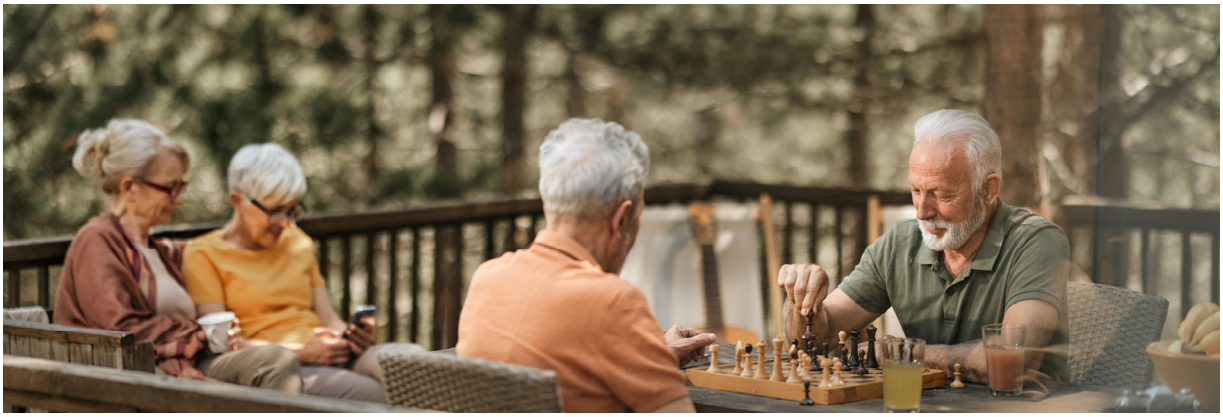

Missouri Medicaid Overview, Supportive Documentation Guidelines and Case Mix Review Preparedness

FORVIS **MAZARS** **Senior Living and Long-Term Care Group**

2025

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1

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2

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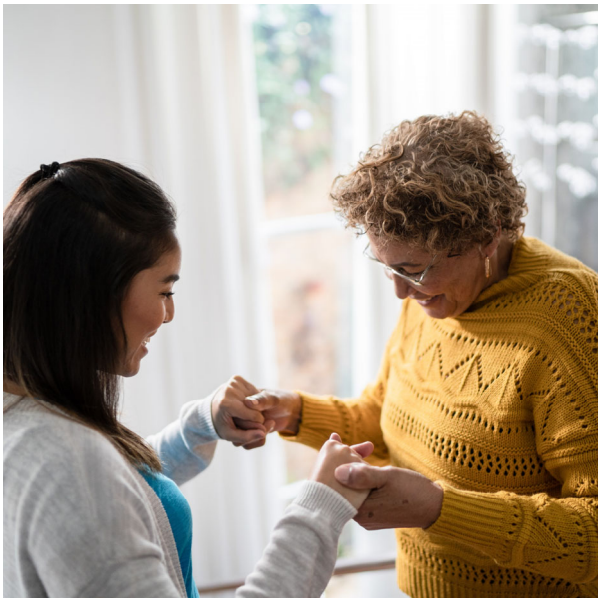
2

Our Agenda for Today

- CMI based on the Nursing Component of PDPM versus RUG IV – State average 1.19 – 1.20
- Clinical components Of Missouri Medicaid
- Missouri Medicaid Value Based Purchasing (VBP) Program – How to work toward success
- Case Mix Reviews – Being Prepared
- Strategies For Success



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3

Clinical Considerations for Medicaid (OBRA Assessments)

4

Questions for You:

- Has your Medicaid rate trended up or down since the inception of case mix in 2022?
- Do you apply a disciplined approach in monitoring and completing MDS assessments?
- What can be done moving forward to positively impact your Medicaid (and Medicare) rate?

