The Texas Medicaid & Healthcare Partnership presents:

2008 Waiver Programs
Quick Reference Guide
# Crosswalk of 3652 Community Services Purpose Codes

<table>
<thead>
<tr>
<th>3652 PC</th>
<th>Current Use</th>
<th>Future Use</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1       | CBA & CWP only: Utilization Review by DADS RN (MN and TILE reset)           | Complete the following for the submission of a Utilization Review (UR):  
  - Medical Necessity and Level of Care Assessment  
  - S2f (purpose code) = blank  
  For UR purposes, the UR button will be selected on the LTC Online Portal. This will auto populate a “1” in field S2f. Purpose Code of the LTC Medicaid Information section of the Medical Necessity and Level of Care Assessment. |                                                                                                                                                                                                          |
| 2       | Pre-enrollment health assessment                                             | Admission (Enrollment) Assessment  
  - Medical Necessity and Level of Care Assessment with AA8a. Primary Reason for Assessment = ‘01’ (Admission Assessment)  
  - S2f (purpose code) = blank  
  **1. Enrollment from Nursing Facility:**  
  When a client enters a Community Services Waiver program from a Nursing Facility, the enrollment is usually handled via a manual process by the case manager. However, if the Home Health Provider or DADS Regional Nurse submits a Medical Necessity and Level of Care Assessment for the enrollment – perhaps to have the RUG recalculated – the TMHP LTC Online Portal will allow the submission and send to DADS for processing. DADS will create applicable SAS records.  
  **2. Enrollment from Home or Non-Nursing Facility:** | The Community Services waiver program does not have to do another assessment when the client is enrolled and already has a Medical Necessity determination and RUG on file; they can wait until the annual is due. However, if the provider or DADS Regional Nurse does choose to submit an assessment, it will be processed (i.e. MN and RUG determination will be made on the assessment). |
<table>
<thead>
<tr>
<th>PC</th>
<th>Current Use</th>
<th>Future Use</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (-cont.)</td>
<td>When a client seeks enrollment into a Community Services Waiver program from home, or another non-nursing facility program, an admission (enrollment) assessment (AA8a = 01), <em>Medical Necessity and Level of Care Assessment</em>, will need to be submitted via the TMHP LTC Online Portal. This submission results in DADS creating the applicable SAS records.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3    | Annual assessment by HCSSA RN (MN and TILE reset)                                               | For an Annual Assessment the provider should submit:  
- Medical Necessity and Level of Care Assessment with AA8a. *Primary Reason for Assessment* = ‘02’ (Annual Assessment)  
- S2f (purpose code) = blank                                                                                                           | The annual cannot be submitted more than 90 days prior to the current ISP (Service Plan) period end date. This assessment is submitted for MN determination according to the reassessment due date as based on the individual service plan (ISP) expiration date. The nurse must complete the Annual Medical Necessity Review and submit the Medical Necessity and Level of Care Assessment within the time frames specified in policy. |
| R    | Off-cycle case mix change in condition (TILE reset) once per calendar year                      | A Significant Change in Status Assessment (RUG Reset) should be submitted when there is a significant change in client condition during the assessment year as follows:  
- Medical Necessity and Level of Care Assessment with AA8a. *Primary Reason for Assessment* = ‘03’ (Significant Change in Status Assessment)  
- S2f (purpose code) = blank                                                                                                           | SCSA forms must be submitted no more than 30 days beyond the end of the ISP in which the SCSA applies. R2b (Date Assessment Completed) determines the ISP period.  
Note: SCSA is not applicable for PACE.                                                                                          |
**RUG-III VERSION 5.12 CALCULATION WORKSHEET**

What is it?
The following worksheet has been provided to describe the method for calculation of the RUG using the 108 data items from the MN and LOC Assessment. Texas will be using the Index Maximizing Method to arrive at the final RUG.

Why use it?
If the reader has an interest in understanding how the scores of the 108 RUG items affect the resulting RUG.
RUG-III VERSION 5.12 CALCULATION WORKSHEET
34 GROUP MODEL

This RUG-III Version 5.12 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III classification based on the information from an MDS 2.0 assessment. The worksheet takes the computer programming and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 34 group RUG-III Version 5.12 model. There is also a 44 group model and a separate worksheet available for the 44 group model. The major difference between the 44 group model and the 34 model involves the Rehabilitation groups.

In the 44 group model, there are 14 different Rehabilitation groups representing 5 different levels of rehabilitation services. The 44 group model is therefore well suited for use with restorative programs that classify residents on the basis of both nursing care needs and rehabilitation needs. The SNF Medicare program is a good example of such a program. RUG-III models order the groups from high to low resource need. In the 44 group model, the residents in the Rehabilitation groups have the highest level of combined nursing and rehabilitation need, while residents in the Extensive Services groups have the next highest level of need. Therefore, the 44 group model has the Rehabilitation groups first followed by the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Functions groups.

In the 34 group model the Rehabilitation groups have been collapsed to 4 groups and different levels of rehabilitation service are not distinguished. The simplified Rehabilitation classification in the 34 group model is better suited to long-term care programs, which often classify on the basis of nursing care needs only. Medicaid long-term care programs in many States are examples. In the 34 group model, the Extensive Services groups have the highest level of nursing care needs, while the Rehabilitation groups have the next highest level of need. For this reason, the order of the Rehabilitation and Extensive Services groups are reversed in the 34 group model, with the Extensive Services groups first.

There are two important issues that must be considered prior to using the RUG-III worksheet:

1. Checking **out-of-range** MDS data values.
2. Choosing **hierarchical versus index maximizing** RUG-III classification.

