 5?*

A) YES because level 5 refers to being taken to a bathroom, whether within or outside the resident's room.

Q) *Which level applies to the resident only on a bedpan schedule (during the day and night)?*

A) Level 4. Level 5 refers to being taken to a bathroom, whether within or outside of the resident's room.

Q) *If a resident is taken to the bathroom about twice per day on an 'as needed' basis and during the rest of the toileting time the resident is **changed** in bed, is this a level 4 or 5?*

A) Level 4. The 60 percent rule must be used in this case; further, level 5 refers to a formal schedule, not an ad hoc 'as needed' basis.

SECTION IV. BEHAVIORS

Q) *Can the psychiatric assessment be a general one?*

A) In order to qualify for level 4 for questions 23, 24, 25 or a 'YES' for question 26, the psychiatric assessment MUST address the specific problem behavior and the behavior must still be exhibited by the resident. The assessment must specifically address the behaviors exhibited to be considered clinically valid and countable.

Q) *Who may do the psychiatric assessment?*

A) This qualifier refers to a professional who has a formal academic degree or specialization in the psychiatric field and works as a psychiatric specialist. Other than a

psychiatrist or psychologist, this may be a psychiatric social worker or a registered nurse who has an advanced degree in psychiatric nursing. Psychiatric experience, without formal training, does not fulfill this educational requirement. 'Mental health workshops' or psychiatric seminars do not constitute formal education. If the psychiatric assessment is done by anyone other than a psychologist or psychiatrist, evidence of this person's psychiatric formal training must be produced upon request of the PRI reviewer.

Q) *What are the qualifications of the psychiatric registered nurse or social worker?*

A) This professional must be recognized by others as being a **specialist** in the psychiatric field. This specialty and recognition has been acquired though these methods: psychiatric education, psychiatric training and psychiatric experience. There is not a specific PRI qualifier for the amount of psychiatric training and experience to acquire this specialty. However, to be recognized and practice as a psychiatric professional does denote considerable years of training, education and experience. Experience working with psychiatric patients is not sufficient in itself.

Q) *For what time period is a psychiatric evaluation valid in terms of this PRI qualifier?*

A) The PRI does not provide a specific frequency for psychiatric evaluations. However, the evaluation must be clinically valid, meaning the assessment must be specific in terms of addressing the resident's behaviors and type of mental disability.

Q) *What type of documentation is required for a level 4 (questions 23, 24, 25) or a 'YES' for question 26?*

A) There must be appropriate notes on the chart describing **each occurrence** of the behavior, the date and time, the intervention and the results of the intervention. Behavior must occur at least once per week and be **unpredictable**. The psychiatric assessment must address the specific problem behavior and the behavior must still be exhibited by the resident. There must be an active treatment plan currently in use.

Q) *Can 'flow sheets' and/or monthly summaries be the sole documentation for Behavioral problems?*

A) Monthly summaries require supportive documentation specifically recording incidents of the behavior, the intervention required and the results of the intervention. "Flow sheets" are acceptable **as long as** all the required information and endorsements are present.

Q) *Does a dementia diagnosis on question 30 automatically qualify a resident for the behavioral hierarchy?*

A) No, The resident must meet the behavioral qualifiers to be included in the behavioral hierarchy.

Q) *What does weekly mean? Is this a calendar week?*

A) Weekly means once in each of the four seven-day cycles which commence on the first day of the 28 day relevant period. For example, for a PRI completed on a Wednesday, there must have been a behavioral incident within each of the Thursday through Wednesday periods in the preceding 28 days. Weekly does NOT mean merely four episodes at any time within the 28 days; two episodes in one week would not offset a week with no episodes.

23. VERBAL DISRUPTION:

Q) *Are verbal suicidal tendencies measured by this question?*

A) NO.

24. PHYSICAL AGGRESSION:

Q) *What does 'intent for injury' mean in the PRI definition of aggression?*

A) 'Intent for injury' means the resident was aggressive on purpose (may be due to the resident's physical or mental disfunction) and this behavior **could or did** hurt the resident or others. Behavior such as throwing a pillow on the floor would hurt neither the resident nor others and would not be considered aggressive behavior. The staff would not have to intervene immediately.

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:

Q) *Do behaviors need to be disruptive to be captured here?*

A) Yes. Include only physical actions which need **immediate** attention by the staff. The examples provided on the PRI are good illustrations of the intensity of the behaviors included under this question. Do not include physical actions by the resident which are unusual or anti-social but do not cause the staff to stop what they are doing at the very moment they observe the resident's behavior. For example, messy clothes, clothing thrown on the floor or unusual eating habits may be irritating or cause reaction by the staff some time in the future, but are not immediately disruptive.

Q) *Are 'sloppy' eating habits considered socially inappropriate behavior? For example, the resident smears food on the tray or mixes food together.*

A) The key is whether this socially inappropriate behavior is **disruptive**. Whether 'sloppy' eating is socially inappropriate and disruptive to staff depends on the severity of this behavior. If the resident smears food and makes a slight mess, but it does not require immediate staff intervention, then this is NOT a behavioral problem.

Q) *The resident displays a number of **different** infantile behaviors. Does the assessor separately measure each of these infantile behaviors?*

A) Measure together all the **infantile** behaviors which are **disruptive** to determine how often per week these behaviors occur.

SECTION V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

(Q) *What is the General Approach to answering these questions?*

A) The information required is filled out in a two step process. ***Step one*** requires a determination as to ***therapy level*** for physical therapy (PT) and occupation therapy (OT). Level of therapy is a function of various qualifiers: whether therapy was provided, what was the duration of therapy, whether the therapy was restorative or maintenance, whether there was a physician, nurse practitioner or appropriately cosigned physician assistant order for therapy, and whether there was an evaluation and treatment plan. Once the level of therapy is delineated, ***step two*** involves identifying the number of ***days*** and amount of ***time*** the specific type of therapy (e.g. restorative physical therapy) was delivered. To count a day of therapy or amount of time of therapy, there are certain rules related to what type of professional performed the therapy and under what conditions. The combination of all these answers determines whether a resident is categorized in the rehabilitation hierarchy. **Please read all the Qs and As associated with Question 27 to gain a full picture of the correct application of qualifiers.** In reference to appropriately cosigned physician assistant order for therapy, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

LEVEL

Q) What are the qualifiers for entering level 3 restorative therapy for PT and/or OT and what are the associated day and time qualifiers?

A) To determine the therapy to be level three restorative, the following qualifiers must all be met.

1) A physician, nurse practitioner or cosigned physician assistant order must be present which refers the resident for a therapy evaluation and treatment plan. This order does not have to specify whether the referral is for maintenance or restorative therapy, but should specify the reason for the referral. The physician, nurse practitioner or physician assistant must also sign the therapy plan of care to further support that the resident needs therapy. The physician, nurse practitioner or cosigned physician assistant order must be updated **monthly**. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy

requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

2) An Initial Evaluation and Treatment Plan by a licensed therapist must exist as a follow up to the physician's, cosigned physician assistant's or nurse practitioner's order. The evaluation must confirm whether the therapy is required and specify whether it is maintenance or restorative. The immediate and ultimate rehabilitation goals must be written and in accordance with the physician's, physician assistant's or nurse practitioner's diagnosis. The Treatment Plan should specify the type and number of treatments needed by the resident. It should include the intensity of the treatment; duration of the program, number of days per week, and length of treatment sessions. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

3) There must be a positive potential for significant improvement in a resident's functional status within a short and predictable period of time. Consequently, the therapy plan of care should support that the resident has this potential and is improving.

4) The therapist, in accordance with professional practices, should assess the resident's progress and responses to treatments, and at least every 30 days, review the resident's progress with the physician, physician assistant or nurse practitioner and revise the treatment plan as necessary. The therapist must be a licensed professional person with a four year, specialized therapy degree.

5) The therapy must be provided for the four consecutive weeks covered by the PRI, unless the resident is a new admission or readmission. If the resident is a new admission or re-admission, the following are the duration related qualifiers:

-- There must have been at least one treatment, in addition to the evaluation. An evaluation is not to be counted as treatment.

-- A licensed therapist must have documented in the care plan that the therapy is restorative in nature and needed for 4 consecutive weeks.

If all the above qualifiers are met, the resident is appropriately marked level three restorative. The next step is to mark separately the number of days and amount of time spent providing the restorative PT and/or restorative OT. For a resident to be included in the rehabilitation hierarchy, the restorative therapy must be provided fives times each week for at least 2.5 hours in total. The following are qualifiers associated with marking a day or time as having been spent on restorative therapy.

1) Care must be provided **one to one** rather than on a group basis. Enter only the total days and time **per week** (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the **constant assistance** of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) Care must have been given by either a certified therapist (a person with a two year specialized therapy degree who has been certified by the NYS Education Department) or a licensed therapist (a person with at least a four year specialized therapy degree licensed by the NYS Education Department). A therapy aide may not provide restorative therapy. If a certified therapist provides the care, then a licensed therapist must be in the facility (but not necessarily in the treatment room) at the time the therapy is provided. For occupational therapy, a certified therapist is a certified occupational therapy assistant (COTA) and for physical therapy, a certified therapist is a physical therapy assistant (PTA).

Q) What are the qualifiers for entering level 2 maintenance therapy for PT and/or OT and what are the associated day and time qualifiers?

A) To determine the therapy to be level two maintenance, the following qualifiers must all be met.

1) A physician, nurse practitioner or cosigned physician assistant order must be present which refers the resident for a therapy evaluation and treatment plan. This order does not have to specify whether the referral is for maintenance or restorative therapy, but should specify the reason for the referral. The physician, physician assistant or nurse practitioner must also sign the therapy plan of care to further support that the resident needs therapy. Unlike the qualifier for restorative therapy, such orders are not required to be updated monthly. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

2) An Initial Evaluation and Treatment Plan by a licensed therapist must exist as a follow up to the physician's, nurse practitioner's or cosigned physician assistant's order. The evaluation must confirm whether the therapy is required

and specify whether it is maintenance or restorative. The immediate and ultimate rehabilitation goals must be written and in accordance with the physician's, physician assistant's or nurse practitioner's diagnosis. The Treatment Plan should specify the type and number of treatments needed by the resident. It should include the intensity of the treatment; duration of the program, number of days per week, and length of treatment sessions. In reference to cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

3) Therapy must be provided to maintain and/or retard deterioration of current functional/ADL status.