5

Clinical Components Overview

Medicaid Plan transitioned from RUGS CMI to Nursing Component of PDPM effective 7/1/24

- **Six Major Classifications**
  - ❑Extensive Services
  - ❑Special Care High
  - ❑Special Care Low
  - ❑Clinically Complex
  - ❑Behavior Symptoms and Cognitive Performance
  - ❑Reduced Physical Function
- Each Major Classification contains specific qualifiers that include the Nursing Function Score calculated from Section GG of the MDS
- The CMI ranges from .62 to 3.84
- Each provider will continue to have an updated average CMI for their Medicaid population at each “snapshot” on January 1 and July 1

6

Extensive Services

Qualifiers:

- Tracheostomy
- Ventilator or Respirator
- Infectious Isolation
- All of the above are required during the look back period while a patient is in the facility

The Nursing Function Score must be 14 or below to qualify for this Major Classification

ES3:	Tracheostomy and Ventilator or Respirator	CMI - 3.84
ES2:	Tracheostomy or Ventilator or Respirator	CMI - 2.90
ES1:	Infectious Isolation	CMI - 2.77

7

Supporting Documentation for Extensive Services:

- Tracheostomy Care:
  - Documentation of ***"cleansing"*** of the tracheostomy and or cannula during the observation period
- Invasive Mechanical Ventilator:
  - Documentation of use of any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration.
- Isolation:
  - Active infection, precautions are over and above standard precautions, in a room along and all services are brought to the room.
    - Documentation of supporting infectious disease – symptomatic and or a positive test when in a contagious stage
    - Documentation of need for transmission-based precautions and strict isolation alone in a separate room.
    - Documentation of highly transmissible or epidemiologically significant pathogens acquired by physical contact, airborne or droplet precautions.

Worth Noting: During the Case Mix Reviews by M&S the trach care was disallowed because the order for "trach care" did not specifically indicate "cleansing" of the site and cannula. Isolation for COVID was disallowed because the isolation order and documentation did not support "droplet precautions"

8

Special Care High

Qualifiers - Receive one of the following with a Nursing Function Score of 14 or below:

- Comatose and completely dependent for functional tasks or the functional tasks did not occur
- Septicemia
- Diabetes with both daily insulin injections and two or more days of insulin order changes in the 7-day look back period
- Quadriplegia with a Nursing Function Score of 11 or below
- COPD and shortness of breath while lying flat
- Parenteral/IV feedings
- Respiratory therapy for all 7-days in the look back period
- Fever with one of the following: pneumonia, vomiting, weight loss or feeding tube

The PHQ score also impacts this major classification:

HDE2: Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI - 2.27
HDE1: Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI - 1.88
HBC2: Nursing Function Score 6-14- PHQ total severity score of 10 or greater	CMI - 2.12
HBC1: Nursing Function Score 6-14- PHQ total severity score of 9 or less	CMI - 1.76

9

Supporting Documentation for Special Care High

- Comatose, Septicemia, Diabetes, Quadriplegia, COPD, and Pneumonia : **Active diagnosis**: A physician documented diagnosis in the last 60 days and nursing monitoring or treatment in the 7-day look-back period
- Days of insulin injections and Days of insulin order changes: Documentation in the 7-day look-back period consistent with physician orders. Documentation to include the number of days the insulin orders were changed by the physician. Can include sliding scale if the order is new, discontinued or this is the first sliding scale order
- Shortness of breath while lying flat: Documentation of the presence of or observation of shortness of breath while lying flat in the observation period. Can include refusal of the resident to lay flat due to complaints of shortness of breath.
- Fever: 2.4 degrees above baseline or admitted with a temperature of at least 100.4 degrees
- Vomiting: Documentation of regurgitation of stomach contents in the observation period
- Weight loss: Weights both 30 days and/0r 180 days prior to current weight in the observation period.
- Feeding tube of 51% of total calories or 26% of total calories and at least 501cc of fluid via tube: Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, hospital or elsewhere, provided the documentation supports the need for nutrition and hydration
- Respiratory therapy: physician order specific to the resident's needs, documentation of actual minutes with signature, care planned documentation of education provided to nursing personnel and those who attended
- PHQ: Interview - Validation of completion of interview items D0150A-I at Z0400 on or before the ARD and within the observation period. Staff Assessment – Documentation of the date(s) staff member(s) interviewed across all shifts along with observations and frequency of each item D0150A - I

