Target Area	Definition	SUGGESTED INTERVENTIONS IF AT/ABOVE 80TH PERCENTILE	SUGGESTED INTERVENTIONS IF AT/BELOW 20TH PERCENTILE
Therapy RUGs with High ADL (Therapy High ADL)	**Numerator (N):** count of days billed within episodes of care ending in the report period with RUG equal to RUX (Rehabilitation ultra-high & extensive services w/ Activities of Daily Living [ADL] 11-16), RVX (Rehabilitation very high & extensive services w/ ADL 11-16), RHX (Rehabilitation high & extensive services w/ ADL 11- 16), RMX (Rehabilitation medium & extensive services w/ ADL 11-16), RUC (Rehabilitation ultra-high w/ ADL 11-16), RVC (Rehabilitation very high w/ ADL 11-16), RHC (Rehabilitation high w/ ADL 11-16), RMC (Rehabilitation medium w/ ADL 11-16), RLB (Rehabilitation low with ADL 11-16) **Denominator (D):** count of days billed within episodes of care ending in the report period for all therapy RUGs (See Appendix 1) *Note: An episode of care is defined as a series of claims from a SNF for a beneficiary where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to thirty days. The "From" and "Through" dates in form locator 6 (statement covers period) on the claim identify the span of service dates included in a particular bill; the "From" date is the earliest date of service on the claim.*	This could indicate a risk of potential over coding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.	This could indicate a risk of potential under-coding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL, as reported on the MDS, is supported and consistent with medical record documentation.
Nontherapy RUGs with High ADL	**N:** count of days billed within episodes of care ending in the report period with RUG equal to HE2 (Special care high w/ depression & ADL 15-16), HE1 (Special care high w/o depression & ADL 15-16), LE2 (Special care low w/ depression & ADL 15-16), LE1 (Special care low w/o depression & ADL 15-16), CE2 (Clinically complex w/ depression & ADL 15-16), CE1 (Clinically complex w/o depression & ADL 15-16), BB2 (Behavior/cognitive w/ 2+ restorative nursing & ADL 2-5), BB1 (Behavior/cognitive w/ <=1 restorative nursing & ADL 2-5), PE2 (Physical function w/ 2+ restorative nursing & ADL 15-16), PE1 (Physical function w/ <=1 restorative nursing & ADL 15-16) **D:** count of days billed within episodes of care ending in the report period for all nontherapy RUGs (See Appendix 2)	See above.	See above.
Change of Therapy Assessment (COT Assmnt)	**N:** count of assessments with AI second digit equal to "D" within episodes of care ending in the report period. **D:** count of all assessments within episodes of care ending in the report period.	This could indicate that the SNF is experiencing challenges with delivering services to the beneficiary as anticipated. The SNF may look into factors that lead to the need for the COT assessment (e.g., Can care planning be improved? Are there issues with completing therapy as scheduled?)	Not applicable.

Ultrahigh Therapy RUGs (Ultrahigh)	**N:** count of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL (Rehabilitation ultrahigh & extensive services w/ ADL 2- 10), RUC, RUB (Rehabilitation ultrahigh w/ ADL 6-10), RUA (Rehabilitation ultrahigh w/ ADL 0-5) **D:** count of days billed within episodes of care ending in the report period for all therapy RUGs (See Appendix 1)	This could indicate that the SNF is improperly billing for therapy services. The SNF should determine whether therapy provided was reasonable and medically necessary, and the SNF should also determine whether the amount of therapy reported on the MDS is supported by documentation in the medical record.	Not applicable.
20-Day Episodes of Care (20 Days)	**N:** count of episodes of care ending in the report period with a LOS of 20 days. **D:** count of all episodes of care ending in the report period.	This could indicate that the SNF is continuing treatment beyond the point where services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 20 days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review the appropriateness of plans of care and discharge planning.	Not applicable.
90+ Day Episodes of Care (90+ Days)	**N:** count of episodes of care ending in the report period with a LOS of 90+ days. **D:** count of all episodes of care ending in the report period.	This could indicate that the SNF is continuing treatment beyond the point where those services are necessary. The SNF should review documentation for beneficiary episodes of care with a LOS of 90+ days to ensure that beneficiaries' continued care was appropriate and that they received a skilled level of care. The SNF should review appropriateness of plans of care and discharge planning.	Not applicable.
3-to 5-Day Readmissions (3-5 Day Readm) ***new as of the Q4FY19 release**	**N:** count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period. **D:** count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20 (expired)(See Appendix 3)	This could indicate that patients are being discharged prematurely or that patients are being readmitted after the interrupted stay threshold, thereby resetting the variable per diem adjustment. A sample of readmission cases should be reviewed to identify the appropriateness of admission, discharge, quality of care, post-discharge care, and billing errors. The facility is encouraged to generate data profiles for readmissions to its facility within three to five consecutive calendar days. Suggested data elements to include in these profile areas follows: patient identifier, date of admission, date of discharge, patient discharge status code, and principal and secondary diagnoses.	Not applicable.

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