4) The therapist, in accordance with professional practices, should assess the resident's progress and responses to treatments, and at least every 30 days, review the resident's progress with the physician, physician assistant or nurse practitioner, and revise the treatment plan as necessary. The evaluator must be a licensed professional person with a four year, specialized therapy degree.

5) The therapy must be provided for four consecutive weeks (at least once per-week). There is no new admission qualifier.

If all the above qualifiers are met, the resident is appropriately marked level two maintenance therapy. The next step is to mark the number of days and amount of time spent providing only the maintenance therapy. The following are qualifiers associated with marking a day or time as having been spent on maintenance therapy. Effective March 1, 2006, the Department will no longer use this information for level two maintenance therapy. Therefore, please automatically enter "0" for days and "0000" for time.

1) Care must be provided **one to one** rather than a group basis. Enter only the total days and time **per week** (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the **constant assistance** of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) Care may be given by a therapy aide, certified therapist (a person with a two

year specialized therapy degree who has been certified by the NYS Education Department) or a licensed therapist (a person with at least a four year specialized therapy degree licensed by the NYS Education Department). If a therapy aide provides the care, then a certified therapist or licensed therapist must be in the facility (but not necessarily in the treatment room) at the time the therapy is provided. Unlike the qualifier related to restorative therapy days and time, if a certified therapist provides the therapy, there is no requirement that a licensed therapist be in the facility. For occupational therapy, a certified therapist is a certified occupational therapy assistant (COTA) and for physical therapy, a certified therapist is a Physical Therapy Assistant (PTA).

ADDITIONAL QUESTIONS SPECIFIC TO LEVEL DETERMINATION

Q) When is it appropriate to enter level 1 for PT and/or OT?

A) Level one applies when no therapy has been provided.

Q) When is it appropriate to enter level 4 for PT and/or OT?

A) Level 4 applies when maintenance or restorative therapy has been provided but one or more of the other level qualifiers has not been met. There may not have been a physician, appropriately cosigned physician assistant or nurse practitioner order for the therapy, an appropriate evaluation and treatment plan may not have been performed, or the therapy may not have been provided at least once per-week for four consecutive weeks. Therapy provided for less than four consecutive weeks is permissible only if the resident meets the new admission or re-admission qualifiers for restorative therapy. It is not appropriate to enter level 4 based on the number of days per week and/or amount of time therapy was provided since these are not qualifiers for level of therapy. In addition, effective March 1, 2006, the Department will no longer require facilities to provide days and time when a resident is appropriately marked level "4". In reference to appropriately cosigned physician assistant order, effective for PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. For PRI submissions attributable to assessment periods of July 1, 1999 through November 22, 2005 the Department's policy requiring all physician assistant orders to be countersigned by a supervising physician within 24 hours remains in effect.

Q) *Can a re-admission to the facility qualify for level 3?*

A) If a resident is discharged to the hospital, returns to the facility and meets the new admit qualifiers for rehab therapy, they may be assessed at this level. Changes in resident condition between the full house and the quarterly assessment periods are not included under the new admit qualifiers.

Q) *Is the definition of restorative and maintenance therapy as explained in the PRI instructions a qualifier?*

A) YES. If the resident meets the PRI definition of restorative therapy (as defined under

the 'potential for Increased Functional/ADL Ability' qualifier), then this resident cannot be entered on the PRI as a maintenance therapy resident and vice versa.

Q) *If the resident is receiving both maintenance and restorative therapy, what is entered as the Level on the PRI?*

A) Enter that the resident is receiving restorative therapy, but when computing days and time the assessor must only enter those days and time restorative therapy has been provided.

Q) *The PRI instructions, which are in regulation, make a requirement for a physician order for therapy. Does the order of a physician assistant or nurse practitioner satisfy the requirement for a physician order?*

A) The Department is implementing a policy whereby nurse practitioners' and physician assistants' orders for therapy do count for PRI submissions attributable to assessment periods on or after July 1, 1999. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *Does a routine standing order for a therapy evaluation on admission meet the requirement for a physician, physician assistant or nurse practitioner order?*

A) No. The order must state the reason for the referral and the specific condition to be

addressed by the therapist.

Q) *How is the qualifier for an on-site specialized professional to supervise/provide care accounted for under 'Level'?*

A) It is not accounted for under 'Level'. (Level qualifiers address the program evaluation and design, not the professional providing therapy). The type and frequency of the on-site specialized professional is only a qualifier for 'Days' and 'Time'.

Q) *If a resident experiences a new physical occurrence which necessitates specialized therapy, but the therapy has NOT been provided yet for four consecutive weeks, what is entered on the PRI?*

A) Level 4, unless the resident is a new admission or a re-admission and meets the new admission/re-admission qualifier stated in the instructions.

Q) *If the resident has been receiving therapy, but due to physical complications the resident's therapy has been on hold during the past two weeks, what is entered on the PRI?*

A) Level 4. The resident does not meet the PRI 'Level' qualifier of receiving therapy for at least 'four consecutive weeks'.

Q *If the resident starts receiving a course of therapy, but has only received two weeks so far, what level is entered on the PRI?*

A) Level 4, unless the resident is a new admission or a re-admission receiving restorative therapy and meets all the new admission qualifiers stated in the instructions.

Q) *To meet the new admit qualifiers for level 3, how soon after admission does an evaluation need to be performed and when must therapy begin?*

A) The therapy evaluation must be done within one week of the day on which the physician, physician assistant or nurse practitioner orders an evaluation for therapy. Treatment must begin within 48 hours subsequent to the physician, physician assistant or nurse practitioner order for treatment and be provided daily thereafter. Keep in mind that at least one treatment must have been given to claim a level 3 under the new admit qualifiers.

Q) *Is a hospital admission necessary to claim restorative therapy?*

A) No, but a medical event precipitating a hospital admission can often result in a clinical profile predictive of the likelihood for a resident to improve significantly within a short and predictable time, as is required for restorative therapy classification.

Q) *Do certain diagnoses, such as dementia, preclude a classification as restorative?*

A) No, each case must be judged individually. Certain diagnoses do call into question the appropriateness of restorative classification. If a resident with Parkinson's Disease falls and has a fracture, therapy may restore the resident to pre-fall capabilities. Because

the disease is degenerative, however, restoration without such an event is improbable.

Q *A resident has been in the facility for four years. She was able to transfer with an assist of one, but was unable to ambulate. The resident has become generally weaker in ADLs during the last ten days but there was no identifiable precipitating event for this deterioration. She is alert and oriented. The physician, physician assistant or nurse practitioner has ordered physical therapy evaluation and treatment as appropriate. Is the therapy provided maintenance or restorative?*

A) The therapy is **maintenance**--to maintain and/or retard deterioration of current functional/ADL status. The lack of a precipitating event for this resident's deterioration makes restorative classification inappropriate because it is likely the deterioration was avoidable. Further, since the resident has been non-ambulatory for four years, she cannot realistically be expected to have improved functional status in a short and predictable period of time. The goal is to maintain her current status

Q) *A resident has been hospitalized recently for three days. Upon return to the facility, an occupational therapy evaluation is ordered. The evaluation notes decline in ADL status from prior to hospitalization but no change in mental status. Resident has no carry-over ability; alert and oriented to the person only, he is able to follow most simple one-step commands with numerous repetitions. Is the therapy provided maintenance or restorative?*

A) The therapy is **maintenance**--to maintain and/or retard deterioration of current functional/ADL status. Due to the mental status, the resident does not have a positive potential for improved functional status within a short and predictable period of time.

Q) *A resident sustained a fractured left leg after an incident at the facility, was admitted to the hospital, and now has been readmitted to the nursing facility. There is a physician, physician assistant or nurse practitioner order for a physical therapy evaluation and treatment on the day of readmission. The evaluation is completed the following day, with a short term goal of ambulating with a walker independently and a long term goal of returning to independent ambulation. Resident is alert, but still not weight bearing on the left leg. Resident is able to keep leg elevated and take steps with assist of walker and therapist. Range of motion and gait training tolerated well. Potential expected to be good. Is the therapy provided maintenance or restorative?*

A) The therapy is **restorative**--there is a positive potential for improved functional status within a short and predictable time.

Q) Is a resident on traumatic brain injured extended care status automatically precluded from restorative therapy categorization because one of the qualifiers for such status is that the resident has been assessed as being inappropriate for an intensive rehabilitation program?

A) No. It must be determined whether the qualifiers for restorative therapy have been met without regard to the resident's TBI status.

QUESTIONS SPECIFIC TO DAY AND TIME DETERMINATIONS

Q) What qualifiers should be considered before entering the days and time for therapies?

A) There are two general qualifiers.

1) **Care Must Be One to One Care:** For both a maintenance program and restorative therapy, enter only the total days and time per week (NOT per month) that the resident receives one-to-one care. One-to-one care refers to providing treatments which are specific to a resident and require the constant assistance of the therapy staff. Constant assistance refers to physical hands on care and is more than supervision. For example, supervision of a resident in the whirlpool does not constitute hands on care for purposes of counting physical and occupational therapy days and times. Verbal cueing may be counted if it is provided as one-to-one care. The therapist would need to be constantly close to the resident, ready to offer physical assistance and providing treatments which are specific to the resident. Group sessions or general supervision of a resident would not be appropriately counted.

2) There Must Be A Specialized Licensed Professional On-site While Care Is Being Provided. Please note that Certified Occupational Therapy Assistants (COTAs), Physical Therapy Assistant (PTAs) and aides are not specialized licensed professionals.

Q *What factors should be considered in determining days and time for maintenance as opposed to restorative therapy?*

A) There are only two differences between maintenance and restorative therapy when entering the 'Days and Time' per week?:

1) **Restorative** Therapy requires a **licensed** therapist to be within that facility at the **time the therapy is being provided to the resident.** This does not mean the licensed therapist has to be in the treatment room with the certified professional. A **maintenance** program requires a **certified**, NOT licensed, therapist to be within the facility at the time of the therapy.