10

Special Care Low

Qualifiers: Received one of the following with a Nursing Function Score of 14 or below:

- Cerebral Palsy, Multiple Sclerosis or Parkinson's with a Nursing Function Score of 11 or less
- Respiratory failure with oxygen therapy while a resident
- Feeding Tube: at least 26% of total calories and 501(cc) via tube daily
- Stage 2, 3, and 4 pressure ulcers with two or more selected skin treatments
- Venous and arterial ulcers with two or more selected skin treatments
- Foot infections, diabetic foot ulcers and other open lesions of the foot with application of a dressing
- Radiation treatment while a resident
- Dialysis treatment while a resident (hemodialysis or peritoneal dialysis)

The PHQ Score impacts this major classification:

LDE2:	Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI -1.97
LDE1:	Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI -1.64
LBC2:	Nursing Function Score 6-14 - PHQ total severity score of 10 or greater	CMI -1.63
LBC1:	Nursing Function Score 6-14 - PHQ total severity score of 9 or less	CMI -1.35

11

Supporting Documentation for Special Care Low

- Cerebral Palsy, Multiple Sclerosis, Parkinson's Disease, Respiratory Failure: **Active Diagnosis** requirements
- Oxygen therapy: Documentation of administration of oxygen continuously or intermittently delivered for hypoxia during the observation period. If PRN oxygen use there must be **documentation of the precipitating event requiring the oxygen use.**
- Tube Feeding of 51% of total calories or 26% of total calories and at least 501cc of fluid – Documentation same as Special Care High
- Stage 2, 3, 4, or Unstageable pressure ulcers: Documentation of pressure ulcer(s)/injury withing the observation period must include but is not limited to; identification of wound as a pressure ulcer, location and description
- Venous or Arterial ulcers: Documentation must include with in the observation period the identification, location and description.
- Infection of the foot: Documentation of signs and symptoms of infection of the foot within the observation period
- Diabetic Foot Ulcer: Documentation of diabetic foot ulcer during the observation period must include but is not limited to the identification, location and description
- Other open lesion on the foot: Documentation must include location and description of the lesion and the lesion must be open during the observation period.
- Application of dressings to feel: Documentation of dressing changes to the feel during the observation period along with other interventions
- Radiation and Dialysis: Documentation must be provided that the resident **actually received the treatment** not just that they were transported out for the treatment.
- PHQ: Same as Special Care High requirements.

12

Clinically Complex

Qualifiers: The Nursing Function Score can be 0-16

- Pneumonia
- Hemiplegia/hemiparesis with a Nursing Function Score of 11 or less
- Surgical wound or open lesions with surgical wound care or application of a dressing or ointment other than to the feet
- Burns – second or third degree thermal or chemical
- Chemotherapy, oxygen therapy, IV medications or transfusion while a resident

The PHQ total severity score impacts this major classification

CDE2:	Nursing Function Score 0-5 - PHQ total severity score of 10 or greater	CMI - 1.77
CDE1:	Nursing Function Score 0-5 - PHQ total severity score of 9 or less	CMI - 1.53
CBC2:	Nursing Function Score 6-14 - PHQ total severity score of 10 or greater	CMI - 1.47
CBC1:	Nursing Function Score 6-14 - PHQ total severity score of 9 or less	CMI - 1.27
CA2:	Nursing Function Score 15-16 - PHQ total severity score of 10 or greater	CMI - 1.03
CA1:	Nursing Function Score 15-16 - PHQ total severity score of 9 or less	CMI - 0.89