Our recommendations for handling these two issues are described below.
**OUT-OF-RANGE VALUES**

Out-of-range means that an item was answered with an invalid response. Consider an MDS assessment with an out-of-range value of "2" on the B1 comatose item (the valid values for this item are "0", "1", and ":-"). If an MDS record indicates the value of "2" as the response for item B1 comatose, it is impossible to determine the actual RUG-III classification. The standard State software will assign a default RUG-III classification of "BC1" to the record, and the default value may have an impact on Medicaid and Medicare PPS payments.

When using the attached worksheet, first determine if there are any RUG-III items that are out-of-range. If any out-of-range values are present, then the RUG-III classification would be BC1 (the default), and there is no reason to work through the rest of the steps in the worksheet. If there are no out-of-range values, then the worksheet should be used to determine the actual classification. The attached "Table of Valid RUG-III Item Ranges" gives the valid range of values for each of the 108 RUG-III items. Note that a value ":-" (dash) is allowed as valid for most items, this value indicating "unable to determine."

**HIERARCHICAL VERSUS INDEX MAXIMIZING**

There are two basic approaches to RUG-III classification: (1) hierarchical classification and (2) index maximizing classification. The present worksheet is focused on the hierarchical approach but can be adapted to the index maximizing approach.

**Hierarchical Classification.** The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top and work down through the RUG-III model, and the classification is the first group for which the resident qualifies. In other words, start with the Extensive groups at the top of the RUG-III model. Then you work your way down through the groups in hierarchical order: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. When you find the first of the 34 individual RUG-III groups for which the resident qualifies, then assign that group as the RUG-III classification and you are finished.

If the resident would qualify in one of the Extensive Services groups and also in a Rehabilitation group, always choose the Extensive Services classification, since it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearer the top of the model.

**Index Maximizing Classification.** Index maximizing classification is used in Medicare PPS and most Medicaid payment systems. For a specific payment system, there will be a designated Case Mix Indices (CMI) for each RUG-III group. The first step in index maximizing is to determine all of the RUG-III groups for which the resident qualifies. Then from the qualifying groups you choose the RUG-III group that has the highest case mix...
index. Index maximizing classification is simply choosing the group with the highest index.

While the present worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. To index maximize, you would evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, you again start at the beginning of the worksheet. You then work down through all of the 34 RUG-III classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When you finish, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index maximized classification for the resident.

If the resident would qualify in one of the Extensive Services groups and a Rehabilitation group choose the RUG-III classification with the higher CMI. Likewise, if the resident qualifies for Special Care and Clinically Complex, again choose the RUG-III classification with the higher CMI. Always select the classification with the highest CMI.
## TABLE OF VALID RUG-III ITEM RANGES

<table>
<thead>
<tr>
<th>RUG-III Items</th>
<th>Valid Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aa8b</td>
<td>1,2,3,4,5,6,7,8 or blank</td>
</tr>
<tr>
<td>B1</td>
<td>0,1,-</td>
</tr>
<tr>
<td>B2a</td>
<td>0,1,- or blank</td>
</tr>
<tr>
<td>B4,C4</td>
<td>0,1,2,3,- or blank</td>
</tr>
<tr>
<td>E1a,E1b,E1c,E1d,E1e,E1f,E1g, E1h,E1i,E1j,E1k,E1l,E1m, E1n,E1o,E1p</td>
<td>0,1,2,- or blank</td>
</tr>
<tr>
<td>E4aA,E4bA,E4cA,E4dA,E4eA</td>
<td>0,1,2,3,- or blank</td>
</tr>
<tr>
<td>G1aA,G1bA,G1hA,G1iA</td>
<td>0,1,2,3,4,8,-</td>
</tr>
<tr>
<td>G1aB,G1bB,G1iB</td>
<td>0,1,2,3,8,-</td>
</tr>
<tr>
<td>H3a,H3b</td>
<td>0,1,-</td>
</tr>
<tr>
<td>I1a,I1r,I1s,I1v,I1w,I1z</td>
<td>0,1,2,3,4,5,- or blank</td>
</tr>
<tr>
<td>I2e,I2g</td>
<td>0,1,2,3,4,5,- or blank</td>
</tr>
<tr>
<td>J1c,J1e,J1h,J1i,J1j,J1o</td>
<td>0,1,2,3,4,5,6,7,8,9,-</td>
</tr>
<tr>
<td>K3a</td>
<td>0,1,-</td>
</tr>
<tr>
<td>K5a,K5b</td>
<td>0,1,2,3,4,- or blank</td>
</tr>
<tr>
<td>K6a</td>
<td>0,1,2,3,4,- or blank</td>
</tr>
<tr>
<td>K6b</td>
<td>0,1,2,3,4,5,- or blank</td>
</tr>
<tr>
<td>M1a,M1b,M1c,M1d</td>
<td>0,1,2,3,4,5,6,7,8,9,-</td>
</tr>
<tr>
<td>M2a</td>
<td>0,1,2,3,4,-</td>
</tr>
<tr>
<td>M4b,M4c,M4g</td>
<td>0,1,-</td>
</tr>
<tr>
<td>M5a,M5b,M5c,M5d,M5e,M5f,M5g,M5h</td>
<td>0,1,2,3,4,5,6,7,8,9,-</td>
</tr>
<tr>
<td>M6b,M6c,M6f</td>
<td>0,1,2,3,4,5,6,7,8,9,-</td>
</tr>
<tr>
<td>N1a,N1b,N1c</td>
<td>0,1,2,3,4,5,6,7,-</td>
</tr>
<tr>
<td>O3</td>
<td>0,1,2,3,4,5,6,7,-</td>
</tr>
<tr>
<td>P1aa,P1ab,P1ac,P1ag,P1ah, P1ai,P1aj,P1ak,P1al</td>
<td>0,1,-</td>
</tr>
<tr>
<td>P1baA,P1bbA,P1bcA,P1bdA</td>
<td>0,1,2,3,4,5,6,7,-</td>
</tr>
<tr>
<td>P1baB,P1bbB,P1bcB</td>
<td>0000 thru 9999 or ----</td>
</tr>
<tr>
<td>P3a,P3b,P3c,P3d,P3e,P3f,P3g, P3h,P3i,P3j</td>
<td>0,1,2,3,4,5,6,7,-</td>
</tr>
<tr>
<td>P7</td>
<td>00 thru 14 or --</td>
</tr>
<tr>
<td>P8</td>
<td>00 thru 14 or --</td>
</tr>
<tr>
<td>T1b</td>
<td>0,1,- or blank</td>
</tr>
<tr>
<td>T1c</td>
<td>00 thru 15 or -- or blank</td>
</tr>
<tr>
<td>T1d</td>
<td>0000 thru 9999 or ---- or blank</td>
</tr>
</tbody>
</table>
CALCULATION OF TOTAL "ADL" SCORE  
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