2) A therapy aide CANNOT provide **restorative** therapy and have it be included in the treatment time for the resident on the PRI. A therapy aide CAN provide **maintenance** therapy and this time can be included on the PRI provided either a 4 year therapist or 2 year certified therapy assistant is in house at the time. A certified therapy assistant can provide maintenance therapy without the supervision of a 4 year therapist, but restorative therapy REQUIRES a 4 year therapist in house. NOTE: Effective March 1, 2006, the Department will no longer require facilities to provide days and time when a resident is appropriately marked level "2" for maintenance therapy or level "4" received therapy, but does not fulfill the qualifier's stated in the instructions.

Q) *Is there a distinction between physical and occupational therapy staff?*

A) Licensed professionals cannot supervise the certified professionals from a different therapy discipline. For example, a licensed registered Physical Therapist CANNOT

supervise the Certified Occupational Therapy Assistant, NOR can licensed practical nurses be substituted as Physical Therapy or Occupational Therapy Assistants. Moreover, a licensed physical therapist cannot provide therapy that has been ordered by a physician, physician assistant or nurse practitioner as occupational therapy and a licensed occupational therapist cannot provide therapy that has been ordered by a physician, physician assistant or nurse practitioner as physical therapy.

Q) *If a resident is receiving physical therapy and occupational therapy, can the days and time be combined in order to qualify for restorative therapy?*

A) NO. Each specialized service must be considered independently.

Q) *Is a **licensed physical therapist** able to supervise the **certified occupational assistant**? In other words, can a licensed therapist supervise personnel who are in a **different** therapy field/discipline?*

A) NO. The personnel providing therapy must be supervised by a professional of the same discipline.

Q) *For restorative therapy - New Admission or Re-admission to the facility that meets all other qualifiers. What days and time should be entered if the resident has just started the program?*

A) If all qualifiers are met - enter level 3 for Restorative Therapy. Enter the assumed days and time as stated in the therapist plan of care for the resident. The licensed therapist MUST document in the care plan that therapy is needed for **four (4) consecutive weeks.**

Q) *Can whirlpool treatments or Hubbard tank treatments be captured under P.T.?*

A) Not for restorative therapy or maintenance therapy. The days and time would be entered as zero because **supervision** of a resident in a whirlpool or Hubbard Tank does NOT constitute hands on care.

Q) *Can treatments provided in the therapy department for decubitus care be captured under P.T.?*

A) No.

Q) *For restorative therapy, is the treatment time provided by therapy aides included?*

A) NO. For restorative therapy, aide time is NOT considered. However, for a maintenance program, therapy aide time can be counted.

Q) *Do the 'minutes' under the 'Times Per Week' question **have** to be entered only by the quarter hour?*

A) NO. But minutes can be rounded off to 15, 30 or 45. If there are no minutes of therapy, the time would be entered as four zeros (0000).

Q) *Can a resident be receiving maintenance or restorative therapy under the 'Level' question and be a zero for the 'Days and Time' question?*

A) YES. If the 'Days and Time' qualifiers are not met.

Q) *How exact does the documentation have to be for 'Days and Time' of therapy?*

A) 'Days' have to be EXACT; there needs to be a schedule and therapy notes stating the resident received therapy for each day. 'Time' needs documentation which should minimally verify the time blocks the resident receives therapy. For instance, a time block may be 9-10 on the given days of scheduled therapy. **However, the assessor will need to discuss with the therapists how much treatment time was actually provided during this time block.**

17) *If the days and time are more than five days/2.5 hours per week, what should be entered on the PRI?*

A) Enter the actual days and time. Five days/2.5 hours per week of restorative therapy is the minimum for being in the rehabilitation hierarchy, and higher amounts will also qualify.

Q) *If the resident's therapy schedule has changed within the past four weeks, what is entered on the PRI?*

A) An **average** is computed for the past four weeks, regardless of whether the schedule, in terms of days and time, has decreased or increased. To compute an average, divide the total days and the hours during the past four weeks by four.

Q) *Can restorative therapy (level 3) be provided by a certified (2 year degree) therapy professional?*

A) YES. If there is a licensed (4 year) therapy professional supervising on-site.

Q) *What is the rule for allowable absences?*

A) A resident may miss unlimited sessions for legal holidays and religions observance. Legal holidays for a RHCF are defined as those holidays written in the facility's personnel policy manual as paid time off for all employees. Further, for absences related to religious observance, there must be documentation that the resident actually observed these holidays. Missed sessions are also allowable for illnesses, refusals or social engagements **only TO THE EXTENT THAT absences of this type do not cause the resident to have more than two absences in aggregate for all reasons**. For example, if a resident had 2 or more absences due to legal holidays and/or religious observance, no additional absences would be allowed for illness, refusal or social engagements. If a resident had 1 absence due to legal holidays and/or religious observance, one additional absence would be allowed for illness, refusal or social engagements. If a resident had no absences due to legal holidays and/or religious observance, two absences would be allowed for illness, refusal or social engagements.

Q) *If due to a holiday/religious observance therapy is not given, do the days and times have to be averaged?*

A) NO. If therapy is not provided due to a legal holiday or religious observance the plan of care may be assumed. The legal holidays for a RHCF are defined as those holidays written in the facility's personnel policy manual as paid time off for the employee. However, if the resident misses two days of therapy due to legal holidays and/or religious observances, no ADDITIONAL days may be missed for any other reason. EXAMPLE: A resident misses 3 days of therapy for legal holidays and missed 2 additional days for a social engagement, the days and time must be averaged for the 28 day period.

Q) *If there are 4 (or more) religious holidays during the 28 day PRI period, could the restorative resident still fall in the heavy rehab category?*

A) YES. The documentation MUST substantiate that the RESIDENT observed these holidays and that he/she missed NO other sessions. The resident must also meet the level qualifiers for restorative therapy. All other qualifiers must be met as well.

Q) *If the physical or occupational therapist was on vacation/leave during a portion of the four week period, how are 'Days and Time' counted for the residents?*

A) Compute an average of the therapy actually provided during the past four weeks. For example, if the therapist did not provide therapy for one week, the assessor should total the days and time of therapy provided during three of the four weeks and divide by four.

Q) *If more than two therapy sessions are missed, can they be made up?*

A) Sessions missed in a week may be made up on days during that week when therapy is not normally provided. The intent of the system is that therapy be given five days in each of the four weeks of the assessment period; not, for example, six days in one week then four days in another week. If therapy sessions missed in one week are made-up in a different week, there would need to be a justifiable reason and the Department should be notified of these circumstances and consulted as to their appropriateness.

Q) *If residents are sent outside of the facility for therapy, can this therapy be counted on the PRI?*

A) NO. Unless the facility is a hospital-based nursing home and the therapy is provided in the hospital's department, rather than physically in the nursing home.

Q) *If a resident receives restorative P.T. 3 days a week and each session is one hour, does this resident fall into the heavy rehab category?*

A) NO. A resident who meets the level qualifiers must be receiving therapy 5 days a week and at least 2 1/2/hours per week.

28. NUMBER OF PHYSICIAN VISITS

Q) *Do all the physician, physician assistant or nurse practitioner visits need to be for the same unstable condition?*

A) No. The cause of the unstable condition may change over the four week period. The diagnoses and symptoms of the unstable condition(s) may change over the four week period.

Q) *Do visits of physician assistants or nurse practitioners satisfy the requirement for a physician visit?*

A) The Department is implementing a policy whereby visits by nurse practitioners and physician assistants do count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on or after July 1, 1999. This does not in any way change the patient type/need qualifiers. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *Does the resident have to be medically unstable during the **entire** past four weeks?*

A) NO. The resident qualifies if he/she has been medically unstable for any period of time during the past four weeks. However, only the physician, nurse practitioner or physician assistant visits to care for the unstable condition during this time period are to be

entered on the PRI.

Q *Do the physician, nurse practitioner or physician assistant visits have to occur once in every week of the 28 day period?*

A) No, the four visits may occur at any time during the four weeks, corresponding to the instability of the resident. Count only those visits during which the physician, nurse practitioner or physician assistant personally examines the resident to address an unstable condition.

Q) *Can the visits of all the different physicians, nurse practitioners and physician assistants caring for the resident be counted (e.g. specialist, primary physician, ophthalmologist)?*

A) ONLY **physicians, physicians assistants and nurse practitioners caring for the resident's medically unstable condition(s)** can be considered in counting the number of visits.

Q) *Is a podiatrist or dentist considered a physician?*

A) NO.

Q) *Can visits by psychiatrists be included?*

A) No. PRI regulations specifically prohibit the counting of psychiatrist visits.

Q) *Is a fracture considered medical instability?*

A) In most resident cases a fracture would cause medical instability. However, a fracture, such as a fractured finger, may not cause medical instability.

Q) *Are the regulatory visits (e.g. 30, 60, 90 days) by physicians counted?*

A) ONLY if the resident is medically unstable at the time of the regulatory visit and during this visit the physician cares for the medically unstable condition as documented.

29. MEDICATIONS

Q) *How should this question be answered?*

A) Effective January 1, 1999, the Department will no longer use this information. Therefore, please automatically enter a '00' for both 29A and 29B.

VI. DIAGNOSIS

30. PRIMARY PROBLEM

Q) *Can only the attachment in the PRI instructions titled "ICD-9 Codes for Common Diagnoses" be used to answer this questions?*

A) NO. The ICD-9 Code books in your nursing office and/or medical records office will offer a more complete listing of ICD-9 Codes. If your facility has a medical records office, their personnel can help in locating the ICD-9 codes for the diagnoses listed by the assessors.

Q) *Some residents may have a primary problem that is NOT listed in the ICD-9 books. Generally this is because the primary problem for the residents in terms of nursing time is not a medical diagnosis. What is entered on the PRI?*

A) Enter a zero in the far right hand box for any Primary Problems not readily available in the ICD-9 books.

