AC, BI, CADI, EW Case Mix Classification Worksheet

How To Arrive At A Case Mix Classification

The completed assessment form (DHS-3428) includes many items of information about a client, but only a few of these items are used in determining the case mix classification. Use form DHS-3428C, Children’s Supplemental Form to determine age appropriate ADL dependency scores. Then return to this form for additional steps.

Step 1 for Elderly Waiver Participants
Review score in Ventilator Dependency item from the LTCC Assessment to determine whether the individual meets the criteria for ventilator dependency. The item and the dependency scores are:

<table>
<thead>
<tr>
<th>Ventilator Dependency Score</th>
<th>Not Dependent</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>00</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td>01</td>
<td>03</td>
</tr>
</tbody>
</table>

If dependent, Case Mix = V. If not dependent, proceed to Step 1 for All Other Classifications.

Step 1 for all other classifications
Review scores in the eight Activities of Daily Living (ADLs) from the LTCC Assessment (DHS-3428) to determine the total number of key ADLs in which the client is considered “dependent”. The ADLs and the dependency scores are:

<table>
<thead>
<tr>
<th>Value Coded for Item</th>
<th>Not Dependent</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>0-1</td>
<td>2-4</td>
</tr>
<tr>
<td>Grooming</td>
<td>0-1</td>
<td>2-3</td>
</tr>
<tr>
<td>Bathing</td>
<td>0-3</td>
<td>4-5</td>
</tr>
<tr>
<td>Eating</td>
<td>0-1</td>
<td>2-4</td>
</tr>
<tr>
<td>Bed Mobility (Positioning)</td>
<td>0-1</td>
<td>2-3</td>
</tr>
<tr>
<td>Transferring (Mobility)</td>
<td>0-1</td>
<td>2-4</td>
</tr>
<tr>
<td>Walking</td>
<td>0-1</td>
<td>2-4</td>
</tr>
<tr>
<td>Toileting</td>
<td>0-0</td>
<td>1-6</td>
</tr>
</tbody>
</table>

In order to arrive at the appropriate case mix classification, the following next steps must occur in the order in which they are listed. An individual can only be classified in one case mix. After determining the ADL category for the individual:

Step 2
Determine the ADL Category as follows:
- Low ADL = Dependent in 0-3 key Activities of Daily Living
- Medium ADL = Dependent in 4-6 key Activities of Daily Living
- High ADL = Dependent in 7-8 key Activities of Daily Living

In order to arrive at the appropriate case mix classification, the following next steps must occur in the order in which they are listed. An individual can only be classified in one case mix. After determining the ADL category for the individual:

Step 3
Special Nursing Case Mix Categories
If Tube Feeding (01) OR other Special Treatment (02) in combination with Clinical Monitoring every 8 hours (02), resulting case mix is Low ADL = C, Medium ADL = F, High ADL = K.

Step 4
If NOT Special Nursing, for High ADL individuals only, skip to Step 7. For Low and Medium ADL individuals, review the score in the Behavior item from the assessment. If the score is 02 or greater, the resulting case mix is Low ADL = B, Medium ADL = E.
Step 5
If NOT Special Nursing and NOT Behavior: Low ADL = A, Medium ADL = D.

Step 6
Skip this step for individuals aged 65 and older who are returning to, changing to, or continuing on the CADI, BI, CAC, or DD waiver programs. Go to Step 7.

Very Low ADL
For individuals aged 65 and over only who are classified as Case Mix A after completing Steps 1-5, additional review of ADLs is required. An individual with NO ADL dependency, no dependency in Toileting (>00), or Positioning (>01), or Transferring (>01) and less than 3 dependencies in Bathing, Dressing, Grooming, Walking or Eating is classified as Case Mix L.

Step 7
High ADL Classifications
Classification of individuals in the High ADL category who did not meet the Special Nursing criteria specified in Step 3 begins with a review of the assessment score for Eating. (Individuals with High ADLs and Special Nursing needs are classified as Case Mix K under Step 3). See more information about Case Mix G, H, I and J classification in Steps 7 through 12.

If the score in Eating is 02 or less, skip Steps 8-10 and proceed to Step 11. If the score is 3 or more, go on to Step 8.

Step 8
High Score in Eating Plus Neurodiagnosis
When an individual has a score of 3 or more in Eating, consider whether the individual also has a neuromuscular diagnosis from the following list:
- Diseases of nervous system excluding sense organs and excluding Alzheimer disease. These include intracranial infections, meningitis, encephalitis, myelitis, and similar conditions.
- Cerebrovascular Disease excluding atherosclerosis. These include cerebral hemorrhage, embolisms, infarctions, ischemia, and similar conditions.
- Fracture of skull (excluding cases without intracranial injury).
- Spinal cord injury without evidence of spinal bone injury.
- Injury to nerve roots and spinal plexus.
- Neoplasms of the brain and spine.

