Objectives

- Describe the new items added to the MDS on October 1, 2018
- Understand how the QRP Quality Measures intersect with the MDS
- Review the coming Patient-Driven Payment System (PDPM) and the impact on MDS Coding

Section B
Hearing, Speech, and Vision

**Intent**
To document the resident’s ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons
B0700: Makes Self Understood

- Resident’s ability to communicate essentially all types of daily information

Definition:
Makes Self Understood
Able 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. Deficits in the ability to communicate using these methods should be documented.

RAI, pg. B-8

- Assess using resident’s preferred language or method of communication; use interpreter if necessary
- Communication of needs may be via any effective method (e.g., orally, writing, pointing, sign language, or cue cards)

- Interact with resident: Observe, listen to interactions with others in different settings and circumstances
- Consult others (all shifts) who interact with resident, including family, therapists
- If residents unable to communicate, offer alternatives
- Answer options describe characteristics of decreasing levels of making self understood

10/1/18: Item cannot be coded “3” if resident completed any of the resident interviews
10/1/18: B0700 and resident interview items are not directly dependent, inconsistencies to be evaluated

MDS 3.0
Scripted Interviews

BIMS, PHQ-9©, Activities/Preferences, Pain
The Scripted Interviews

BIMS, PHQ-9®, Activities/Preferences, Pain

• Proper preparation critical for each interview
  – Ensure a private, quiet environment
  – Use resident’s preferred language (arrange for interpreter, if needed)
  – Be sure resident can hear you and see you and has access to preferred method for communication
  – If resident appears unable to communicate, offer alternatives, such as writing, pointing, American sign language, or cue cards
  – Attempt to conduct interview with all residents using appropriate look-back period; the interviews are NOT contingent upon B0700

• Interview techniques that can be used if resident having difficulty:
  – Unfolding = general question asked and then narrowing the response options by asking which is closer to accurate for the resident
  – Disentangling – breaking a list into its parts and asks about each component
  – Echoing = summarizing the resident’s answer and what response depicts what the resident said
  – Probing = ask neutral questions, such as “Tell me more” or “Tell me what you mean”

• If the resident interview was not conducted within look-back period (preferably the day before or on the ARD), the gateway items are coded “1,” YES but a dash (“-“) must be entered in the resident interview items AND the Staff Assessment would not be completed

• If the resident did not complete the interview the items C0600, D0500, F0700, J0700 ask if STAFF should complete assessment. When?
  – Interview attempted but not completed by resident
  – Resident unable to participate in interview
  – Resident refused to participate
Special Situations for Scripted Interviews

• When coding stand-alone OMRAs (COT, EOT, or SOT), the interview items may be coded using the responses provided by the resident on a previous assessment ONLY if the DATE of the interview responses from the previous assessment (as documented in Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in Z0400).

Special Situations for Scripted Interviews

• If completing a stand-alone, unscheduled PPS assessment, the resident interview may be conducted up to two calendar days after the ARD. This flexibility period can be used even if the resident discharges from the facility during that period.

Special Situations for Scripted Interviews

• If the resident is discharged unexpectedly before an interview was completed:
  – Stand-alone OBRA Discharge assessment
    ▪ Scripted Mood and Pain interview sections not required
    ▪ Only section C, Staff Assessment of Mental Status is to be completed
  – Other assessment types (PPS, Quarterly, etc.)
    ▪ Use information available at time of discharge
    ▪ Dash items only if information is not available
    ▪ Staff may be interviewed after the discharge (up to 2 days)
For All Interviews

- Stick to script and cues
- Same if interpreter used

- Each interview has its own definition of an incomplete interview to determine when the assessor must conduct the staff assessment
- Single-point-in-time interview documented directly on the MDS
- Other documentation, interviews, and observations during look-back period are not taken into account, but are relevant to care planning

SECTION G

START HERE
Remember to review the instructions for the Rule 3 and the ADL Self-Performance Coding Level Definitions before using the algorithm. STOP at the first code that applies when moving down the algorithm.