Q) *Most of the ICD-9 categories/classifications, such as organic brain syndrome, are also broken down further into more specific ICD-9 codes describing origin, severity, etc. How specific does an assessor have to be in diagnosing and choosing these specific ICD-9 codes?*

A) The **general** ICD-9 diagnosis code is acceptable to enter on the PRI. **Specific** variations of this diagnosis can be entered on the PRI but considerable time should not be spent deciding between two different variations of the diagnosis. For example, the specific variation of the diagnosis, organic brain syndrome, should not be a major concern for an assessor. However, be specific with quadriplegia and UTI ICD-9 codes; INCLUDE DIGITS AFTER THE DECIMAL IF DIGITS EXIST. (e.g. 599.0)

Q) *Does the primary problem have to be diagnosed by a physician?*

A) NO. The primary problem is a reflection of nursing time and this should be exemplified in the nursing notes. Please note, however, that all the diagnoses which assign a resident to a RUG category are among those that must be made by a physician, nurse practitioner or physician assistant. The Department is implementing a policy whereby such diagnoses made by nurse practitioners and physician assistants will also count under the PRI. This policy will be effective for PRI submissions attributable to assessment periods on or after July 1, 1999. The following are some important overall points in this regard.

-- All physician assistant orders must be countersigned by a supervising physician within 24 hours. Effective with PRI submissions attributable to assessment periods on or after November 23, 2005, an amendment to Article 37 of the Public Health Law authorizes physician assistants to write inpatient medical orders without a supervising physician's countersignature, if permitted by the supervising physician and the facility's by-laws, rules, and regulations. There is no countersigning requirement for nurse practitioner orders.

-- The State Education Department (SED) requires that a formal practice agreement be entered into between the nurse practitioner and physician. This clarification sheet does not attempt to enumerate any of SED's requirements regarding these agreements.

-- Department regulation precludes a physician from delegating a task if such

delegation is prohibited by the facility's own policies,

-- Department regulation establishes certain minimum requirements for physician visits of residents (which facilities must ensure are followed) and allows for delegation of some, but not all, of these visits to nurse practitioners and physician assistants.

-- All ordering should be within the scope of specialty practice of the physician, physician assistant and nurse practitioner.

-- A respiratory therapist is not allowed to accept orders from a physician assistant or nurse practitioner.

Q) *How much time should be spent looking for an ICD-9 code*?

A) Most diagnoses not listed in the PRI instructions can be easily located by using the index in the ICD-9 code books. However, some "primary problems" for the resident may not be listed in the ICD-9 code books since the problem is not actually a diagnosis. For instance, if the resident's main problem in terms of nursing time is the need for psychological support or supervision, then an ICD-9 code will not be available for this problem. Enter a zero (0) on the PRI if no diagnosis if found.

Q) *A resident with a diagnosis of hemiplegia experiences a UTI during the 28 day PRI period. What is the primary diagnosis?*

A) Whatever created the most need for nursing care during the 28 day period. For example, if the resident was unstable because the UTI was severe then the diagnosis would be UTI. This should be documented in the medical record.

Q) *Does a missing limb on the affected side of the body preclude a diagnosis of hemiplegia?*

A) No, as long as the remaining limb is affected by the hemiplegia.

Q) *How does a resident qualify for dementia reimbursement through the ICD-9 code answer to question 30?*

A) A resident MUST fall into one of the following RUG-II groups: Clinical A, Behavioral A, Physical A or Physical B and have the specific ICD-9 code listed in the regulations reported under question 30 in order to qualify for additional reimbursement. There are 30 specific ICD-9 codes that will qualify a resident for dementia reimbursement. These codes must appear EXACTLY AS SHOWN in Part 86-2.10(o) in question 30 on the PRI.

Q) *Does the computer read those diagnoses written without an ICD-9 code?*

A) NO. If there is no diagnosis, enter a zero (0) on the PRI.

Q) *If no ICD-9 code is entered but rather the diagnosis is written, will the computer pick this up as an error?*

A) YES. A zero must be entered in the far right hand box if no ICD-9 code is entered.

Q) *Is hemiparesis included in the RUG-II system besides hemiplegia?*

A) YES. Either diagnosis qualifies a resident for the clinically complex hierarchy.

Q) I*s quadriparesis included in the RUG-II system besides quadriplegia?*

A) NO. Only quadriplegia qualifies a resident for the special care hierarchy.

Q) *The physician, physician assistant or nurse practitioner wrote a diagnosis of quadriparesis. Does this resident fall into the special care category?*

A) NO. Quadriplegia, not quadriparesis, places a resident in the special care category. DO NOT use the ICD-9 code for quadriplegia (344.0) if the resident has quadriparesis. Further, the ICD-9 for quadriplegia should not be used in instances where a resident has not incurred a spinal cord injury or spinal cord disease. The medical record must indicate the etiology of the quadriplegia to be spinal cord injury or spinal cord disease for quadriplegia to be cited. Factors other than spinal cord injury or spinal cord disease often result in the symptoms of quadriplegia or 'functional quadriplegia' but these are not appropriate for quadriplegia classification on the PRI.

Q) *If a resident has the capacity for voluntary movement, is he/she precluded from being classified quadriplegic?*

A) NO. The ICD-9 code for quadriplegia is correct if the appropriate spinal cord injury or spinal cord disease has occurred and the resident meets all the other quadriplegia criteria under the ICD-9 classification system.

Q) *Does a specific ICD-9 code need to be entered to capture a resident as qualifying for Traumatic Brain Injury - Extended Care?*

A) No. Traumatic Brain Injury - Extended Care status is reported by entering "TBI99" for question 7, room number.

Q) *What are the specific ICD-9 codes which qualify a resident for a hierarchy? Do they have to be entered in a special way?*

A) There are only five ICD-9 codes which assign a resident to a hierarchy group, as shown in the following table. All must be entered as indicated to qualify a resident for the hierarchy.

Hierarchy	**Diagnosis**	**Code**	**Comment**
Special Care	Quadriplegia	344.0	Enter exactly. Any last digit may be used.
	Multiple Sclerosis	340.	Any last two digits may be used
Clinically	Cerebral Palsy	343.	Any last two digits may be

Complex			used
	Urinary Tract Infection	599.0	Enter exactly. Leave last data field blank
	Hemiplegia / Hemiparesis	342.	Any last two digits may be used

GENERAL DATA COLLECTION PROCEDURES

Q) *What should be done in case of an error detected in completing the PRI?*

A) All PRI submissions should be checked for accuracy. Once the data have been submitted electronically and accepted, the facility is given an additional seven days to make corrections. Enter the correct data, re-run the edit checks, re-encrypt, and resubmit the ENTIRE file. This must be done by the update date provided in the acceptance message. **NO CORRECTIONS WILL BE ALLOWED AFTER THE UPDATE DATE.**

Q) *Does the facility get a copy of the responses entered on all the PRIs?*

A) NO. As the facility keys the data, it is the responsibility of the facility to ensure that the data have been entered correctly on the file. Because changes are not permitted after the update date, checking the data is an important step.

Q) *For the twenty eight day review period, which day is considered the 28th day?*

A) The 28th day is the day the PRI is completed. Be sure to complete the whole PRI on the same day, so all questions will have the same 28 day period.

Q) *What happens if a resident is on bed hold or enters the hospital during the data collection period?*

A) Effective January 1, 1999, a PRI should be submitted for **all** residents on the nursing facility's census at 4:00 PM on the last day of the collection period. The only residents excluded would be those out of the facility on bed hold or therapeutic leave. This means that if a patient is on bed hold a PRI is NOT submitted. If a PRI is completed on a resident who then enters the hospital/leaves the facility before 4:00 PM on the last day of the collection period, then the PRI for this resident is NOT to be used.

Q) *How is the date completed data field (Question 5) used during the on-site review?*

A) The completion date is used to determine the specific 28-day period for each resident. It is, therefore, **very important** that this date be accurate. It should be within the data collection period provided by the Department. **DO NOT** use the date the PRI is keyed, or the date the file is created.

Q) *For residents to be classified under Special Care of the RUG-II system, must an ADL sum of 5 of more be applicable? Is this new to the system?*

A) YES. An ADL sum of 5 or more and the specific special care problem MUST be present to be classified as Special Care. NO. This is not new to the system.

Q) *Do only Medicaid residents have a PRI completed?*

A) No. A PRI is to be completed on ALL residents in a facility.

Q) *Who is the on-site reviewer and what will she/he be doing in the facility?*

A) The on-site reviewer is a registered nurse who has experience in long term care and with assessment measures. This reviewer is NOT a Department of Health employee; rather has been hired through a contractor and trained independently by the Department of Health for this data collection.

Q) *What is the purpose of the Stage I on-site review?*

A) The purpose of this visit is to review the selected residents, in particular, to focus on certain PRI indicators. This is a reliability measure to insure accurate data. The reviewer will read medical records, interview facility personnel, (e.g. unit nurses) and observe residents to complete the resident reviews. This on-site reviewer will NOT be judging quality of care. The reviewer will not be comparing her/his PRI review of residents with the facility's PRI review. A major function is to pinpoint systematic errors that would trigger a more intense audit.

Q) *At the end of the on-site reviewer's visit (Stage I review), will she/he discuss her/his results, such as the facility error rate?*

A) NO. The on-site reviewer is not comparing her/his data with the facility's PRI data. The Stage I review is a "blind" review and the reviewer is not aware of the facility's responses on the PRI. Any questions on the audit process should be directed to the Department of Health.

Q) *Will the on-site reviewer need the assistance of facility staff?*

A) Yes. Each facility's documentation is different, so the reviewer will need assistance in finding and interpreting facility medical records. If the reviewer cannot find the documentation to support a hierarchy reported by the facility, she/he will ask the facility staff for assistance in finding the record. If no documentation can be found for a resident, ADL responses will be reduced to the lowest level and other questions will be denied.

Q) *Will the on-site reviewer help a facility with their error report?*

A) NO. The error report should be reviewed by facility staff. All errors must be corrected before the data will be accepted electronically. Note, however, that either a keying or coding error will affect the audit outcome. The facility should make every effort to ensure that the PRI is correctly keyed.

Q *When can medical record charts be thinned?*

A) This is a decision that each facility must make independently. Please keep in mind that an auditor may still need to see these records. Facilities are encouraged to keep thinned records accessible and in order until processing of PRIs for the relevant time frame has been completed.