The ADL score is used in all determinations of a resident's placement in a RUG-III category. It is a very important component of the classification process.

► **STEP # 1**  
To calculate the ADL score use the following chart for G1a (bed mobility), G1b (transfer), and G1i (toilet use). **Enter the ADL scores to the right.**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>ADL score</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>-, 0 or 1</td>
<td>and (any number)</td>
<td>= 1</td>
<td>G1a=</td>
</tr>
<tr>
<td>2</td>
<td>and (any number)</td>
<td>= 3</td>
<td>G1b=</td>
</tr>
<tr>
<td>3, 4, or 8</td>
<td>and -, 0, 1 or 2</td>
<td>= 4</td>
<td>G1i=</td>
</tr>
<tr>
<td>3, 4, or 8</td>
<td>and 3 or 8</td>
<td>= 5</td>
<td></td>
</tr>
</tbody>
</table>

► **STEP # 2**  
If K5a (parenteral/IV) is checked, the eating ADL score is 3. If K5b (feeding tube) is checked and EITHER (1) K6a is 51 % or more calories OR (2) K6a is 26% to 50% calories and K6b is 501cc or more per day fluid enteral intake, then the eating ADL score is 3. **Enter the ADL eating score (G1h) below and total the ADL score. If not, go to Step #3.**

► **STEP # 3**  
If neither K5a nor K5b (with appropriate intake) are checked, evaluate the chart below for G1hA (eating self-performance). **Enter the score to the right and total the ADL score.** This is the RUG-III **TOTAL ADL SCORE.** (The total ADL score range possibilities are 4 through 18.)

<table>
<thead>
<tr>
<th>Column A (G1h)</th>
<th>ADL score</th>
<th>EATING SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>-, 0 or 1</td>
<td>= 1</td>
<td>G1h=</td>
</tr>
<tr>
<td>2</td>
<td>= 2</td>
<td></td>
</tr>
<tr>
<td>3, 4, or 8</td>
<td>= 3</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL RUG-III ADL SCORE**

Other ADLs are also very important, but the researchers have determined that the late loss ADLs were more predictive of resource use. They determined that allowing for the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.
**CATEGORY I: EXTENSIVE SERVICES**

**RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION**

The classification groups in this hierarchy are based on various services provided. Use the following instructions to begin the calculation:

▶ **STEP # 1**

Is the resident coded for receiving one or more of the following extensive services?

- K5a Parenteral / IV
- P1ac IV medication
- P1ai Suctioning
- P1aj Tracheostomy care
- P1al Ventilator or respirator

If the resident does not receive one of the above, **skip to Category II now**.

▶ **STEP # 2**

If at least one of the above treatments is coded then examine the total RUG-III ADL score.

a. If the total RUG-III ADL score is 7 or more, then the resident classifies as Extensive Services. **Move to Step #3**.

b. If the resident's ADL score is 6 or less, **skip to Category II now** to determine if the resident will qualify for a Rehabilitation group. If the resident does not qualify for Rehabilitation then they will automatically qualify for Special Care (SSA).

▶ **STEP # 3**

The resident classifies in the Extensive Services category. To complete the scoring, however, an extensive count will need to be determined. If K5a (Parenteral IV) is checked, add 1 to the extensive count below. If P1ac (IV Medication) is checked, add 1 to the extensive count below. To complete the extensive count, determine if the resident also meets the criteria for Special Care, Clinically Complex, and Impaired Cognition. The final split into either SE1, SE2, or SE3 will be completed after these criteria have been scored. **Go to Category III, Step #3 now**.

- K5a Parenteral / IV
- P1ac IV Medication

**Extensive Count**

*(Enter this count in Step #4 on Page 17.)*
CATEGORY II: REHABILITATION
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical, occupational, or speech therapy. This information is found in Section P1b. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in Section P3 and H3a,b of the MDS Version 2.0.

► STEP # 1
Sum the therapy minutes in section P1b (a,b,c). If the total number of therapy minutes is less than 45 minutes, the resident does not classify in the Rehabilitation Category. Skip to Category III now.

► STEP # 2
If the total number of therapy minutes is equal to or greater than 45 minutes, use the following to complete the Rehabilitation Classification.