(see RAI manual p. G-8)
Section GG

• GG0100 Prior Functioning Everyday Activities
• Code only at the Start of the SNF PPS stay (5-day)

GG0100: Prior Functioning: Everyday Activities. Indicate the resident’s usual ability with everyday activities prior to the current
5-day respite stay.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Independent: Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.</td>
</tr>
<tr>
<td>1</td>
<td>Needed Some Help: Resident needed partial assistance from another person to complete activities.</td>
</tr>
<tr>
<td>2</td>
<td>Dependent: A helper completed the activities for the resident.</td>
</tr>
<tr>
<td>3</td>
<td>Unknown.</td>
</tr>
<tr>
<td>4</td>
<td>Not Applicable.</td>
</tr>
</tbody>
</table>

Coding: Scale 0-4

- 0: Independent
- 1: Needed Some Help
- 2: Dependent
- 3: Unknown
- 4: Not Applicable

Relates to the amount of human assistance.
Coding GG0100 Task Descriptions

A. Self-Care: Code the resident’s need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

B. Indoor Mobility (Ambulation): Code the resident’s need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

C. Stairs: Code the resident’s need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

D. Functional Cognition: Code the resident’s need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Many examples of coding scenarios and rationale on pages GG-2 through GG-4

Section GG

New item, GG0110: Prior Device Use
Coding based on an assessment of the resident’s function PRIOR to the current illness, exacerbation, or injury

(GG0110: Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury)

- Check all that apply
  - A. Manual wheelchair
  - B. Electrical wheelchair
  - C. Mechanical lift
  - D. Walker
  - E. Orthotics
  - F. None of the above

Same information sources as GG0100

Code only at the start of SNF PPS stay

GG0130 and GG0170

- GG0130. Self-Care
- GG0170. Mobility
  - Usual performance collected at the start and end of the Medicare Stay
  - Discharge goal(s) established on the 5-day MDS

5-Day Part A PPS Discharge
Assessment of Admission Performance

- The admission assessment period is the first 3 days of the Medicare Part A, starting with the date in A2400B, Start of Most Recent Medicare Stay (5-day)
- May need to use the entire 3-day assessment period to obtain the resident’s usual performance

If a fluctuation in the performance of activities during the three-day assessment:
- the performance wouldn’t be the worst, and
- it wouldn’t be the best, but
- it would be what’s “usual” (or baseline performance) for that individual

Assessment of Discharge Performance

- 3-day assessment period = the last 3 days of the SNF PPS stay ending on A2400C (occurs as close to the time of the resident’s discharge as possible), defined as the day of discharge from Medicare Part A and the 2 days prior to that day of discharge from Part A
- Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03
- Either as a stand-alone assessment when the resident’s Medicare Part A stay ends, but the resident remains in the facility; or combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident’s Discharge Date (A2000)

Definition: Usual Performance

- A resident’s functional status can be impacted by the environment or situations encountered at the facility
- Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status
  - If the resident’s functional status varies, record the resident’s usual ability to perform each activity
  - Do not record the resident’s best performance
  - Do not record the resident’s worst performance
  - Record the resident’s usual performance
Steps for Assessment

1. Assess the resident’s self-care and mobility performance based on direct observation, as well as the resident’s self-reports and reports from qualified clinicians, care staff, or family documented in the resident’s medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessment the resident during the 3-day assessment period.
   - **Qualified clinician**: Healthcare professionals practicing within their score of practice and consistent with Federal, State, and local law and regulations.

2. Resident should be allowed to perform activities as independently as possible, as long as they are safe.

3. For Section GG a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff)
   - Does NOT include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/certified nursing assistant students, etc.
   - Helper is NOT family members and “sitters” hired by the family.
   - If a helper’s assistance is required because a resident’s performance is unsafe or of poor quality, only consider staff assistance when scoring according to the amount of assistance provided.

4. Activities may be completed with or without assistive device(s).

5. Admission functional assessment, when possible, should be conducted prior to the person benefiting from treatment interventions in order to determine a true baseline functional status on admission.

6. Refer to facility, Federal and State policies and procedure to determine which staff members may complete an assessment.
Coding Instructions GG0130 & GG0170

To code resident’s usual performance and discharge goal(s), use the “six-point scale” OR use 1 of the 4 “activity was not attempted” codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06.</td>
<td>Independent: Resident completes the activity by him/herself with no assistance from a helper</td>
</tr>
<tr>
<td>05.</td>
<td>Setup or clean-up assistance: helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity but NOT during the activity</td>
</tr>
<tr>
<td>04.</td>
<td>Supervision or touching assistance: helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Help may be provided throughout or intermittently</td>
</tr>
</tbody>
</table>

Coding Instructions GG0130 & GG0170

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.</td>
<td>Partial/moderate assistance: If helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort</td>
</tr>
<tr>
<td>02.</td>
<td>Substantial/maximal assistance: If helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort</td>
</tr>
<tr>
<td>01.</td>
<td>Dependent: If the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two (2) or more helpers is required for the resident to complete the activity</td>
</tr>
</tbody>
</table>

More than half or less than half – what if effort seems be half? Use your clinical judgment.