Q) *If a facility needs more PRIs, what should they do?*

A) Now that the data are collected electronically, the PRI used for reimbursement (DOH-3) is no longer printed and supplied to facilities. Each facility must arrange for printing or copying to ensure an adequate supply.

Q) *Are PRI admits and discharges always the same as the facility admits and discharges?*

A) No. The RUG-II system uses a snapshot of who is in the facility, rather than tracking all residents. PRI admits and discharges are an adjustment to the previous full house. Submit an admit PRI for those residents **currently** in the facility but who were **not** included in the full house. Submit a discharge for those residents who **were** in the previous full house but are **no longer** in the facility.

Q) *If a resident goes to the hospital, loses bed hold, and is then readmitted to the facility between the full house and admit and discharge dates, should an admit be submitted?*

A) No. No forms should be submitted for this resident. The loss of bed hold is irrelevant. The resident was in the facility on both collection dates, so only the full house PRI is submitted.

Q) *Is there a quick way to check that the correct number of admits and discharges are being submitted?*

A) Start with the number of records submitted for the previous full house, add the number of admit PRIs, then subtract the number of discharges. This should yield the number of residents in the facility on the last day of the assessment period (the census date). This test will not catch all errors, but will help to detect simple ones.

Attachment 9

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
ADL VERIFICATION FORM

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 9
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-4).

	FIELD # (23-24)	AUDIT LEVEL (25)
EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE).		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. FEEDS SELF WITHOUT SUPERVISION OR PHYSICAL ASSISTANCE. MAY USE ADAPTIVE EQUIPMENT. OR REQUIRES INTERMITTENT SUPERVISION (THAT IS, VERBAL ENCOURAGEMENT/GUIDANCE) AND/OR MINIMAL PHYSICAL ASSISTANCE WITH MINOR PARTS OF EATING, SUCH AS CUTTING FOOD, BUTTERING BREAD OR OPENING MILK CARTON.	50	_____
2= CONTINUAL SUPERVISION/ASSISTANCE. REQUIRES CONTINUAL HELP (ENCOURAGEMENT/ TEACHING/PHYSICAL ASSISTANCE) WITH EATING OR MEAL WILL NOT BE COMPLETED.		
3= TOTAL FEEDING BY HAND. TOTALLY FED BY HAND; PATIENT DOES NOT MANUALLY PARTICIPATE.		
4= TUBE OR PARENTERAL FEEDING. TUBE OR PARENTERAL FEEDING FOR PRIMARY INTAKE OF FOOD. (NOT JUST FOR SUPPLEMENTAL NOURISHMENTS).		

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

ADL VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT ID (9-17) _____

CHECKLIST (18) 9

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-3).

	FIELD # (23-24)	AUDIT LEVEL (25)
TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING. (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. REQUIRES NO SUPERVISION OR PHYSICAL ASSISTANCE TO COMPLETE NECESSARY TRANSFERS. MAY USE EQUIPMENT, SUCH AS RAILINGS, TRAPEZE. OR REQUIRES INTERMITTENT SUPERVISION (THAT IS, VERBAL CUEING/GUIDANCE) AND/OR PHYSICAL ASSISTANCE FOR DIFFICULT MANEUVERS ONLY.	51	_____
2= CONSTANT SUPERVISION/ASSISTANCE BY ONE PERSON. REQUIRES ONE PERSON TO PROVIDE CONSTANT GUIDANCE, STEADINESS AND/OR PHYSICAL ASSISTANCE OR TASK WILL NOT BE COMPLETED. PATIENT MAY PARTICIPATE IN TRANSFER.		
3= CONSTANT SUPERVISION/ASSISTANCE BY TWO PEOPLE OR BEDFAST. REQUIRES TWO PEOPLE TO PROVIDE CONSTANT SUPERVISION AND/OR PHYSICALLY LIFT OR TASK WILL NOT BE COMPLETED. MAY NEED LIFTING EQUIPMENT. OR CANNOT AND IS NOT GOTTEN OUT OF BED.		

*AUDIT PURPOSE: 1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

ADL VERIFICATION FORM

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 9
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

REVIEW THE ADL STATUS OF THE ABOVE PATIENT ON THIS FORM AND ENTER THE APPROPRIATE LEVEL CODE(1-3).

	FIELD # (23-24)	AUDIT LEVEL (25)
TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.		
1= MINIMAL OR NO SUPERVISION/ASSISTANCE. REQUIRES NO SUPERVISION OR PHYSICAL ASSISTANCE. MAY REQUIRE SPECIAL EQUIPMENT, SUCH AS A RAISED TOILET OR GRAB BARS. OR REQUIRES INTERMITTENT SUPERVISION FOR SAFETY OR ENCOURAGEMENT; OR MINOR PHYSICAL ASSISTANCE (FOR EXAMPLE, ADJUSTING CLOTHES OR WASHING HANDS).	52	_____
2= CONSTANT SUPERVISION/ASSISTANCE (CONTINENT WITH OR WITHOUT EQUIPMENT) OR INCONTINENT - NOT TOILETED. CONTINENT OF BOWEL, AND BLADDER, REQUIRES CONSTANT SUPERVISION AND/OR PHYSICAL ASSISTANCE WITH MAJOR OR ALL PARTS OF THE TASK OR TASK WILL NOT BE COMPLETED, INCLUDING APPLIANCES (I.E. COLOSTOMY, ILEOSTOMY, URINARY CATHETER). OR IS INCONTINENT OF BOWEL AND/OR BLADDER AND IS NOT TAKEN TO A BATHROOM.		
3= INCONTINENT - TOILETED. INCONTINENT OF BOWEL AND/OR BLADDER AND IS TAKEN TO A BATHROOM EVERY 2-4 HOURS DURING THE DAY AND AS NEEDED AT NIGHT.		

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - COMATOSE		
A. PATIENT UNCONSCIOUS, CANNOT BE AROUSED, AND CAN AT MOST RESPOND ONLY TO POWERFUL STIMULI	50	_____
B. AT A MINIMUM, PATIENT WAS COMATOSE FOR AT LEAST FOUR DAYS DURING THE PAST 4 WEEKS.	51	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND AN ACTIVE TREATMENT PLAN EXISTS	52	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - QUADRIPLEGIA		
A. ALL FOUR LIMBS OF PATIENT ARE PARALYZED AND DIAGNOSIS IS QUADRIPLEGIA.	54	_____
B. AMONG ALL THE MEDICAL PROBLEMS, QUADRIPLEGIA CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	55	_____

*AUDIT PURPOSE:
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
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PATIENT NAME _____
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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - MULTIPLE SCLEROSIS		
A. DEMYELINATION IN THE PATIENT'S CENTRAL NERVOUS SYSTEM; SYMPTOMS INCLUDE WEAKNESS, UNCOORDINATION, PARESTHESIAS, SPEECH DISTURBANCES, AND VISUAL COMPLAINTS. DIAGNOSIS IS MULTIPLE SCLEROSIS	58	_____
B. AMONG ALL THE MEDICAL PROBLEMS, MULTIPLE SCLEROSIS CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	59	_____

*AUDIT PURPOSE:
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DECUBITUS LEVEL - STAGE 4		
A. PATIENT HAS NECROTIC BREAKDOWN OF SKIN AND SUBCUTANEOUS TISSUE AT A PRESSURE POINT, WHICH MAY INVOLVE MUSCLE, FASCIA, AND BONE	61	_____
B. DOCUMENTATION BY A LICENSED CLINICIAN EXISTS WHICH DESCRIBES DECUBITUS AT STAGE 4 LEVEL, GIVES CIRCUMSTANCES OR MEDICAL CONDITION WHICH LED TO THIS DECUBITUS, AND PROVIDES ACTIVE TREATMENT PLAN .	62	_____

*AUDIT PURPOSE:
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - NASAL GASTRIC FEEDING		
A. PATIENT'S PRIMARY FOOD INTAKE IS BY A TUBE INSERTED THROUGH A NOSTRIL AND INTO THE STOMACH; RESORTED TO WHEN IT IS THE ONLY ROUTE TO THE STOMACH (GASTROSTOMY NOT APPLICABLE)	63	_____
B. TREATMENT WAS GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY)	64	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 1
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - NASAL GASTRIC FEEDING		
A. PATIENT'S PRIMARY FOOD INTAKE IS BY A TUBE INSERTED THROUGH A NOSTRIL AND INTO THE STOMACH; RESORTED TO WHEN IT IS THE ONLY ROUTE TO THE STOMACH (GASTROSTOMY NOT APPLICABLE)	63	_____
B. TREATMENT WAS GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY)	64	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	65	_____

*AUDIT PURPOSE: 1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE)	66	
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY)	67	
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	68	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE).	66	_____
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY).	67	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	68	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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NEW YORK STATE DEPARTMENT OF HEALTH
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PATIENT ID (9-17) _____

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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - PARENTERAL FEEDING		
A. PATIENT RECEIVES INTRAVENOUS OR SUBCUTANEOUS ADMINISTRATION OF FLUIDS USED TO MAINTAIN FLUID, AND/OR NUTRITIONAL INTAKE, ELECTROLYTE BALANCE (E.G., PATIENT IN COMA, DAMAGED STOMACH) (GASTROSTOMY NOT APPLICABLE).	66	_____
B. TREATMENT GIVEN AT SOME TIME DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. (DOES NOT HAVE TO BE CONTINUOUS/DAILY).	67	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	68	_____

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NEW YORK STATE DEPARTMENT OF HEALTH
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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE.	70	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	_____
D. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	72	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	70	
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	
D. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	72	

*AUDIT PURPOSE:
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NEW YORK STATE DEPARTMENT OF HEALTH
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RUG CATEGORY CHECKLIST

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PATIENT NAME _____
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PATIENT ID (9-17) _____