Rehabilitation Criteria (section P1b [a,b,c])
In the last 7 days:
Received 150 or more minutes AND
At least 5 days of any combination of the 3 disciplines OR

Alternative Rehabilitation Criteria (section P1b [a,b,c,] and P3)
In the last 7 days:
Received 45 or more minutes
At least 3 days of any combination of the 3 disciplines
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days
*Nursing Rehabilitation Services

**H3a,b**
Any scheduled toileting program and/or bladder retraining program

**P3a,b**
Passive and/or active ROM

**P3c**
Splint or brace assistance

**P3d,f**
Bed mobility and/or walking training

**P3e**
Transfer training

**P3g**
Dressing or grooming training

**P3h**
Eating or swallowing training

**P3i**
Amputation/Prosthesis care

**P3j**
Communication training

**Count as one service even if both provided**

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>17-18</td>
<td>RAD</td>
</tr>
<tr>
<td>14-16</td>
<td>RAC</td>
</tr>
<tr>
<td>10-13</td>
<td>RAB</td>
</tr>
<tr>
<td>4-9</td>
<td>RAA</td>
</tr>
</tbody>
</table>

**RUG-III Classification**

If the resident does not classify in the Rehabilitation Category, *skip to Category III.*
CATEGOR I II: SPECIAL CARE
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this hierarchy are based on certain resident conditions. Note: Residents receiving extensive services but with an ADL score of 6 or less also qualify in this hierarchy. Use the following instructions:

▶ STEP # 1
Determine if the resident is receiving one or more of the extensive services.

- K5a Parenteral / IV
- P1ac IV Medication
- P1ai Suctioning
- P1aj Tracheostomy Care
- P1al Ventilator or Respirator

▶ STEP # 2
If at least one of the extensive services is received, then the resident qualifies for the Special Care category. Go to Step #6. If none of the extensive services are received then, go to Step #3.

▶ STEP # 3
Determine if the resident is coded for one of the following special care conditions:

- I1s Cerebral palsy, with ADL sum >=10
- I1w Multiple sclerosis, with ADL sum >=10
- I1z Quadriplegia, with ADL sum >=10
- J1h Fever and one of the following:
  - I2e Pneumonia
  - J1c Dehydration
  - J1o Vomiting
  - K3a Weight loss
  - K5b Tube feeding*
  - K5b, I1r Tube feeding* and aphasia
- M1a,b,c,d Ulcers 2+ sites over all stages with 2 or more skin treatments**
- M2a Any stage 3 or 4 pressure ulcer with 2 or more skin treatments**
- M4g,M4c Surgical wounds or open lesions with 1 or more skin treatments***
- P1ah Radiation treatment
- P1bdA Respiratory therapy =7 days

*Tube feeding classification requirements:
(1) K6a is 51% or more calories OR
(2) K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake in the last 7 days.
**CATEGORY III: SPECIAL CARE**

RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this hierarchy are based on certain resident conditions.

**Note:** Residents receiving extensive services but with an ADL score of 6 or less also qualify in this hierarchy.

**Use the following instructions:**

1. **STEP # 1**
   - Determine if the resident is receiving one or more of the extensive services.
     - K5a Parenteral / IV
     - P1ac IV Medication
     - P1ai Suctioning
     - P1aj Tracheostomy Care
     - P1al Ventilator or Respirator

2. **STEP # 2**
   - If at least one of the extensive services is received, then the resident qualifies for the Special Care category. Go to Step #6.
   - If none of the extensive services are received, then, go to Step #3.

3. **STEP # 3**
   - Determine if the resident is coded for one of the following special care conditions:
     - I1s Cerebral palsy, with ADL sum >=10
     - I1w Multiple sclerosis, with ADL sum >=10
     - I1z Quadriplegia, with ADL sum >=10
     - J1h Fever and one of the following:
       - I2e Pneumonia
       - J1c Dehydration
       - J1o Vomiting
       - K3a Weight loss
       - K5b Tube feeding*
       - K5b, I1r Tube feeding* and aphasia
     - M1a,b,c,d Ulcers 2+ sites over all stages with 2 or more skin treatments**
     - M2a Any stage 3 or 4 pressure ulcer with 2 or more skin treatments**
     - M4g,M4c Surgical wounds or open lesions with 1 or more skin treatments***
     - P1ah Radiation treatment
     - P1bdA Respiratory therapy =7 days

   *Tube feeding classification requirements:
   - (1) K6a is 51% or more calories
   - (2) K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake

4. **STEP # 4**
   - If at least one of the special care conditions in Step #3 above is met:
     - a. If the resident previously qualified for Extensive Service, proceed to Extensive Count Determination. Go to Step #5. OR
     - b. If the RUG-III ADL score is 7 or more, the resident classifies as Special Care. Go to Step #6. OR
     - c. If the RUG-III ADL score is 6 or less, the resident classifies as Clinically Complex. Skip to Category IV, Step #4.

5. **STEP # 5 (Extensive Count Determination)**
   - If the resident previously met the criteria for the Extensive Services category and the evaluation of the Special Care category is done only to determine if the resident is an SE1, SE2, or SE3, enter 1 for the extensive count below if the evaluation met at least one of the special care criteria and skip to Category IV, Step #1.

   **Extensive Count**

   (Enter this count in Step #4 on Page 17.)

---

**Skin treatments:**

- **M5a, b** Pressure relieving chair and/or bed
- **M5c** Turning/repositioning
- **M5d** Nutrition or hydration intervention
- **M5e** Ulcer care
- **M5g** Application of dressings (not to feet)
- **M5h** Application of ointments (not to feet)

**Skin Treatments**

- **M5f** Surgical wound care
- **M5g** Application of dressing (not to feet)
- **M5h** Application of ointments (not to feet)

If the resident does not have one of the above special care conditions skip to Category IV now.

**STEP # 4**

If at least one of the special care conditions in Step #3 above is met:

- a. If the resident previously qualified for Extensive Service, proceed to Extensive Count Determination. **Go to Step #5. OR**
- b. If the RUG-III ADL score is 7 or more, the resident classifies as Special Care. **Go to Step #6. OR**
- c. If the RUG-III ADL score is 6 or less, the resident classifies as Clinically Complex. **Skip to Category IV, Step #4.**

**STEP # 5 (Extensive Count Determination)**

If the resident previously met the criteria for the Extensive Services category and the evaluation of the Special Care category is done only to determine if the resident is an SE1, SE2, or SE3, enter 1 for the extensive count below if the evaluation met at least one of the special care criteria and skip to Category IV, Step #1.