13

Supporting Documentation for Clinically Complex

- Pneumonia, Hemiplegia/hemiparesis: **Active Diagnosis** documentation
- Open lesions other than ulcers, rashes or cuts: Documentation during the observation period must include but is not limited to location and description. Lesion must be open during the observation period.
- Surgical wound: Documentation of the surgical wound during the observation period must include but is not limited to identification of the wound as a surgical wound, location and description.
- Burns: Documentation of the description of the second or third degree burn during the observation period must include but is not limited to location and description.
- Chemotherapy: Documentation of administration of any type of chemotherapy agent given by any route for the sole purpose of cancer treatment during the observation period.
- Oxygen therapy: Documentation of administration of oxygen continuously or intermittently delivered to relieve hypoxia during the observation period. Documentation must include a precipitating even for PRN usage resulting in the application of oxygen.
- IV Medications: Documentation of the administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port during the observation period.
- Transfusions: Documentation of the administration of blood or any blood products directly into the bloodstream during the observation period.
- PHQ: Same requirements as in Special Care High

14

Behavioral Symptoms & Cognitive Impairment

Qualifiers: Must have a Nursing Function Score of 11-16 and BIMS Summary Score of 9 or less

One of the following exist:

- Comatose and completely functional task dependent
- Severely impaired cognitive skills for daily decision making
- Difficulty making self understood
- Short term memory impairment – MDS data elements C1000, B0700, C0700 depending on coding.

If none of the cognitive conditions are met, does the resident have the following:

- ✓ Hallucinations
- ✓ Delusions
- ✓ Physical/verbal behaviors directed toward others
- ✓ Other behaviors not directed at others
- ✓ Rejection of care
- ✓ Wandering

15

15

Behavioral Symptoms & Cognitive Impairment

Restorative Nursing Services impacts this major classification:

At least 6 days in the 7-day look back period, two or more programs for at least 15 minutes each per day.

BAB2: Nursing Function Score 11-16, Restorative Nursing qualifier	CMI value of 0.98
BAB1: Nursing Function Score 11-16, No Restorative Nursing qualifier	CMI value of 0.94

16

16

Supporting Documentation for Behavioral Symptoms and Cognitive Performance

- BIMS Interview: Validation of completion of interview items C0200, C0300A, B, C, C0400A, B, and C at Z0400 dated on or before the ARD and within the observation period.
- Comatose: Active Diagnosis requirement. All components of the nursing function score must = 1, 9, or 99
- Cognitive Skills for Daily Decision Making: Examples and dates of the resident's actual performance documenting the degree of compromised daily decision-making about everyday decisions for tasks of daily activities
- Makes Self Understood: Examples and dates of the resident's verbal and or non-verbal ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, gestures or a combination of these.
- Short-Term Memory: Examples and dates documenting the resident's ability to: describe an event 5 minutes after it occurred if their response can be validated OR follow through on a direction given 5 minutes earlier.
- Hallucinations, delusions, physical behaviors directed toward others, verbal behavior symptoms directed toward others, other behavioral symptoms not directed toward others, rejection of care, and wandering: Examples and dates of observations or of staff interviews regarding the specific behavioral symptoms listed above.
- Restorative Nursing: At least 6 days per week, 2 or more programs for at least 15 minutes each per day: See page 22-23 of the Myers & Stauffer Supportive Documentation Requirements for additional information

17

Reduced Physical Education

Qualifications: **Residents who do not meet any previous case mix group qualifiers.**

Restorative Nursing services impact this major classification:

At least 6 days in the 7-day look back period, two or more programs for at least 15 minutes each per day

➢ PDE2:	Nursing Function Score 0-5	Restorative Nursing qualifier	CMI - 1.48
➢ PDE1:	Nursing Function Score 0-5	No Restorative Nursing qualifier	CMI - 1.39
➢ PBC2:	Nursing Function Score 6-14	Restorative Nursing qualifier	CMI - 1.15
➢ PBC1:	Nursing Function Score 6-14	No Restorative Nursing qualifier	CMI - 1.07
➢ PA2:	Nursing Function Score 15-16	Restorative Nursing qualifier	CMI - 0.67
➢ PA1:	Nursing Function Score 15-16	No Restorative Nursing qualifier	CMI - 0.62