CHECKLIST (18) 1

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - SUCTIONING		
A. PATIENT RECEIVES SUCTIONING TO CLEAR AWAY FLUID OR SECRETIONS FROM THE MOUTH OR NASOPHARYNX EXCLUSIVE OF TRACHEOSTOMY SUCTIONING	69	
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE.	70	
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	71	
D. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY.	72	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
SPECIALIZED SERVICES - PHYSICAL THERAPY		
A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	53	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	55	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	56	_____
H. THERE IS A PHYSICIAN ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY.	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005 SPECIALIZED SERVICES - PHYSICAL THERAPY A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE	53	
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	55	
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	56	
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	57	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
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RUG CATEGORY CHECKLIST

FACILITY NAME: _____

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PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
SPECIALIZED SERVICES - PHYSICAL THERAPY		
A. PATIENT RECEIVES THERAPEUTIC PROGRAM OF PHYSICAL THERAPY	50	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	51	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED PT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, OCCUPATIONAL THERAPISTS)	52	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	53	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	54	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	55	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED PT PROFESSIONAL).	56	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

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PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 2

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005 SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
SPECIALIZED SERVICES - OCCUPATIONAL THERAPY		
A. PATIENT RECEIVES A THERAPEUTIC PROGRAM OF OCCUPATIONAL THERAPY	58	_____
B. FOR A NEW ADMIT OR READMIT WITHIN THE FOUR WEEKS, THE PATIENT'S CONDITION IS REALISTICALLY EXPECTED TO IMPROVE SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) WITHIN A REASONABLE (AND GENERALLY PREDICTABLE) PERIOD OF TIME OR FOR A PATIENT IN THE FACILITY THROUGHOUT THE FOUR WEEKS, THE PATIENT'S CONDITION HAS IMPROVED SIGNIFICANTLY (FUNCTIONAL ADL IMPROVEMENT) DURING THE FOUR WEEKS	59	_____
C. ON-SITE SUPERVISION AND/OR CARE BY A LICENSED OT PROFESSIONAL EXISTS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (E.G., SPEECH THERAPISTS, PHYSICAL THERAPISTS)	60	_____
D. MONTHLY EVALUATION BY A LICENSED PROFESSIONAL PERSON WITH A 4 YEAR, SPECIALIZED THERAPY DEGREE . . .	61	_____
E. TREATMENT GIVEN FOR PAST 4 CONSECUTIVE WEEKS OR MORE. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	62	_____
F. TREATMENT PROVIDED AT LEAST 5 DAYS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	63	_____
G. TREATMENT PROVIDED AT LEAST 2.5 HOURS PER WEEK (ONE-TO-ONE CARE UNDER ON-SITE SUPERVISION/CARE OF A LICENSED OT PROFESSIONAL).	64	_____
H. THERE IS A PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER FOR THERAPY AND THE ORDER IS UPDATED MONTHLY	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - CEREBRAL PALSY		
A. PATIENT HAS PERSISTANT QUALITATIVE MOTOR DISORDER DUE TO DAMAGE TO THE BRAIN. DIAGNOSED AS CEREBRAL PALSY.	51	_____
B. AMONG ALL THE MEDICAL PROBLEMS, CEREBRAL PALSY CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	52	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

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DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

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PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - HEMIPLEGIA		
A. ONE SIDE OF PATIENT'S BODY PARALYZED AND THE DIAGNOSIS IS HEMIPLEGIA.	55	_____
B. AMONG ALL THE MEDICAL PROBLEMS, HEMIPLEGIA CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	56	_____

*AUDIT PURPOSE: 1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____ PATIENT ID (9-17) _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - URINARY TRACT INFECTION		
A. PATIENT'S URINARY TRACT INFECTED AND DIAGNOSIS IS URINARY TRACT INFECTION.	59	_____
B. AMONG ALL THE MEDICAL PROBLEMS, URINARY TRACT INFECTION IS THE MAJOR PROBLEM OF THE PATIENT. IT CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION.	60	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

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PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
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PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - DEHYDRATION		
A. PATIENT HAS EXCESSIVE LOSS OF BODY FLUIDS REQUIRING IMMEDIATE MEDICAL TREATMENT AND ADL CARE	62	
B. PATIENT DEHYDRATED AT SOME TIME DURING THE PAST 4 WEEKS.	63	
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND ACTIVE TREATMENT PLAN EXISTS.	64	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - INTERNAL BLEEDING		
A. PATIENT HAS BLOOD LOSS STEMMING FROM A SUBACUTE OR CHRONIC CONDITION (E.G. GASTROINTESTINAL, RESPIRATORY OR GENITOURINARY CONDITIONS) WHICH MAY RESULT IN LOW BLOOD PRESSURE AND HEMOGLOBIN, PALLOR, DIZZINESS, FATIGUE, OR RAPID RESPIRATION. THIS EXCLUDES EXTERNAL HEMORRHOIDS OR OTHER MINOR BLOOD LOSS WHICH IS NOT DANGEROUS AND REQUIRES ONLY MINOR INTERVENTION	65	_____
B. PATIENT BLEEDING INTERNALLY AT SOME TIME DURING THE PAST 4 WEEKS	66	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND AN ACTIVE TREATMENT PLAN EXISTS	67	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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RUG CATEGORY CHECKLIST

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PATIENT NAME _____
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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - STASIS ULCER		
A. PATIENT HAS OPEN LESION, USUALLY IN LOWER EXTREMITIES, CAUSED BY DECREASED BLOOD FLOW FROM CHRONIC VENOUS INSUFFICIENCY	68	_____
B. PATIENT HAS HAD STASIS ULCER(S) AT SOME TIME DURING PAST 4 WEEKS	69	_____
C. DOCUMENTATION THAT THE PATIENT HAS THE CONDITION AND ACTIVE TREATMENT PLAN EXISTS.	70	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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FACILITY NAME: _____

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PATIENT NAME _____
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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL CONDITION - TERMINAL ILLNESS		
A. PATIENT'S CONDITION IS RAPIDLY DETERIORATING DURING THE LAST FOUR WEEKS AND PATIENT WILL LIKELY DIE WITHIN 3 MONTHS ACCORDING TO PROFESSIONAL PROGNOSIS (JUDGMENT)	71	_____
B. THERE IS DOCUMENTATION OF CONDITION WHICH WOULD LEAD YOU TO JUDGE THAT A TERMINAL ILLNESS EXISTS. . .	73	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

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FACILITY NAME: _____

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MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

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REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	75	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	_____
D. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY	77	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABLITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	75	_____
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	_____
D. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY.	77	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - OXYGEN THERAPY		
A. PATIENT RECEIVES OXYGEN BY NASAL CATHETER, MASK (NASAL OR ORONASAL), FUNNEL/CONE, OR OXYGEN TENT FOR CONDITIONS RESULTING FROM OXYGEN DEFICIENCY (E.G. CARDIOPULMONARY CONDITION). TREATMENT EXCLUDES USE OF OXYGEN WITH INHALATORS FOR MEDICATION ADMINISTRATION AND OXYGEN IN ROOM BUT NOT IN USE. . . .	74	
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED. IF TREATMENT PROVIDED FOR LESS THAN 4 WEEKS DUE TO RECENT ADMISSION, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABLITY OF TREATMENT CONTINUING FOR 4 WEEKS OR MORE	75	
C. DOCUMENTATION EXISTS THAT THE TREATMENT IS GIVEN DAILY	76	
D. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN AND THE FREQUENCY.	77	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	80	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	80	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - WOUND CARE		
A. PATIENT RECEIVES CARE FOR SUBCUTANEOUS LESIONS RESULTING FROM SURGERY, TRAUMA OR OPEN CANCEROUS ULCERS. EXCLUDES DECUBITI, STASIS ULCERS, SKIN TEARS, AND FEEDING TUBES	78	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS; DURING THIS TIME PERIOD AT LEAST 3 CONSECUTIVE WEEKS OF CARE IS NEEDED OR IF TREATMENT PROVIDED FOR LESS THAN 3 WEEKS, DOCUMENTATION SUPPORTS SERIOUSNESS OF CONDITION AND PROBABILITY OF TREATMENT CONTINUING FOR AT LEAST 3 CONSECUTIVE WEEKS OR MORE	79	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	80	_____

*AUDIT PURPOSE: 1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - CHEMOTHERAPY		
A. PATIENT'S CARCINOMA TREATED THROUGH IV AND/OR ORAL CHEMOTHERAPEUTIC AGENTS. (MAY HAVE TO GO TO A HOSPITAL FOR TREATMENT).	81	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	83	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
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ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - CHEMOTHERAPY		
A. PATIENT'S CARCINOMA TREATED THROUGH IV AND/OR ORAL CHEMOTHERAPEUTIC AGENTS. (MAY HAVE TO GO TO A HOSPITAL FOR TREATMENT).	81	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	83	_____

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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

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PATIENT NAME _____
MEDICAL RECORD # _____
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	FIELD # (23-24)	AUDIT RESPONSE (25)
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B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	82	_____
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
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ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	86	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	_____
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	86	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
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PATIENT ID (9-17) _____

CHECKLIST (18) 3

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LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
MEDICAL TREATMENT - TRANSFUSIONS		
A. WHOLE BLOOD OR BLOOD COMPONENTS INTRODUCED DIRECTLY INTO PATIENT'S BLOOD STREAM. (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	84	
B. TREATMENT WAS GIVEN DURING THE PAST 4 WEEKS AND IS STILL REQUIRED.	85	
C. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	86	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

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PATIENT NAME _____
MEDICAL RECORD # _____
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ROOM _____

CHECKLIST (18) 3

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*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
MEDICAL TREATMENT - DIALYSIS		
A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	88	_____
C. PHYSICIAN ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN	89	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____ PATIENT ID (9-17) _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
JULY 1, 1999 - NOVEMBER 22, 2005		
MEDICAL TREATMENT - DIALYSIS		
A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
B. TREATMENT GIVEN DURING PAST 4 WEEKS AND STILL REQUIRED	88	_____
C. PHYSICIAN, NURSE PRACTITIONER, OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER SPECIFIES THAT THE TREATMENT SHOULD BE GIVEN.	89	_____