**Extensive Count**

(Enter this count in Step #4 on Page 17.)
STEP # 6
If (1) at least one of the extensive services is coded (Step #1) OR (2) at least one of the special care conditions above is coded (Step #3) and the RUG-III ADL score is 7 or more, the resident classifies in the Special Care category. Select the Special Care classification below based on the ADL score and record this classification:

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 - 18</td>
<td>SSC</td>
</tr>
<tr>
<td>15 - 16</td>
<td>SSB</td>
</tr>
<tr>
<td>7 - 14</td>
<td>SSA</td>
</tr>
</tbody>
</table>

Record the appropriate Special Care classification:

RUG-III CLASSIFICATION

_______
**CATEGORY IV: CLINICALLY COMPLEX**

**RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION**

The classification groups in this category are based on certain resident conditions. Use the following instructions:

► **STEP # 1**

Determine if the resident is coded for **one** of the following conditions:

- **B1** Coma and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA= 4 or 8)
- **I1a, O3, P8** Diabetes mellitus and injection 7 days and Physician order changes >= 2 days
- **I1v** Hemiplegia with ADL sum >=10
- **I2e** Pneumonia
- **I2g** Septicemia
- **J1c** Dehydration
- **J1j** Internal bleeding
- **K5b** Tube feeding*
- **M4b** Burns
- **M6b,c,f** Infection of foot (M6b orM6c) with treatment in M6f
- **P1aa** Chemotherapy
- **P1ab** Dialysis
- **P1ag** Oxygen therapy
- **P1ak** Transfusions
- **P7, P8** Number of Days in last 14, Physician Visit/order changes: Visits >= 1 day and changes >= 4 days  **OR**

Visits >= 2 days and changes >= 2 days

*Tube feeding classification requirements

(1)  **K6a** is 51% or more calories  **OR**

(2)  **K6a** is 26% to 50% calories and **K6b** is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of the above conditions, **skip to Category V** now.

► **STEP # 2**

If at least one of the clinically complex conditions above is met:

a. Extensive Count Determination. **Go to Step #3**  **OR**

b. Clinically Complex classification. The resident classifies as Clinically Complex. **Go to Step #4.**
**STEP # 3 (Extensive Count Determination)**
If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Clinically Complex category is done only to determine if the resident is an SE1, SE2, or SE3, enter 1 for the extensive count below if the evaluation met at least one of the clinically complex criteria and skip to Category V Step #1.

**Extensive Count __________**  
*(Enter this count in Step #4 on Page 17.)*

**STEP # 4**
Evaluate for Depression. Signs and symptoms of a depressed or sad mood are used as a third level split for the Clinically Complex category. Residents with a depressed or sad mood are identified by the presence of a combination of symptoms, as follows:

Count the number of indicators of depression. The resident is considered depressed if he/she has at least 3 of the following:

(Indicator exhibited in last 30 days and coded "1" or "2")
- E1a Negative statements
- E1b Repetitive questions
- E1c Repetitive verbalization
- E1d Persistent anger with self and others
- E1e Self deprecation
- E1f Expressions of what appear to be unrealistic fears
- E1g Recurrent statements that something terrible is going to happen
- E1h Repetitive health complaints
- E1i Repetitive anxious complaints/concerns  
  *(Non-health related)*
- E1j Unpleasant mood in morning
- E1k Insomnia/changes in usual sleep pattern
- E1l Sad, pained, worried facial expression
- E1m Crying, tearfulness
- E1n Repetitive physical movements
- E1o Withdrawal from activities of interest
- E1p Reduced social interaction

Does the resident have 3 or more indicators of depression?  **YES____NO____**
**STEP # 5**
Assign the Clinically Complex category based on both the ADL score and the presence or absence of depression.

<table>
<thead>
<tr>
<th><strong>RUG-III ADL Score</strong></th>
<th><strong>Depressed</strong></th>
<th><strong>RUG-III Class</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>17 - 18</td>
<td>YES</td>
<td>CC2</td>
</tr>
<tr>
<td>17 - 18</td>
<td>NO</td>
<td>CC1</td>
</tr>
<tr>
<td>12 - 16</td>
<td>YES</td>
<td>CB2</td>
</tr>
<tr>
<td>12 - 16</td>
<td>NO</td>
<td>CB1</td>
</tr>
<tr>
<td>4 - 11</td>
<td>YES</td>
<td>CA2</td>
</tr>
<tr>
<td>4 - 11</td>
<td>NO</td>
<td>CA1</td>
</tr>
</tbody>
</table>

**RUG-III CLASSIFICATION** _______
CATEGORY V: IMPAIRED COGNITION
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

► STEP # 1
Determine if the resident is cognitively impaired according to the RUG-III Cognitive Performance Scale (CPS). The resident is cognitively impaired if one of the three following conditions exists:

(1) B1 Coma and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA = 4 or 8) and B4 is blank or unknown (value ",\n"
)
(2) B4 Severely impaired cognitive skills (B4 = 3)
(3) B2a, B4, C4 These three items (B2a, B4, and C4) are all assessed with none being blank or unknown (N/A)

AND
Two or more of the following impairment indicators are present

- B2a = 1 Short term memory problem
- B4 > 0 Cognitive skills problem
- C4 > 0 Problem being understood

AND
One or more of the following severe impairment indicators are present:

- B4 >= 2 Severe cognitive skills problem
- C4 >= 2 Severe problem being understood

If the resident does not meet the criteria for cognitively impaired:

a. and the evaluation is being done to determine if the resident is in SE1, SE2, or SE3, skip to Step #4 on Page 17, "Category II: Extensive Services (cont.)."
b. Skip to Category VI now.