Coding Instructions GG0130 & GG0170

If activity was not attempted, code reason

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.</td>
<td>Resident refused</td>
</tr>
<tr>
<td>09.</td>
<td>Not applicable – Not attempted and resident did not perform prior to current illness, exacerbation, or injury</td>
</tr>
<tr>
<td>10.</td>
<td>Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</td>
</tr>
<tr>
<td>88.</td>
<td>Not attempted due to medical condition or safety concerns</td>
</tr>
</tbody>
</table>

CMS stated that allowing staff to use the “activity was not attempted reasons” will reduce the number of dashes used in GG.
### Section GG0130: Self-Care Functional Abilities

**GG0130A. Eating**
The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once meal is placed before the resident. Includes modified food consistency.

**GG0130B. Oral Hygiene**
The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

**GG0130C. Toileting Hygiene**
The ability to maintain perineal hygiene, adjust clothes before and after having a bowel movement using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

3 tasks to assess: 1) perineal hygiene; 2) adjust clothes before; 3) adjust clothes after voiding or having a bowel movement.

### GG0130: Self-Care Functional Abilities

**GG0130E. Shower / bathe self**
The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

**GG0130F. Upper body dressing**
The ability to dress and undress above the waist; including fasteners, if applicable. (Includes orthotic/prosthesis)

**GG0130G. Lower body dressing**
The ability to dress and undress below the waist, including fasteners; does not include footwear. (Includes orthotic/prosthesis)

**GG0130H. Putting on/taking off footwear**
The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. (Includes orthotic/prosthesis)

### Section GG0170: Mobility Functional Abilities

**GG0170A. Roll left and right**
The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

**GG0170B. Sit to lying**
The ability to move from sitting on side of bed to lying flat on the bed.

**GG0170C. Lying to sitting on side of bed**
The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

**GG0170D. Sit to stand**
The ability to come to a standing position from sitting in a chair, or wheelchair, or on the side of the bed.

**GG0170E. Chair/Bed-to-chair transfer**
The ability to transfer to and from a bed to a chair (or wheelchair).

**GG0170F. Toilet transfer**
The ability to safely get on and off a toilet or commode.
## Section GG0170: Mobility Functional Abilities

<table>
<thead>
<tr>
<th>GG0170. Car transfer</th>
<th>The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0170. Walk 10 feet</td>
<td>Once standing, the ability to walk at least 10 feet in a room, corridor or similar space. If admission or discharge performance coded 07, 09, 10, or 88, skip to GG0170M, 1 step (curb)</td>
</tr>
<tr>
<td>GG0170. Walk 50 ft w/2 turns</td>
<td>Once standing, the ability to walk at least 50 feet and make two 90-degree turns</td>
</tr>
<tr>
<td>GG0170. Walk 150 feet</td>
<td>Once standing, the ability to walk at least 150 feet in a corridor or similar space</td>
</tr>
<tr>
<td>GG0170. Walk 10 ft on uneven surfaces</td>
<td>The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel</td>
</tr>
</tbody>
</table>

- Walking items do not need to occur in one session
- Mobility items do not consider parallel bars

### New 10/1/18

<table>
<thead>
<tr>
<th>GG0170M. 1 step (curb)</th>
<th>The ability to go up and down a curb and/or up and down one step. If admission or discharge performance coded 07, 09, 10, or 88, skip to GG0170P, Picking up object</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG0170N. 4 steps</td>
<td>The ability to go up and down 4 steps with or without a rail. If admission or discharge performance coded 07, 09, 10, or 88, skip to GG0170P, Picking up object</td>
</tr>
<tr>
<td>GG0170O. 12 steps</td>
<td>The ability to go up and down 12 steps with or without a rail.</td>
</tr>
<tr>
<td>GG0170P. Picking up object</td>
<td>The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. Could also occur if the resident is upright in a wheelchair</td>
</tr>
</tbody>
</table>

### New 10/1/18

- Skip pattern used for the question “Does the resident use a wheelchair and/or scooter?”
  - If no, skip:
    - GG0170R. Wheel 50 feet with two turns
    - GG0170S. Wheel 150 feet
  - Indicate the type of wheelchair or scooter used:
    1. Manual
    2. Motorized

- Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
- Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space
Section GG – Wheelchair (w/c) Items

• The intent of items: assess the ability of residents who are learning to self-mobilize using a wheelchair or who used a wheelchair prior to admission
  – Use clinical judgment to determine if resident’s use of a w/c is for self-mobilization as a result of the resident’s medical condition or safety
• Do not code w/c mobility if the resident uses a w/c only when transported between locations within the facility
  – Only code w/c mobility based on an assessment of the resident’s ability to mobilize in the wheelchair
• Admission assessment for w/c items should be coded for residents who used a wheelchair prior to admission
  – The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments

Coding Tips – Admission or Discharge Performance

• If two or more helpers are required to assist the resident to complete the activity, code 01, Dependent

• Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity
  – If a resident does not perform oral hygiene during therapy, determine the resident’s abilities based on performance on the nursing care unit
• To clarify your own understanding of the resident’s performance, ask probing questions to staff about the resident

Examples of Probing with Staff

Oral hygiene: Example of a probing conversation between a nurse and a CNA to determine a resident’s oral hygiene routine

• Nurse: “Does Mrs. K help with brushing her teeth?”
• Certified nursing assistant: “She can help clean her teeth.”
• Nurse: “How much help does she need to brush her teeth?”
• Certified nursing assistant: “She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth.”

Code = Substantial/maximal assistance (more than half of the effort)
Examples – Please also Check RAI Manual

Eating: Mr. R is unable to eat by mouth since he had a stroke a week ago. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

- **Coding:** GG0130A. Eating would be **coded 88**, Not attempted due to medical condition or safety concerns.
- **Rationale:** The resident does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

Toileting hygiene: Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the CNA to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls up her underwear.

- **Coding:** GG0130C. Toileting hygiene = **03**, Partial/moderate assistance
- **Rationale:** The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

Discharge Goals for GG0130/GG0170 Column 2

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.
Discharge Goal: Coding Tips

- Licensed qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the resident’s prior medical condition, admission assessments, discussions with the resident and family, professional judgment, profession’s practice standards, expected treatments, resident motivation, anticipated length of stay, and the resident’s discharge plans.

- Goals should be established as part of the resident care plan.

Discharge Goals Based on Expectations at Admission

- **Expected to Improve**: The IDT determines the resident is expected to make gains in function by discharge.

- **Not Expected to Improve**: The IDT determines the resident is not expected to progress to a higher level of functioning during the Medicare Part A stay.

- **Expected to Decline**: The IDT determines decline in function is anticipated and unavoidable.

Discharge Goal Example

Using GG0170K-Walk 150 Feet as an example:

- Mr. Jones was admitted to the SNF after a fall with a humeral fracture. He used a walker prior to his fall and that is his baseline activity.

- Section GG0170K column 1 Admission Performance is 03: Partial/Moderate assist.

- His goal for his skilled stay is to regain ability to walk independently with the walker again. Therapy and nursing agree this is a realistic goal for Mr. Jones.

- Column 2 Discharge Goal, would be coded as a 06 because he hopes to be become independent again.
Toilet transfer: Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two CNAs assist during the toilet transfer.

Mobility Coding Scenarios

How would you code GG0170F?
- 04. Supervision or touching assistance
- 02. Substantial/maximal assistance
- 01. Dependent
- 07. resident refused

Choose One

Coding: GG0170F. Toilet transfer would be coded 01, Dependent

Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.
I0020: Primary Medical Condition

- Item Intent – Captures the medical condition category that best describes primary reason for admission

Steps for Assessment

1. Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions: Complete only if A0310B = 01

- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days
- Enter the code that represents the primary medical condition that resulted in the resident's admission. If codes 1–13 do not apply, use code 14, “Other Medical Condition,” and proceed to I0020A and add the ICD-10 code, including the decimal.
- If I0020 is coded 1–13 – do not complete I0020A

Read carefully the examples of each code in the RAI manual, pp. I-2 and 1-3

Note: if the hip and knee replacement is secondary to a hip fracture, code as 10, Fractures and Other Multiple Trauma. Example include hip fracture, pelvic fracture, and fracture of tibia and fibula.
10100 – I8000: Active Diagnoses

- Code diseases that have relationship to current:
  - Functional status
  - Cognitive status
  - Mood or behavior status
  - Medical treatments
  - Nursing monitoring
  - Risk of death

  **Do not include conditions that:**
  - Have been resolved
  - No longer affected
  - the resident’s functioning or plan of care

10100 – I8000: Active Diagnoses

**Active diagnosis**

- Requires physician/provider diagnosis within 60 days
  - May be in person, fax, telephone, or within another order (e.g., Metformin 500 mg p.o. bid for Diabetes Mellitus); may be signed renewal of orders
  - Must have relationship to status during 7-day look-back period (UTI is 30-day look-back), such as:
    - Medication
    - Monitoring
    - Risk of death
    - Treatment
    - Symptoms present
    - Lab test results

10100 – I8000: Active Diagnoses

- Examples of indicators of active diagnoses:
  - Recent onset or acute exacerbation indicated by a positive study test, or procedure
  - Hospitalization for acute symptoms and/or recent change in therapy
  - Symptoms and abnormal signs specifically attributable to an ongoing decompensated disease
  - Ongoing therapy with meds or other interventions to manage a condition that requires monitoring for therapeutic efficacy to monitor potential adverse effects
I0100 – I8000: Active Diagnoses