If any diagnosis is included within the list above the classification is High ADL = J

Step 9
High Need in Eating and Behavior
If the individual has no diagnosis from the above code list, review the score on the assessment form for Behavior. If the score is 3-4, the classification is High ADL = J

Step 10
If there is no diagnosis from the above code list and if the score on the Behavior is not 3-4, proceed to the alternative box marked Not Neuro Diagnosis and mark the classification High ADL = I

Step 11
If the score on the assessment form for Eating is 2 or less, proceed to the box marked Behavior. If the score is 2 or more for Behavior, the classification is High ADL = H

Step 12
If the assessment form score does not meet the criteria for Behavior, proceed to the alternative box marked Not Behavior and mark the classification High ADL = G

See the Case Mix Classification Summary on page 4 for a short description of each case mix.
Notes on Special Treatments
For a coding of Special Treatments, the medical record must establish that:

1. The physician has performed a medical evaluation of the client’s immediate and long-term needs, as related to the special treatments;
2. A registered nurse has assessed the health needs of the client as they relate to the need for special treatments, and has communicated these needs to a physician;
3. A registered nurse has implemented the delegated medical functions and the nursing functions, which may be performed in collaboration with other health team members, or may be delegated by the registered nurse to other nursing personnel; and
4. A registered nurse has periodically reassessed the health needs of the client as they relate to the need for special treatments, and has regularly communicated these needs to a physician.

Special treatments can include:

Oxygen and Respiratory Therapy
Special measures to improve respiratory function. Standby oxygen would not be coded unless actually administered.

Ostomies and Catheters
Code if routine care is provided by licensed staff.

Wound Care/Decubiti
Includes wound and decubitus dressings and care, ostomy dressings and warm moist packs ordered for inflamed areas. The medical record must establish that:

1. The physician or a registered nurse has documented the presence of a wound;
2. A written wound treatment plan has been developed;
3. Progress notes indicating the client’s response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status and treatment of the wound and determined the need for continued wound care.

Skin Care
Recognized therapeutic and preventive measures in response to an identified medical condition or an identified high risk factor(s) which is related to a medical condition or a functional disability. The client’s medical record must establish that:

1. The physician has identified the medical condition or a registered nurse has identified the high risk factor(s) for which skin care is needed;
2. A written plan for skin care has been developed;
3. Progress notes indicating the client’s response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status of the client’s medical condition.

Symptom Control for the Terminally Ill
A program designed by a physician, registered nurse, and the client for ongoing management of pain, nausea, or other disabling symptoms.

The medical record must establish that:

1. A physician has diagnosed a terminal illness;
2. A written symptom control program has been developed;
3. Progress notes indicating the client’s response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status of the client’s medical condition as it relates to the symptom control plan.

Isolation Precautions
Procedures in accordance with the “Guideline for Isolation Precautions in Hospitals,” written by Julie S. Garner, RN, MS, and Bryan P. Simmons, MD, reprinted by the U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, from Infection Control, July/August 1983 (Special Supplement); 4 (suppl): p.p. 245-325. The medical record must establish that:

1. A physician has diagnosed the disease or infectious agent;
2. Progress notes indicating that the isolation precautions are being followed and have been recorded by licensed nurses; and
3. The physician has documented periodic reassessment of the status of the client’s medical condition as it relates to the need for isolation precautions.

Other Treatments
Other treatments for which the same medical record requirements can be and have been met with respect to assessment, written treatment planning, monitoring of progress, periodic reassessment of the condition and/or treatment and communications.
Notes on Clinical Monitoring

Clinical monitoring includes nursing procedures emanating from the client’s diagnosis and medically unstable condition and high risk condition(s). The medical record must establish that:

1. The physician has identified the medically unstable condition for which the clinical monitoring is needed;
2. A registered nurse has completed an assessment identifying the high risk condition(s);
3. A written plan for clinical monitoring has been developed;
4. Systematically recorded measurements (such measurements may be collected by licensed or unlicensed nursing personnel) have been made;
5. The clinical monitoring data has been interpreted by a registered nurse and communicated to the physician; and
6. The physician has documented periodic reassessment of the client’s medical status and documented the need for continued clinical monitoring.

Scale:
00 = Less than once a day, less than once every 24 hours
01 = One or two shifts a day, at least once every 24 hours
02 = Monitoring on every shift, at least once every 8 hours

Notes on Special Nursing

“Special Nursing” is calculated by either:
01 = Tube Feeding (special treatment)
or 02 = Other Special Treatment
and 02 = in Clinical Monitoring

Case Mix Classification Summary

A – Low ADL
B – Low ADL Behavior
C – Low ADL Special Nursing
D – Medium ADL
E – Medium ADL Behavior
F – Medium ADL Special Nursing
G – High ADL
H – High ADL Behavior
I – Very High ADL (Eating 3-4)
J – High ADL, Severe Neurological Impairment/3+ Behavior
K – High ADL Special Nursing
L – Very Low ADL/Age 65+
V - Ventilator Dependent - EW

Case Mix Classification

*Key Activities of Daily Living (ADLs)