18

Section GG Functional Abilities and Goals Supportive Documentation Requirements

- **THIS WILL BE REQUIRED FOR EACH MDS ASSESSMENT IN THE CASE MIX REVIEWS**
- Documentation during the observation period to accurately capture resident usual performance
- Direct observations, resident self-reports, reports from qualified clinicians, care staff and family – documented in the medical record during the observation period
- Interdisciplinary team decision making on how each functional task should be coded to accurately capture the usual performance in the observation period. They will expect to see this information documented in the medical record.

19

GG Definitions for Functional Tasks

- Self-Care: **Eating** – Tube feedings and parenteral nutrition are not considered when coding this activity
- Self-Care: **Toilet Hygiene** – Managing clothing and perineal cleansing – takes place before and after the use of toilet, commode, bedpan or urinal
- Mobility: **Sit to Lying** – The ability to move from sitting on side of bed to lying flat on the bed
- Mobility: **Lying to sitting on side of bed** – The ability to move from lying to sitting on the side of the bed with no back support
- Mobility: **Sit to Stand** – The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
- Mobility: **Chair/bed to chair transfer** – The ability to transfer to and from a bed to a chair or wheelchair
- Mobility: **Toilet transfer** – The ability to get on and off a toilet or commode

20

Strategies for Success

MDS Accuracy

- Interdisciplinary team involvement with OBRA assessments just as if they were PPS assessments
- Strategic scheduling of assessments when approaching a "snapshot date":

January 1	MDS assessments with assessment reference dates October 1 – December 31
April 1	MDS assessments with assessment reference dates January 1 – March 31
July 1	MDS assessments with assessment reference dates April 1 – June 30
October 1	MDS assessments with assessment reference dates July 1 – September 30

- Monitor for changes in resident conditions that can impact CMI values:
  - Isolation
  - COPD with shortness of breath while lying flat
  - IV fluid administration in the facility or in the ER
  - Changes in skin conditions and treatments
  - PRN oxygen use
  - Changes in functional abilities that would impact the Nursing Function Score

21

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21

Strategies for Success

- Use clinical software to run reports when approaching a snapshot date to see the Nursing Component calculated from each resident's prior MDS assessment.
- Schedule a weekly meeting to discuss Medicaid patients and any changes in condition that would impact the CMI value from their prior MDS assessment. This could be in conjunction with care planning or an add on to the weekly Medicare Meeting.
- Use your MDS scheduler in the clinical software package to determine who will be discussed each week, just as used for care planning purposes.
- Become familiar with the Nursing Component major categories and the case mix groups and what items from the MDS are impactful to the case mix index values.

22

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22

Strategies for Success

- Educate the licensed nursing staff to provide more quality documentation for Medicaid residents especially with changes in condition or when approaching an ARD for OBRA assessments (admission, quarterly, annual and significant change in status).
- Determine if scheduled documentation for Medicaid residents would be beneficial to capturing information that impacts the CMI values
- Determine if developing a Medicaid documentation assessment would be beneficial to assist licensed nursing personnel to capture pertinent information that impacts the MDS data elements that impacts the case mix groups and subsequent case mix index values

23

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23

Value Based Purchasing Incentive

24

MDS Changes Impact Quality Measures:

- The below QMs were frozen from April 2024 – January 2025 due to the removal of Section G from the MDS October 1, 2023.
  - Percentage of Residents Who Made Improvements in Function (short stay)
  - Percent of Residents Whose Need for Help with ADLs has increased (long stay)
  - Percent of Residents Whose Ability to Move Independently Worsened (long stay)
  - Percent of High-Risk Residents with Pressure Ulcers (long stay)