► STEP # 2
If the resident meets the criteria for cognitive impairment:

a. Extensive Count Determination. Go to Step #3. OR
b. The resident classifies as Impaired Cognition. Go to Step #4.
STEP # 3 (Extensive Count Determination)
If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Impaired Cognition category is done to determine if the resident is in SE1, SE2, or SE3, enter 1 for the extensive count below if the evaluation met at least one of the impaired cognition criteria and skip to Step #4 on Page 17, "Category II: Extensive Services (cont.)".

Extensive Count __________
(Enter this count in Step #4 on Page 17.)

STEP # 4
The resident’s total RUG-III ADL score must be 10 or less to be classified in the RUG-III Impaired Cognition categories. If the ADL score is greater than 10, skip to Category VII now. If the ADL score is 10 or less and one of the impaired cognition conditions above is present, then the resident classifies as Impaired Cognition. Proceed with Step #5.

STEP # 5
Determine Nursing Rehabilitation Count
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:
Enter the nursing rehabilitation count to the right.

| H3a,b* | Any scheduled toileting program and/or bladder retraining program |
| P3a,b* | Passive and/or active ROM |
| P3c  | Splint or brace assistance |
| P3d,f* | Bed mobility and/or walking training |
| P3e  | Transfer training |
| P3g  | Dressing or grooming training |
| P3h  | Eating or swallowing training |
| P3i  | Amputation/Prosthesis care |
| P3j  | Communication training |

*Count as one service even if both provided

Nursing Rehabilitation Count ______

STEP # 6
Select the final RUG-III classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>Nursing Rehabilitation</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 10</td>
<td>2 or more</td>
<td>IB2</td>
</tr>
<tr>
<td>6 - 10</td>
<td>0 or 1</td>
<td>IB1</td>
</tr>
<tr>
<td>4 - 5</td>
<td>2 or more</td>
<td>IA2</td>
</tr>
<tr>
<td>4 - 5</td>
<td>0 or 1</td>
<td>IA1</td>
</tr>
</tbody>
</table>

RUG-III CLASSIFICATION ______
CATEGORY II: EXTENSIVE SERVICES (cont.)
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

If the resident previously met the criteria for the Extensive Services category with an ADL score of 7 or more, complete the Extensive Services classification here.

► **STEP # 4 (Extensive Count Determination)**
Complete the scoring of the Extensive Services by summing the extensive count items:

<table>
<thead>
<tr>
<th>Page</th>
<th>Extensive Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Extensive Count - Extensive Services</td>
</tr>
<tr>
<td>10</td>
<td>Extensive Count - Special Care</td>
</tr>
<tr>
<td>13</td>
<td>Extensive Count - Clinically Complex</td>
</tr>
<tr>
<td>16</td>
<td>Extensive Count - Impaired Cognition</td>
</tr>
</tbody>
</table>

Total Extensive Count ____________

Select the final Extensive Service classification using the Total Extensive Count.

<table>
<thead>
<tr>
<th>Extensive Count</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 or 5</td>
<td>SE3</td>
</tr>
<tr>
<td>2 or 3</td>
<td>SE2</td>
</tr>
<tr>
<td>0 or 1</td>
<td>SE1</td>
</tr>
</tbody>
</table>

RUG-III CLASSIFICATION ______
**CATEGORY VI: BEHAVIOR PROBLEMS**

*RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION*

► **STEP # 1**  
The resident's total RUG-III ADL score must be 10 or less. **If the score is greater than 10, skip to Category VII now.**

► **STEP # 2**  
**One** of the following must be met:  
- E4aA  Wandering (2 or 3)  
- E4bA  Verbal abuse (2 or 3)  
- E4cA  Physical abuse (2 or 3)  
- E4dA  Inappropriate behavior (2 or 3)  
- E4eA  Resisted care (2 or 3)  
- J1e  Delusions  
- J1i  Hallucinations

If the resident does not meet one of the above, **skip to Category VII now.**

► **STEP # 3**  
**Determine Nursing Rehabilitation**  
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:  

*Enter the nursing rehabilitation count to the right.*  
- H3a,b* Any scheduled toileting program and/or bladder retraining program  
- P3a,b* Passive and/or active ROM  
- P3c  Splint or brace assistance  
- P3d,f* Bed mobility and/or walking training  
- P3e  Transfer training  
- P3g  Dressing or grooming training  
- P3h  Eating or swallowing training  
- P3i  Amputation/Prosthesis care  
- P3j  Communication training  

*Count as one service even if both provided.*

Nursing Rehabilitation Count ______
**STEP # 4**
Select the final RUG-III classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>Nursing Rehabilitation</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 10</td>
<td>2 or more</td>
<td>BB2</td>
</tr>
<tr>
<td>6 - 10</td>
<td>0 or 1</td>
<td>BB1</td>
</tr>
<tr>
<td>4 - 5</td>
<td>2 or more</td>
<td>BA2</td>
</tr>
<tr>
<td>4 - 5</td>
<td>0 or 1</td>
<td>BA1</td>
</tr>
</tbody>
</table>

**RUG-III CLASSIFICATION** _______
CATEGORY VII: REDUCED PHYSICAL FUNCTIONS
RUG-III, 34 GROUP HIERARCHICAL CLASSIFICATION

► STEP # 1
Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Impaired Cognition or Behavior Problems categories but have a RUG-III ADL score greater than 10, are placed in this category.