*AUDIT PURPOSE:
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 3
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
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A. PATIENT'S BLOOD COMPONENTS SEPARATED, AS IN KIDNEY DIALYSIS (E.G., FOR PATIENTS WITH RENAL FAILURE, LEUKEMIA, BLOOD DYSCRASIA.) (MAY HAVE TO GO TO HOSPITAL FOR TREATMENT)	87	_____
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NEW YORK STATE DEPARTMENT OF HEALTH
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RUG CATEGORY CHECKLIST

FACILITY NAME: _____

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PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PRE 07/1999		
NUMBER OF PHYSICIAN VISITS A. PATIENT HAS MEDICAL CONDITION THAT IS: -- UNSTABLE AND CHANGING OR -- STABLE, BUT WITH HIGH RISK OF INSTABILITY. IF NOT MONITORED AND TREATED CLOSELY BY MEDICAL STAFF, AN ACUTE EPISODE OR SEVERE DETERIORATION CAN RESULT	90	_____
B. PHYSICIAN (NOT A PSYCHIATRIST, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER) HAS PERSONALLY EXAMINED PATIENT TO ADDRESS PERTINENT MEDICAL PROBLEMS ON EACH OCCASION	91	_____
C. PHYSICIAN'S DOCUMENTATION EXISTS SUPPORTING PATIENT'S ACTUAL OR POTENTIAL UNSTABLE CONDITION (E.G. TERMINAL ILLNESS, ACUTE EPISODE, RECENT HOSPITALIZATION, POST SURGERY) AND THE RESULTS OF PHYSICIAN'S EXAMINATION ARE DOCUMENTED (E.G., CHANGE IN MEDICATION ORDER, RENEWAL OF TREATMENT ORDERS, NURSING ORDERS, ORDER LAB TESTS)	92	_____
D. THERE HAVE BEEN AT LEAST FOUR VISITS IN THE PAST 4 WEEKS EXCLUSIVE OF PHONE CALLS OR VISITS WHICH COULD BE ACCOMPLISHED OVER THE PHONE. PHYSICIAN MAY VISIT PATIENT OR PATIENT MAY VISIT PHYSICIAN AS LONG AS THE PATIENT IS NOT AN INPATIENT IN A HOSPITAL / OTHER FACILITY.	93	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 3

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
NUMBER OF PHYSICIAN VISITS A. PATIENT HAS MEDICAL CONDITION THAT IS: -- UNSTABLE AND CHANGING OR -- STABLE, BUT WITH HIGH RISK OF INSTABILITY. IF NOT MONITORED AND TREATED CLOSELY BY MEDICAL STAFF, AN ACUTE EPISODE OR SEVERE DETERIORATION CAN RESULT	90	_____
B. PHYSICIAN (NOT A PSYCHIATRIST), NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT HAS PERSONALLY EXAMINED PATIENT TO ADDRESS PERTINENT MEDICAL PROBLEMS ON EACH OCCASION	91	_____
C. PHYSICIAN'S, NURSE PRACTITIONER'S, OR PHYSICIAN ASSISTANT'S DOCUMENTATION EXISTS SUPPORTING PATIENT'S ACTUAL OR POTENTIAL UNSTABLE CONDITION (E.G. TERMINAL ILLNESS, ACUTE EPISODE, RECENT HOSPITALIZATION, POST SURGERY) AND THE RESULTS OF THAT EXAMINATION ARE DOCUMENTED (E.G. CHANGE IN MEDICATION ORDER, RENEWAL OF TREATMENT ORDERS, NURSING ORDERS, ORDER LAB TESTS).	92	_____
D. THERE HAVE BEEN AT LEAST FOUR VISITS IN THE PAST 4 WEEKS EXCLUSIVE OF PHONE CALLS OR VISITS WHICH COULD BE ACCOMPLISHED OVER THE PHONE. PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT MAY VISIT PATIENT OR PATIENT MAY VISIT PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT AS LONG AS THE PATIENT IS NOT AN INPATIENT IN A HOSPITAL / OTHER FACILITY	93	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
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NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
VERBAL DISRUPTION		
A. PATIENT EXHIBITS UNPREDICTABLE, RECURRING VERBAL DISRUPTION BY YELLING, BAITING, THREATENING, ETC., FOR NO FORETOLD REASON. THIS EXCLUDES VERBAL OUTBURSTS/EXPRESSIONS/UTTERANCES WHICH DO NOT CREATE DISRUPTION	50	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	51	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	52	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	53	_____

*AUDIT PURPOSE: 1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
PHYSICAL AGGRESSION		
A. PATIENT EXHIBITS UNPREDICTABLE, RECURRING ASSAULTIVE OR COMBATIVE BEHAVIOR TO SELF OR OTHERS WITH INTENT FOR INJURY FOR NO APPARENT OR FORETOLD REASON (THAT IS, NOT JUST DURING SPECIFIC CARE ROUTINES OR AS A REACTION TO NORMAL STIMULI). (E.G. HITS SELF, THROWS OBJECTS, PUNCHES, MANEUVERS DANGEROUSLY WITH WHEELCHAIR)	54	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	55	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	56	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	57	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 4
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR		
A. PATIENT EXHIBITS CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES DISRUPTION WITH OTHERS (E.G. CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING SELF TO OTHERS). THIS EXCLUDES VERBAL OUTBURSTS, SOCIAL WITHDRAWAL, HOARDING, PARANOIA.	58	_____
B. DISRUPTION OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS	59	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT PATIENT HAS SEVERE BEHAVIORAL PROBLEM	60	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	61	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
RUG CATEGORY CHECKLIST

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 4

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
HALLUCINATIONS		
A. PATIENT EXPERIENCES VISUAL, AUDITORY, OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY	62	_____
B. A HALLUCINATORY EPISODE OCCURRED AT LEAST ONCE PER WEEK DURING THE PAST 4 WEEKS.	63	_____
C. DOCUMENTATION EXISTS IN FORM OF PSYCHIATRIC ASSESSMENT BY A RECOGNIZED PROFESSIONAL WITH PSYCHIATRIC TRAINING/EDUCATION TO SUPPORT THAT THE PATIENT HAS A SEVERE BEHAVIORAL PROBLEM	64	_____
D. DOCUMENTATION EXISTS IN FORM OF ACTIVE TREATMENT PLAN / BEHAVIOR MODIFICATION PLAN IN CURRENT USE. THE FACILITY MUST BE DOING SOMETHING TO RESPOND TO THE BEHAVIOR.	65	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
TBI VERIFICATION FORM

FACILITY NAME: _____

OP. CERT. # (1-8) _____

PATIENT -
PATIENT NAME _____
MEDICAL RECORD # _____
UNIT _____
ROOM _____

PATIENT ID (9-17) _____

CHECKLIST (18) 7

REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
TBI - EXTENDED CARE.		
A. RESIDENT HAS BEEN DIAGNOSED AS HAVING A COGNITIVE AND/OR PHYSICAL CONDITION THAT HAS RESULTED FROM TRAUMATICALLY ACQUIRED, NON-DEGENERATIVE, STRUCTURAL BRAIN DAMAGE, OR ANOXIA	50	_____
B. DOCUMENTATION THAT RESIDENT HAS PARTICIPATED IN A SPECIALIZED INTENSIVE REHABILITATION PROGRAM FOR PERSONS WITH TBI, (NF, HOSP. REHAB. CTR.), EXISTS.	51	_____
C. DOCUMENTATION THAT RESIDENT HAS BEEN ASSESSED BY A NEUROLOGIST OR A PHYSIATRIST WHO DETERMINED THAT THE INDIVIDUAL WILL NO LONGER BENEFIT FROM AN INTENSIVE REHABILITATION PROGRAM	52	_____
D. A CLASSIFICATION SYSTEM FOR MEASURING PHYSICAL, AFFECTIVE, BEHAVIORAL AND COGNITIVE LEVEL OF FUNCTIONING EXISTS	53	_____
E. DOCUMENTATION THAT AN ACTIVE TREATMENT PLAN EXISTS	54	_____

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING - BUREAU OF FINANCIAL MANAGEMENT & INFORMATION SUPPORT
DEMENTIA VERIFICATION FORM

FACILITY NAME: _____ OP. CERT. # (1-8) _____

PATIENT - PATIENT ID (9-17) _____
PATIENT NAME _____
MEDICAL RECORD # _____ CHECKLIST (18) 7
UNIT _____
ROOM _____ REVIEWER ID (19-22) _____

*AUDIT PURPOSE (29) _____

LOCATE THE ABOVE PATIENT'S CHART AND/OR KARDEX AND COMPLETE THE FOLLOWING CHECK-LIST ITEMS. FILL IN ALL SPACES PROVIDED USING THE CODES: 1 FOR YES, 2 FOR NO

	FIELD # (23-24)	AUDIT RESPONSE (25)
DIAGNOSIS - DEMENTIA		
A. PATIENT HAS A DIAGNOSIS OF DEMENTIA.	55	
B. AMONG ALL THE MEDICAL PROBLEMS, DEMENTIA IS THE MAJOR PROBLEM OF THE PATIENT. IT CREATED THE MOST NEED FOR NURSING TIME DURING THE PAST 4 WEEKS AS CONFIRMED THROUGH DOCUMENTATION	56	

*AUDIT PURPOSE:
1. OVERTURN OF PREVIOUS AUDIT
2. ADDNL PATIENT SELECTED BY AUDITOR
3. OTHER _____

Attachment 10

Offeror's Questionnaire

1. Describe your company's knowledge and experience, including the knowledge and experience of any proposed subcontractors, specific to the contract deliverables as described in Section C 2. Provide details that address but are not limited to the following:

    - Knowledge and experience with the MDS and other similar resident assessment instruments.
    - Knowledge and experience in the long-term care field, including nursing facilities.
    - Knowledge and experience with medical record documentation.
    - Experience with performing projects similar to this RFP.

2. Identify Key Staff that will be assigned to the work performed under this RFP. Include the following:

    - A chart of the offeror's organization that shows the level of responsibility within that organization for key project members, along with a specific chart of the project organization with names, including subcontractors, if applicable.
    - A list of personnel to be assigned, their function on the project and a detailed resume for each person assigned showing quantified experience. Include experience of each staff in performing tasks similar to those required by this RFP.
    - Position descriptions and vitae for all personnel who will carry out the work required under the contract.