Z Codes

• When a resident receives aftercare following a hospitalization, a Z code will be assigned
• When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000

I2300: Urinary Tract Infection

• Active for I2300 - (30-day look-back rather than 7 days) – Both of the following must be present in last 30 days:
  – Physician (or physician designee) documented diagnosis of UTI in last 30 days
  – Determined that the resident had a UTI using evidence-based criteria in the last 30 days
  • Such as McGeer, NHSN, or Loeb

Make sure physician involved in discussion about desired criteria

I1500: Quadriplegia Clarifications

• Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury
• Coding I5100 limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition
• This differs from: functional quadriplegia which is complete immobility due to severe physical disability or frailty
  – Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia
  – For residents where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia
SECTION J
HEALTH CONDITIONS

Intent
The intent of the items in this section is to document a number of health conditions that impact the resident’s functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section address dyspnea, tobacco use, prognosis, problem conditions, and falls.

New Item 10/1/18: J2000 Prior Surgery

J2000. Prior Surgery

Did the resident have major surgery during the 100 days prior to admission?
0. No 1. Yes 2. Unknown

Another risk adjustor for the 4 new SNF QRP functional outcomes measures

• Asks about history of major surgery during the 100 days prior to admission
• Criteria for major surgery – must meet all 3:
  1. Resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF),
  2. Resident had general anesthesia during the procedure, and
  3. Surgery carried some degree of risk to the resident’s life or the potential for severe disability

SECTION M
SKIN CONDITIONS

Intent
The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident’s risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.
Section M: Skin Conditions

Intent continued:
CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

Section M: Skin Conditions

- Section M updated in October 2018 to better coincide with the National Advisory Panel on Pressure Ulcers (NPUAP) terminology
  - Added terms injury or injuries in relation to pressure ulcers
  - Stage 1 and deep tissue injuries are called “pressure injuries” because wounds are closed
  - Stage 2, 3, or 4 unstageable due to slough or eschar are termed “pressure ulcers” since are usually open wounds
  - Unstageable due to non-removable dressing or device use “pressure ulcer/injury” since could be open or closed

Section M: Skin Conditions

- IMPERATIVE: Before proper treatment and wound management can be determined, the underlying cause or etiology must be determined
- Only selected types of skin conditions are captured; cuts, lacerations, and rashes are not
- Skin problems are coded if they were present during the 7-day observation period even if they were present and coded on a previous MDS assessment
M0100: Determination of Pressure Ulcer/Injury Risk

Asks to describe how the risk for pressure ulcers/injuries was determined

M0100. Determination of Pressure Ulcer Risk

Check all that apply

A. Resident has a stage 1 or greater, a sac over bony prominence, or a non-removable dressing/device
B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
C. Clinical assessment
Z. None of the above

M0210: Unhealed Pressure Ulcers/Injuries

- Pressure ulcer/injury: A pressure ulcer/injury is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of intense pressure and/or prolonged pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful
  - The pressure ulcer definitions used in the RAI Manual have been adapted from recommendations by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging System
  - If an ulcer/injury arises from a combination of factors of which pressure is the primary cause, then the area should included in this section as a pressure ulcer/injury

Pressure Ulcer/Injury Definitions

HEALED PRESSURE ULCER
- Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration

PRESSURE ULCER/INJURY RISK FACTOR
- Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, malnutrition, and hydration deficits; and a healed ulcer

Microclimate = temperature, humidity, air flow at the support surface
M0210: Unhealed Pressure Ulcers/Injuries

- Must determine etiology of each wound to code properly
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. (p. M-5) (capture in L0200C)
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here

M0210: Unhealed Pressure Ulcers/Injuries

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound, not a pressure ulcer, even if graft or flap fails
- Resident with DM has heel ulcer from pressure that is present during the 7-day look-back period, capture it as a Pressure Ulcer/Injury
- Resident with DM has ulcer on bottom of foot that is closer to the metatarsals and present during the 7-day look-back period – do not capture it as PrU. This is coded as diabetic ulcer (M1040). It is not likely that pressure is the primary cause of the resident’s ulcer when the ulcer is in this location

M0210: Unhealed Pressure Ulcers/Injuries

- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment – do not capture on current assessment
- Scabs and eschar are different both physically and chemically. Scab represents healing, while eschar is dead tissue
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate areas and stage separately
M0300: Current Number of Unhealed Pressure Ulcers/Injuries