25

Value Based Purchasing Incentive for Missouri Medicaid

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	<=10.0%	$3.04
Decline in Mobility on Unit	<=8.0%	$3.04
High-Risk Residents w/ Pressure Ulcers	<=2.7%	$3.04
Anti-psychotic Medications	<=6.8%	$3.04
Falls w/ Major Injury	<=1.3%	$3.04
In-dwelling Catheter	<=1.1%	$3.04
Urinary Tract Infection	<=1.9%	$3.04

26

Missouri VBP Incentive

A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies based on the total long stay quality measure cores calculated from the Five Star Rating System

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%

27

Section GG items for Decline in Late-Loss ADLs – Threshold <=10.0%

- GG0170B: Sit to lying
- GG0170D: Sit to stand
- GG0130A: Eating
- GG0170F: Toilet transfer
- Residents whose need for help with these tasks have increased when compared to their prior assessment as coded in Section GG
- A decrease of 2 or more coding points in one late-loss ADL or decrease in coding points in two or more ADL items
- If a value of 07, 09, 10, or 88 is present on either the target or previous assessment, the item is recorded to a value of 01 to allow for appropriate comparison.
- The target assessment is compared to the prior assessment

28

Exclusions for Section GG: Decline in Late-Loss ADLs

- All 4 late-loss ADLs were not attempted on the prior assessment
- Three of the late-loss ADL items indicate total dependence or activity not attempted, and the fourth ADL item indicates substantial/maximal assistance on prior assessment
- Resident is comatose (B0100=1) or B0100 is not assessed
- No prior assessment for comparison
- Late-loss ADL items are not assessed (-) on target or prior assessment
- Hospice care (O0100K1b) indicated or not assessed (-) on target assessment
- Prognosis of life expectancy is less than six months (J1400=1) or not assessed (-)

29

Decline in Mobility on the Unit – Threshold <=8.0%

- Residents who have experienced a decline in locomotion during a target period as coded in Section GG of the MDS
- Based on self-performance in Walk 10 feet (GG01701)
- Decrease in one or more points in Walk 10 feet when assessments are compared
- Values of 07, 09, 10, or 88 will be recorded as 01
- Target assessment compared to prior assessment
- ***Exclusions:***
- Comatose (B0100) indicated or not assessed (-)
- Prognosis of less than six months (J1400) is coded a 1 or dashed
- Hospice use (O0110K1b) is checked or dashed
- Resident dependent or activity did not occur on prior assessment
- Missing data on locomotion (GG01701) on target or prior assessment
- Prior assessment is a discharge without a return anticipated
- No prior assessment

30

High Risk Residents with Pressure Ulcers – Threshold <=2.7%

- Residents with Stage II-IV or unstageable pressure ulcers coded in Section M0300B-G on the target assessment
- ***Exclusions:***
- Target assessment is an Admission or 5-day PPS assessment
- MDS items M0300B-G are not assessed (-)

31

Anti-Psychotic Medications – Threshold <=6.8%

- Residents who are receiving an antipsychotic medication during the target period but not on their initial assessment as coded in Section N0415A1 of the MDS
- Look-back scan (not including the initial assessment)
- ***Exclusions:***
- Initial assessment indicates antipsychotics use at N0415A1 or antipsychotic use is unknown on the initial assessment
- Schizophrenia (I6000)
- Tourette's syndrome (I5350)
- Huntington's disease (I5250)

32

Indwelling Catheter – Threshold <=1.1%

- Residents who have had a catheter in the last seven days as coded at H0100A on the MDS
- ***Exclusions:***
- Target assessment is an Admission or 5-day PPS assessment
- H0100A not assessed (-)
- Neurogenic bladder (I1550)
- Obstructive uropathy (I1650)

33

Urinary Tract Infection – Threshold <=1.9%

- Residents who have had a UTI in the last 30 days coded at I2300 of the MDS
- UTI per definition on facility use of evidence-based criteria – McGeer, Loeb, or NHSN
- ***Exclusions:***
- Target assessment is an Admission or 5-day PPS assessment
- I2300 not assessed (-)

34

Falls with Major Injury – Threshold <=1.3%

- Residents who have experienced one or more falls with a major injury in the target period or lookback period as coded at J1900C of the MDS
- Major Injuries include:
  - Bone fracture
  - Joint dislocation
  - Closed head injury with altered consciousness
  - Subdural hematoma

The look back scan for this measure is 275 days.