3. Provide the information shown below for three (3) current or former clients for whom you provided services during the past five years that can provide references for similar activities. This should include references for work performed by a subcontractor for this task if applicable.

    - Name and telephone number of contact.
    - Organization name and address.
    - Description of services performed.
    - Dates when services were performed.
    - Staff assigned to this proposal that worked on the referenced project and a description of their role on the referenced project.

4. Provide detailed approaches to complete the project based on the specifications in Section C 2 of this RFP. Include a work plan describing each major step necessary to complete this project, along with persons responsible, and due dates. The work plan and approach must include sufficient enough detail to permit the Department to evaluate the offeror's understanding of the effort and skills necessary to complete this project. The work plan should demonstrate the offeror's ability to develop an MDS audit system within the first four (4) months of the two –year contract period.

Attachment 11

NEW YORK STATE
DEPARTMENT OF HEALTH

BID FORM

PROCUREMENT TITLE: _____ FAU #_____

Bidder Name:
Bidder Address:

Bidder Fed ID No:

A. _____ bids a total price of $_____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller ("restricted period") to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document.* DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):
   No Yes
   If yes, please answer the next questions:

   1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):
   No Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity:_____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

_____

_____

_____

_____

_____

_____

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No Yes

2b. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

_____

_____

_____

_____

_____

_____

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

D. Offerer/Bidder agrees to provide the following documentation either *with their submitted bid/proposal or upon award* as indicated below:

With Bid	Upon Award	
☐	☐	1. A completed N.Y.S Taxation and Finance Contractor Certification Form ST-220-CA (for procurements greater than or equal to $100,000)
☐	☐	2. A completed N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to $100,000)
☐	☐	3. A completed State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

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_____ (Officer Signature)

_____ (Date)

_____ (Officer Title)

_____ (Telephone)

_____ (e-mail Address)

NEW YORK STATE
DEPARTMENT OF HEALTH

NO-BID FORM

PROCUREMENT TITLE: _____ FAU #_____

Bidders choosing not to bid are requested to complete the portion of the form below:

☐ We do not provide the requested services. Please remove our firm from your mailing list

☐ We are unable to bid at this time because:

_____

_____

_____

_____

☐ Please retain our firm on your mailing list.

_____
(Firm Name)

_____ _____
(Officer Signature) (Date)

_____ _____
(Officer Title) (Telephone)

_____
(e-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

Attachment 12

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section E, Administrative, 8. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

☐ An on-line Vender Responsibility Questionnaire has been updated or created at OSC's website: https://portal.osc.state.ny.us within the last six months.

☐ A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.

☐ A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

Attachment 13

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. the designated payment office (DPO) outlined in the consulting contract.

2. NYS Office of the State Comptroller
   Bureau of Contracts
   110 State Street, 11th Floor
   Albany, NY 12236
   Attn: Consultant Reporting
   or via fax to –
   (518) 474-8030 or (518) 473-8808

3. NYS Department of Civil Service
   Alfred E. Smith Office Building
   Albany, NY 12239
   Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

State Consultant Services

FORM A

OSC Use Only
Reporting Code:
Category Code:
Date Contract Approved:

Contractor's Planned Employment
From Contract Start Date through End of Contract Term

New York State Department of Health — Agency Code 12000
Contractor Name: — Contract Number:

Contract Start Date: / / — Contract End Date: / /

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	$ 0.00
Grand Total:	0	0	$ 0.00

Name of person who prepared this report:

Title: — Phone #:

Preparer's signature:
Date Prepared: / /

Page of
(use additional pages if necessary)

State Consultant Services

FORM B

OSC Use Only
Reporting Code:
Category Code:

Contractor's Annual Employment Report
Report Period: April 1, _____ to March 31, _____

New York State Department of Health — Agency Code 12000
Contract Number:
Contract Start Date: / / — Contract End Date: / /
Contractor Name:
Contractor Address:

Description of Services Being Provided:

Scope of Contract (Chose one that best fits):

Analysis	Evaluation	Research
Training	Data Processing	Computer Programming
Other IT Consulting	Engineering	Architect Services
Surveying	Environmental Services	Health Services
Mental Health Services	Accounting	Auditing
Paralegal	Legal	Other Consulting

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	$ 0.00
Grand Total:	0	0	$ 0.00

Name of person who prepared this report:
Title: — Phone #:

Preparer's signature:
Date Prepared: / /

Page of
(use additional pages if necessary)

Attachment 14

New York State Department of Taxation and Finance

Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA

(6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help? on back*).

Contractor name	*For covered agency use only* *Contract number or description*
Contractor's principal place of business City State ZIP code	
Contractor's mailing address *(if different than above)*	*Estimated contract value over the full term of contract (but not including renewals)* $
Contractor's federal employer identification number (EIN) / Contractor's sales tax ID number (if different from contractor's EIN)	
Contractor's telephone number / Covered agency name	
Covered agency address	*Covered agency telephone number*

I, _____ , hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an **X** *in only one box)*

☐ The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

☐ The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____
(insert contract number or description)

and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this____ day of _____, 20 ____

_____ _____
(sign before a notary public) *(title)*

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency,* with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);

ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and

iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of $100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20___, before me personally appeared _____,

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that

_he resides at _____,

Town of _____,

County of _____,

State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____

of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____

of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____, LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?

Internet access: *www.nystax.gov*
(for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931

To order forms and publications: 1 800 462-8100

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

New York State Department of Taxation and Finance

Contractor Certification

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-TD

(5/07)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a (see Need help? below).*

Contractor name			
Contractor's principal place of business	City	State	ZIP code
Contractor's mailing address *(if different than above)*			

Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)	Contractor's telephone number ( )
Covered agency or state agency	Contract number or description	Estimated contract value over the full term of contract (but not including renewals) $
Covered agency address		Covered agency telephone number

General information

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than $100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

All sections must be completed including all fields on the top of this page, all sections on page 2, Schedule A on page 3, if applicable, and Individual, Corporation, Partnership, or LLC Acknowledgement on page 4. If you do not complete these areas, the form will be returned to you for completion.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006),* available at *www.nystax.gov.* Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

Note: Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

NYS TAX DEPARTMENT
DATA ENTRY SECTION
W A HARRIMAN CAMPUS
ALBANY NY 12227

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227.

Need help?

Internet access: *www.nystax.gov* (for information, forms, and publications)

Fax-on-demand forms: 1 800 748-3676

Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.

To order forms and publications: 1 800 462-8100

Sales Tax Information Center: 1 800 698-2909

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

I, _____ , hereby affirm, under penalty of perjury, that I am _____
(name) *(title)*

of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

Complete Sections 1, 2, and 3 below. Make **only one** entry in each section.

Section 1 — Contractor registration status

☐ The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.

☐ The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 2 — Affiliate registration status

☐ The contractor does not have any affiliates.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 3 — Subcontractor registration status

☐ The contractor does not have any subcontractors.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the $300,000 cumulative sales threshold during such quarters on Schedule A of this certification.

☐ To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this___ day of _____ , 20 ____

_____ _____
(sign before a notary public) *(title)*

Schedule A — Listing of each entity (contractor, affiliate, or subcontractor) exceeding $300,000 cumulative sales threshold

List the contractor, or affiliate, or subcontractor in Schedule A only if such entity exceeded the $300,000 cumulative sales threshold during the specified sales tax quarters. See directions below. For more information, see Publication 223.

A Relationship to Contractor	B Name	C Address	D Federal ID Number	E Sales Tax ID Number	F Registration in progress

Column A – Enter ***C*** in column A if the contractor; ***A*** if an affiliate of the contractor; or ***S*** if a subcontractor.

Column B – Name - If the entity is a corporation or limited liability company, enter the exact legal name as registered with the NY Department of State, if applicable. If the entity is a partnership or sole proprietor, enter the name of the partnership and each partner's given name, or the given name(s) of the owner(s), as applicable. If the entity has a different DBA (doing business as) name, enter that name as well.

Column C – Address - Enter the street address of the entity's principal place of business. Do not enter a PO box.

Column D – ID number - Enter the federal employer identification number (EIN) assigned to the entity. If the entity is an individual, enter the social security number of that person.

Column E – Sales tax ID number - Enter only if different from federal EIN in column D.

Column F – If applicable, enter an X if the entity has submitted Form DTF-17 to the Tax Department but has not received its certificate of authority as of the date of this certification.

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ____ day of _____ in the year 20__ , before me personally appeared _____ ,

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that

_ he resides at _____ ,

Town of _____ ,

County of _____ ,

State of _____; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☐ (If a corporation): _he is the _____

of _____ , the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____

of _____ , the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____ LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

_____
Notary Public

Registration No. _____

Attachment 15

ORGANIZATION:
CONTRACT PERIOD:

COST PROPOSAL FORM

Instructions: A fixed bid price for each the deliverables as described in Section C –2 must be submitted. The fixed bid price amounts must be inclusive of all costs including but not limited to salaries, fringe benefits, administrative costs, overhead, travel, and presentation costs. The total fixed bid amount must reflect all costs for the full term of the contract, including the cost of consultation after audit system development through the end of the contract period. The sum of the fixed bid amounts for each deliverable will be the total fixed bid amount. An individual authorized to bind the Offeror to its provisions must sign this form in ink. Round all amounts to the nearest dollar.

Deliverable	Description of Deliverable	Total Fixed Bid Amount
Audit Selection Criteria	**Refer to Section C 2.1 of RFP**	**$**
Audit Structure	**Refer to Section C 2.2 of RFP**	**$**
Audit Tool & Documentation	**Refer to Section C 2.3 of RFP**	**$**
Implementation of Audit Results	**Refer to Section C 2.4 of RFP**	**$**
Changes to Audit System as a result of CMS's planned Implementation of MDS 3.0	**Refer to Section C 2.5 of RFP**	**$**
Consultation after Audit System Development through end of Contract Period.	**Refer to Section C 2.6 of RFP**	**Costs for this Deliverable must be included in above bid amounts.**
Total Fixed Bid Amount for Contract Period	**Sum of Fixed Bid Amounts for each Contract Deliverable**	**$**

Signature and Title of Authorized Official **Date**