• Asks about the number of pressure ulcers/injuries at each stage during look-back period
  – See staging definitions on MDS form
  – Ulcer staging is based on the deepest anatomical soft tissue damage that is visible or palpable
  – Pressure ulcers do not heal in reverse sequence; clinical standards do not support reverse or backstaging

Definitions added page M-7:
• EPITHELIAL TISSUE
  New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound
• GRANULATION TISSUE
  Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured

• Captures number of stage 1, 2, 3, and 4 PrUs and unstageable pressure ulcers/injuries that were present at that stage on admission/reentry
  – Present on admission/reentry means:
    ▪ The pressure ulcer/injury was present at the time of admission/entry or reentry to this nursing home AND
    ▪ The stage has not worsened at any time since admission AND
    ▪ The pressure ulcer/injury was NOT acquired while the resident was in the care of this nursing home during any stay
M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- When a pressure ulcer/injury that was present on admission, increases in numerical stage, it becomes in-house acquired and is no longer coded as “present on admission”
- If a pressure ulcer/injury was present on admission and becomes unstageable due to slough/eschar, the area is coded at M0300F and is not coded as “present on admission”
- If a pressure ulcer/injury was unstageable on admission or reentry and becomes stageable, it should be considered as “present on admission” at the stage at which it first becomes numerically staged. If it subsequently increases in numerical stage, that higher stage should not be coded as “present on admission”

M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- If a pressure ulcer/injury was originally acquired in facility and the resident is hospitalized. The resident returns with an ulcer/injury at the same stage, do not code as present on admission
- If resident with a pressure ulcer/injury present on admission or reentry is hospitalized and returns with the ulcer at same numerical stage, the area is still coded as present on admission because it originally was acquired outside the facility and has not changed in stage
- If resident with pressure ulcer/injury is hospitalized and the ulcer increases in numerical stage while in the hospital, it should be coded as present on admission at the that higher stage upon reentry

M300: Present on Admission

**Example #1:**
A resident is admitted with no pressure ulcer/injury, but develops a stage 2 ulcer (facility acquired/not present on admission). Resident is hospitalized and returns to the facility with the same stage 2 pressure ulcer. PrU was acquired in the nursing home and should not be considered present on admission when she returns from the hospital.
M300: Present on Admission

Example #2:
A resident is admitted to the facility with a stage 2 PrU (present on admission). Resident is hospitalized and returns with the same stage 2 pressure ulcer. Still considered present on admission – acquired outside the facility and did not change.

Example #3:
A resident who went to the hospital with a facility acquired stage 3 pressure ulcer returned with a stage 3 pressure ulcer that had increased 2 centimeters in both length and width. How would you code this pressure ulcer?

Present on Admission
Not Present on Admission

SECTION N MEDICATIONS
Section N: Drug Regimen Review (DRR)

  - To document whether a DRR was conducted
  - Upon the resident’s admission (start of SNF PPS Stay) and
  - Throughout the resident’s stay (through Part A PPS discharge) and
  - Whether any clinically significant medication issues identified were addressed in a timely manner

N2001: Drug Regimen Review
Completed only on the PPS 5-day Assessment (A0310B = 01)

- Steps for Assessment
  1. Complete a DRR upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible
     - Identify any potential or actually clinically significant medication issues
     - Includes (administered by any route)
       - All medications (prescribed and over the counter)
       - Nutritional supplements
       - Vitamins
       - Homeopathic and herbal products
       - Total parenteral nutrition (TPN)
       - Oxygen

- Steps for Assessment (Cont.)
  2. Review medical record documentation to determine whether a DRR was completed upon admission
     - Review medical record sources – (received from referring facilities, H&P, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available)
     - Discussions with acute care hospital and clinicians responsible for completing the DRR, the resident, and the resident’s family may supplement and/or clarify information gleaned from the medical records
N2001: Drug Regimen Review

• Steps for Assessment (Cont.)

3. Clinically significant medication issues may include, but are not limited to:
   • Medication prescribed despite allergy or prior adverse reaction
   • Excessive or inadequate dose
   • Ineffective drug therapy
   • Drug interactions (serious drug-drug, drug-food, and drug-disease interactions)
   • Duplicate therapy
   • Wrong resident, drug, dose, route, and time errors
   • Medication dose, frequency, route or duration not consistent with condition
   • No adequate indication for use
   • Presence of medical condition that may warrant medication therapy
   • Omissions
   • Non-adherence (purposeful or accidental)

• Coding Instruction
   – Code 0, No: If no clinically significant medication issues were identified during the DRR
   – Code 1, Yes: If one or more clinically significant medication issues were identified during the DRR
   – Code 9, NA: if the resident was not taking any medications at the time of the DRR