► STEP # 2
Determine Nursing Rehabilitation
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

- **H3a,b*** Any scheduled toileting program and/or
  bladder retraining program
- **P3a,b*** Passive and/or active ROM
- **P3c** Splint or brace assistance
- **P3d,f*** Bed mobility and/or walking training
- **P3e** Transfer training
- **P3g** Dressing or grooming training
- **P3h** Eating or swallowing training
- **P3i** Amputation/Prosthesis care
- **P3j** Communication training

*Count as one service even if both provided

Nursing Rehabilitation Count ______
**STEP # 3**
Select the RUG-III classification by using the RUG-III ADL score and the Nursing Rehabilitation Count.

<table>
<thead>
<tr>
<th>RUG-III ADL Score</th>
<th>Nursing Rehabilitation</th>
<th>RUG-III Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 18</td>
<td>2 or more</td>
<td>PE2</td>
</tr>
<tr>
<td>16 - 18</td>
<td>0 or 1</td>
<td>PE1</td>
</tr>
<tr>
<td>11 - 15</td>
<td>2 or more</td>
<td>PD2</td>
</tr>
<tr>
<td>11 - 15</td>
<td>0 or 1</td>
<td>PD1</td>
</tr>
<tr>
<td>9 - 10</td>
<td>2 or more</td>
<td>PC2</td>
</tr>
<tr>
<td>9 - 10</td>
<td>0 or 1</td>
<td>PC1</td>
</tr>
<tr>
<td>6 - 8</td>
<td>2 or more</td>
<td>PB2</td>
</tr>
<tr>
<td>6 - 8</td>
<td>0 or 1</td>
<td>PB1</td>
</tr>
<tr>
<td>4 - 5</td>
<td>2 or more</td>
<td>PA2</td>
</tr>
<tr>
<td>4 - 5</td>
<td>0 or 1</td>
<td>PA1</td>
</tr>
</tbody>
</table>

**RUG-III CLASSIFICATION**

The tables below are an excerpt from Chapter 6 of the Resident Assessment Instrument Manual from the Federal CMS.

### EIGHT MAJOR RUG-III CLASSIFICATION GROUPS

<table>
<thead>
<tr>
<th>MAJOR RUG-III GROUP</th>
<th>CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Plus Extensive Services</td>
<td>Residents receiving physical, speech or occupational therapy AND receiving IV feeding or medications, suctioning, tracheostomy care, or ventilator/respirator. This group is not used in the 34 Group Model.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Residents receiving physical, speech or occupational therapy.</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications, suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the resident eligible for other RUG categories.</td>
</tr>
<tr>
<td>Special Care</td>
<td>Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding.</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot infections or wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes.</td>
</tr>
<tr>
<td>Impaired Cognition</td>
<td>Residents having cognitive impairment in decision-making, recall and short-term memory. (Score on MDS 2.0 cognitive performance scale &gt;=3).</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>Residents displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions</td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td>Residents whose needs are primarily for activities of daily living and general supervision.</td>
</tr>
<tr>
<td>Case Mix Index Array Element</td>
<td>RUG Group Value</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Extensive Services Groups</strong></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>SE3</td>
</tr>
<tr>
<td>25</td>
<td>SE2</td>
</tr>
<tr>
<td>26</td>
<td>SE1</td>
</tr>
<tr>
<td><strong>Rehabilitation Groups for the 34 group model</strong></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>RAD</td>
</tr>
<tr>
<td>28</td>
<td>RAC</td>
</tr>
<tr>
<td>29</td>
<td>RAB</td>
</tr>
<tr>
<td>30</td>
<td>RAA</td>
</tr>
<tr>
<td><strong>Remaining Groups</strong></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>SSC</td>
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<tr>
<td>32</td>
<td>SSB</td>
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<td>49</td>
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<td>50</td>
<td>PD2</td>
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<td>PA2</td>
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<tr>
<td>57</td>
<td>PA1</td>
</tr>
<tr>
<td>58</td>
<td>BC1</td>
</tr>
</tbody>
</table>
Helpful Telephone Numbers

TMHP Long Term Care Department ...................................................... Telephone: 1-800-727-5436/1-800-626-4117
Fax: 1-512-514-4223
General Inquiries: Press 1
Medical Necessity: Press 2
Technical Support: Press 3
Audio Message Paper Submitters: Press 4
Fair Hearing: Press 5

Medicaid Hotline ................................................................. 1-800-252-8263
RUG Training Information .......................................................... 1-512-245-7118
EDI Help Desk ................................................................. 1-888-863-3638
LTC Helpdesk .................................................................................. 1-800-626-4117
TMHP General Customer Service .............................................. 1-800-626-11
Medicaid Fraud ................................................................. 1-800-436-6184

Community Based Alternatives Program Contacts
  • Completing the MN and LOC Assessment: Contact your Regional Nurse

Consolidated Waiver Program Contacts
  • Completing the MN and LOC Assessment: 512-438-3444

Medically Dependent Children Program Contacts
  • Completing the MN and LOC Assessment: Contact the RLS State Office Nurse at 512-438-5724

Integrated Care Management
  • Business Rules Questions: 512-438-3169 or email Heather.Powell@hhsc.state.tx.us

PACE Program Contacts
  • Completing the MN and LOC Assessment: 512-438-2489

Star+Plus Program Contacts
  • Business Rule Questions: Contact David.H.Johnson@hhsc.state.tx.us

Questions regarding Medical Necessity Determinations and other RUG questions: Contact the Texas Medicaid & Healthcare Partnership at 1-800-727-5436
# Texas Health and Human Services Commission
## Office of Inspector General—Utilization Review Unit
### Regional Directory for RUG Questions