Exclusions

- N0415A1 not assessed (-)
- Schizophrenia (I6000)
- Tourette's syndrome (!5350) on the prior assessment if not active on the targe assessment
- Huntington's disease (I5250)

35

VBP Incentive

Semi-annual VBP updates:

The VBP will be re-calculated effective for dates of service beginning January 1 and July 1 of each year

The QM performance date will be updated based on the most current data available as of November 15th for the January 1 rate adjustment and as of May 15th for the July 1 rate adjustment

36

Mental Illness Diagnosis Add-On

If at least 40% of a facility's Medicaid population have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00).

- Schizophrenia: MDS item I6000
- Bi-polar: MDS item I5900

Each facility's mental illness diagnosis data will be re-evaluated semi-annually using data available as of November 15th for the January 1 rate adjustment and as of May 15th for the July 1 rate adjustment. No further detail on if this is going to come from I5900 and I6000 or if there will be additional documentation requirements.

Beginning with the April 1, 2024 Resident Listings - Residents who qualify for the Mental Illness Diagnosis Add-On will be noted in Column K

37

37

- MDS Case Mix Review Training and Implementation

38

Case Mix Validation Reviews coming soon:

- Myers & Stauffer has began conducting case mix validation reviews beginning with rates effective July 1, 2024 – They are only reviewing MDS assessments with ARDs of 1/1/24 – 3/31/24
- Initial round of reviews will not trigger any rate sanctions if the review sample does not meet the pass threshold.
- Myers & Stauffer presented webinars on March 19th and 26th to provide an overview of the MDS review program. The recordings are available through the Myers & Stauffer website.
- An updated education session was held on December 17, 2024 with very limited information provided on only a few topics
- It is anticipated that assessments active during the quarter ending March 31, 2024 will be selected for sampling for the initial reviews, and then will roll forward on a quarterly basis thereafter.

39

M&S Case Mix Reviews include 25 MDS assessments

- These are done remotely and require the IDT to present the supporting documentation for MDS data elements requested by the reviewer.
- Focused on:
  - Active Diagnosis
  - Services provided
  - Section GG nursing functional tasks and supporting documentation
  - Shortness of breath while lying flat
  - Respiratory therapy services
  - Restorative nursing services
  - Behaviors
  - Insulin injections and insulin order changes
  - Z0400 signed and dated on or before the ARD of the MDS assessment for patient interview items
  - Skin issues and corresponding treatments

40

Strategies for Case Mix Reviews

- Know your software and where items are documented
- Develop a process to require MDS personnel to note for each MDS assessment where the supporting documentation is contained in the medical record. This could be then scanned into the electronic health record for each MDS and allow for ease in producing the documentation during the case mix reviews.
- Make sure that correct definitions of Section GG items are used when collecting information. It has been noted that some software programs are still using ADL definitions that came from Section G versus the definitions for Section GG. This will create issues where the documentation is disallowed during the case mix review process.
- Make sure you have an IDT note on or before the ARD of each MDS assessment detailing how the IDT determined each patient's usual performance for functional tasks in Section GG. If this documentation is not present then the information may be disallowed during the case mix review.
- If all mattresses in your facility are pressure reducing then the case mix reviewer will ask to see your policy.
- If you are using electronic signatures then the case mix reviewer will ask to see your policy.

41

Questions?

42

Tools

- Scan the QR Code for access to Forvis Mazars Clinical Tools

43

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44

44

Thank you!

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45