• What is a Potential or Actual Clinically Significant Medication issue?
   – In the clinician’s professional judgement, the issue warrants physician (or designee) communication and completion of prescribed/recommended actions
   – The effects, results, or consequences materially affect or are likely to affect an individual’s mental, physical, or psychosocial well being, either positively, by preventing a condition or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status
   – Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of DRR items
N2003: Medication Follow-up

• Definition of "Medication Follow-up"
  – Must contact the physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions
  • Code 0, No: if the facility did not contact the physician and complete prescribed/recommended actions in response to each identified potential or actual clinically significant medication issues by midnight of the next calendar day
  • Code 1, Yes: if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified

N2003: Medication Follow-up

• Steps for Assessment
  – Only complete this item if one or more potential or actual clinically significant medication issues were identified during the admission DRR (N2001)
  1. Review the medical record to determine whether the following criteria were met:
     • Two-way communication (in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident’s status) between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
     • All physician-prescribed/recommended actions were completed by midnight of the next calendar day

N2003: Medication Follow-up

• Coding Tips
  – If physician prescribes/recommends an action that will take longer than midnight of the next calendar day to complete, code 1, yes, if the facility has taken steps to comply with actions by midnight of the next calendar day
  • Example: Physician writes an order to monitor medication over next three days and to call if the problem persists
N2005: Medication Intervention

Completed only the PPS Part A Discharge Assessment (A0310H = 1)

- **Observation Period:** From the date of admission (Start of SNF PPS Stay) through discharge (Part A PPS Discharge)

- **Planning for care**
  - *Every time* a potential or actual clinically significant medication issue was identified throughout the resident's Medicare A stay, there was:
    - Two-way communication between the clinician(s) and the physician, AND
    - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day
    - Action maximized the reduction in risk for medication errors and resident harm

---

**Coding Instructions**

- Code 0, No: Facility did *not* contact the physician and complete prescribed/recommended actions by midnight of the next calendar day when clinically significant medication issue was identified
- Code 1, Yes: Facility contacted the physician and completed the prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant med. issue was identified
- Code 9, NA: There were *no potential or actual clinically significant medication issues identified* throughout the stay or resident took no meds. during the stay

---

**Other RAI Changes**

- Section K – CMS does not require column 1 "while not a resident"
- Section O – Tamoxifen
- Appendix C – Opioids added to items
IMPACT ACT SNF QRP

Background

• CMS continues to move forward with its strategies to facilitate quality measurement and quality improvement across multiple settings.

• The IMPACT act requires the submission of standardized assessment data across 4 post acute care (PAC) settings:
  1. Skilled Nursing Facilities (SNFs): MDS
  2. Long-Term Care Hospitals (LTCHs): LCDS
  3. Home Health Agencies (HHAs): OASIS
  4. Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

IMPACT Act and SNF QRP

Background

• IMPACT Act of 2014 requires all SNFs to participate in a quality reporting program - SNF Quality Reporting Program (SNF QRP).

• SNF QRP began collecting MDS data October 1, 2016 and continues.

• If the SNF does not submit at least 80% of the data to calculate the quality measures, the facility will receive a 2% reduction to their APU for the applicable payment year.
SNF QRP - FY 2019 Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Data Collected</th>
<th>2% APU Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/Worsened Pressure Ulcers – MDS 3.0</td>
<td>FY 2019 (10/1/2018)</td>
<td></td>
</tr>
<tr>
<td>One or More Major Falls – MDS 3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission / Discharge Functional Assessment and Plan of Care – MDS 3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Medicare Spending Per Beneficiary*</td>
<td>not used for APU compliance calculations</td>
<td></td>
</tr>
<tr>
<td>Discharge to Community*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially Preventable 30-Day Post-Discharge*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = claims based measure

SNF QRP FY 2020 Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Data Collected</th>
<th>2% reduction to APU</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or More Major Falls</td>
<td>January 1 to December 31, 2018</td>
<td>FY 2020 (10/1/2019)</td>
</tr>
<tr>
<td>Admission / Discharge Functional Assessment &amp; POC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in Skin Integrity PAC: Pressure Ulcer/Injury (replaced New or Worsened PU)</td>
<td>October 1 - December 31, 2018</td>
<td>2018 Q4 Data only</td>
</tr>
</tbody>
</table>
SNF QRP: FY 2020 New Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Data Collected</th>
<th>2% reduction to APU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Regimen Review and Follow-up for Identified Issues</td>
<td>October 1 to December 31, 2018</td>
<td>FY 2020 (10/1/2019)</td>
</tr>
<tr>
<td>Outcome Measure: Change in Self-Care Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Measure: Change in Mobility Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Measure: Discharge Self-Care Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Measure: Discharge Mobility Score</td>
<td>2018 Q4 Data only</td>
<td></td>
</tr>
</tbody>
</table>