<table>
<thead>
<tr>
<th>City - Region</th>
<th>Address</th>
<th>Mail Code</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilene - 2</td>
<td>4601 S. First St., Ste H Abilene, TX 79605</td>
<td>001-6</td>
<td>1-325-795-5598</td>
<td>1-325-795-5604</td>
</tr>
<tr>
<td>Austin/Waco - 7</td>
<td>PO Box 977 Waco, TX 76703</td>
<td>942-1</td>
<td>1-254-750-9652</td>
<td>1-254-750-9698</td>
</tr>
<tr>
<td>Corpus Christi - 11</td>
<td>5155 Flynn Pkwy, Ste 211 Corpus Christi, TX 78411</td>
<td>073-4</td>
<td>1-361-878-3211</td>
<td>1-361-878-3298</td>
</tr>
<tr>
<td>Fort Worth - 3</td>
<td>1501 Circle Drive, Ste 155-B Fort Worth, TX 76119</td>
<td>128-9</td>
<td>1-817-321-8116</td>
<td>1-817-321-8113</td>
</tr>
<tr>
<td>Houston - 6</td>
<td>P.O. Box 16017 Houston, TX 77222</td>
<td>179-1</td>
<td>1-713-735-8310 / 1-713-735-8376</td>
<td>1-713-735-8905</td>
</tr>
<tr>
<td>San Antonio - 8</td>
<td>P.O. Box 23990 San Antonio, TX 78223</td>
<td>280-3</td>
<td>1-210-431-8759</td>
<td>1-210-431-2377</td>
</tr>
</tbody>
</table>
Informational Websites

Texas Department of Aging and Disability Services: www.dads.state.tx.us
DADS Services: www.dads.state.tx.us/services
Long Term Care Policies: www.dads.state.tx.us/providers/index.cfm
Medicaid Nursing Facility Program: www.dads.state.tx.us/providers/NF/index.cfm
Community Care Programs: www.dads.state.tx.us/providers/index.cfm
Consumer Rights and Services (includes information about how to make a complaint): www.dads.state.tx.us/news_info/report_problems.html
Health and Human Services Commission: www.hhsc.state.tx.us
HHSC Regions: www.hhsc.state.tx.us/about_hhsc/hhs_regions.html
Vendor Drug Program: www.hhsc.state.tx.us/hcf/vdp/vdpstart.html
Medicaid Fraud: https://oig.hhsc.state.tx.us/
Texas Administration Code: www.sos.state.tx.us/tac/index.html
Centers for Medicare and Medicaid Services: www.cms.gov
Texas Department of State Health Services: www.dshs.state.tx.us
Texas Medicaid & Healthcare Partnership (TMHP): www.tmhp.com
TMHP Long Term Care Division: www.tmhp.com/LTC Programs
RUG Training: www.txstate.edu/continuinged/programs/RUG-Training.html
Medical Necessity and Level of Care Assessment and Instructions: https://www.tmhp.com/LTC%20Programs/default.aspx
TILEs to RUGs Questions: E-mail: RUGS@dads.state.tx.us
TILEs to RUGs Information: http://www.dads.state.tx.us/providers/tilestorugs

Note: All DADS provider information can be found at www.dads.state.tx.us/providers/index.cfm. Please choose your particular provider type for available online resources.
Medical Necessity Determination

Questionable Medical Necessity

A Medical Necessity and Level of Care Assessment “pending denial” status on your Forms Status Inquiry/Current Activity Reports. Questionable medical necessity can be approved when:

- The individual’s condition indicates an unstable medical condition or
- The individual’s condition indicates that the individual has impaired cognitive abilities and is unable to monitor significant medical conditions or medications.

Other Considerations

Some reasons that assessments are put in pending denial include the following:

- Conflicting information on RUG fields, diagnoses, medications, and the comments section
- There may not be additional information in the comments section that describes what licensed nursing care is being performed

Medical Necessity and Level of Care Assessment

It is essential that you include signs and symptoms that present an accurate picture of the individual’s condition. The comments section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:

- Pertinent medical history
- Ability to understand medications
- Ability to understand changes in condition
- Abnormal vital signs
- Previous attempts at outpatient management of medical condition
- Results of abnormal lab work

Please Remember:

- Any pertinent information that is not reflected should be addressed in the comments section.
- Documentation of altered mental acuity and/or cognitive functioning on the Medical Necessity and Level of Care Assessment is vital to determining medical necessity.
- Each assessment stands on its own and the approval determination is based on the information on the current Medical Necessity and Level of Care Assessment.
- Assessments placed in pending denial will remain in this status for a maximum of 21 days.
# Individual Service Plan (ISP) Table

## For CBA and CWP Providers

The due dates for the annual reassessment packets submitted by Home and Community Support Services (HCSS) agencies to the case managers are listed below.

**Note:** TMHP does not support any assessments other than the Medical Necessity & Level of Care Assessment.

The table below lists the reassessment due dates based on the date of the ISP expiration:

<table>
<thead>
<tr>
<th>ISP Expiration Date (&quot;To&quot; date on ISP)</th>
<th>Reassessment Packet Due to Case Manager Between</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 31</td>
<td>November 1 - November 30</td>
</tr>
<tr>
<td>February 28 or 29</td>
<td>December 1 - December 31</td>
</tr>
<tr>
<td>March 31</td>
<td>January 1 - January 31</td>
</tr>
<tr>
<td>April 30</td>
<td>February 1 - February 28 or 29</td>
</tr>
<tr>
<td>May 31</td>
<td>March 1 - March 31</td>
</tr>
<tr>
<td>June 30</td>
<td>April 1 - April 30</td>
</tr>
<tr>
<td>July 31</td>
<td>May 1 - May 31</td>
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<tr>
<td>August 31</td>
<td>June 1 - June 30</td>
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<tr>
<td>September 30</td>
<td>July 1 - July 31</td>
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<tr>
<td>October 31</td>
<td>August 1 - August 31</td>
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<td>September 1 - September 30</td>
</tr>
<tr>
<td>December 31</td>
<td>October 1 - October 31</td>
</tr>
</tbody>
</table>

Waiver Programs Quick Reference Guide - revised 6/16/2008