Remember

- CMS looks at any MDS items that not only go into the calculation of the numerator, but also the MDS items used to calculate the risk-adjustment covariates
- A minimum of one discharge goal must be coded on the 5-day PPS assessment to count towards the 80% threshold
- Discharge assessments must be completed timely and submitted timely

Resource: SNF QRP Over of Data Elements Used for Reporting Assessment-Based QMs FY 2020 APU

VALUE-BASED PURCHASING
Overview of SNF Value-Based Purchasing Program

- CMS SNF Value-Based Purchasing (VBP) Program is one of many VBP programs that aims to reward quality and improve health care
- As of October 1, 2018, SNFs have an opportunity to receive incentive payments based on performance on the specified quality measure
- Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to adopt a VBP payment adjustment for SNFs. By law, the SNF VBP Program is limited to a single readmission measure at a time

SNF VBP Readmissions Measure

- FY2016 SNF PPS final rule adopted the first measure: Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM)
- Defined as: risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare beneficiaries within 30 days of discharge from prior hospitalization. Uses Medicare hospital claims to identify hospital readmissions

Hospital readmissions within 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or after discharge from the SNF as long as the beneficiary was admitted to the SNF within 1 day of discharge from a hospital stay
Performance Scoring – SNF VBP

CMS’ methodologies to measure SNF performance that includes levels of achievement and improvement:

**Achievement Scoring** compares a SNF’s performance rate in a performance period against all SNFs’ performance during the baseline period.

**Improvement Scoring** compares a SNF’s performance during the performance period against its own prior performance during the baseline period.

FY2019 Program:
Baseline period CY 2015

FY2019 Program:
Performance period CY 2017

Baseline and Performance Periods to increase by one year for each subsequent program year. (i.e., FY2020, baseline period is CY 2016 and performance period CY 2018)

QUALITY MEASURES

NH Quality Initiatives

- Nursing facility Quality Measures (QMs) are a product of the Nursing Home Quality Initiative, a component of the federal government’s effort to improve the quality of care in nursing facilities
- Began in 1998 and continues to be revised – slowly at first and recently at a much more rapid pace
- The standardized nature of the data makes it easier to collect, analyze and organize into the QMs
- The intent has been to provide to the public a way to look at differences in quality among nursing facilities
- Have provided market-driven incentive to NH providers to improve the quality of care
**Example: Short Stay Look-Back Scan**

Short Stay Period: Six months

- Admission 8/16/16
- Discharge 10/16/16
- New or Worsened Pressure Ulcer
- Target Assessment:
  - OBRA
  - PPS
  - Discharge

- Short Stay Period:
  - Six months

- Look-back Scan:
  - 4th Q 2016 Oct-Dec
  - 1st Q 2017 Jan-Mar

**Example: Long Stay Look-Back Scan**

Long Stay Period: Three Months

- SCSA MDS ARD 7-14-16
- Quarterly MDS ARD 1-12-17
- Target dates ≤ 275 days prior to the target assessment

- Target Assessment:
  - OBRA
  - PPS
  - Discharge

- Prior Assessment:
  - Fall with Major Injury

- Long Stay
  - CDIF ≥ 101 days at end of target period
  - Target assessment: latest MDS
    - Contained within selected episode
    - Target date (ARD) ≤ 120 before end of episode
  - Prior Assessment
    - Latest assessment 46 to 165 days prior target assessment
  - Look-back scan: target dates ≤ 275 days prior to target MDS
  - Assessments: MDS, OBRA, PPS scheduled and Discharge

**Short Stay Versus Long Stay**

- Short Stay
  - CDIF ≤ 100 days at end of target period
  - Initial MDS following entry record at beginning of selected episode
    - Target date is ≤ 130 days prior to target date of target record
    - Initial MDS cannot be same as target MDS
  - Look-back scan: target date ≤ 120 days before end of episode
    - All MDS’ in current episode target MDS and earlier MDS

- Long Stay
  - CDIF ≥ 101 days at end of target period
  - Target assessment: latest MDS
    - Contained within selected episode
    - Target date (ARD) ≤ 120 before end of episode
  - Prior Assessment
    - Latest assessment 46 to 165 days prior target assessment
  - Look-back scan: target dates ≤ 275 days prior to target MDS
    - Assessments: MDS, OBRA, PPS scheduled and Discharge
Short Stay MDS 3.0 QMs
1. Self-report of moderate to severe pain
2. Pressure ulcers that are new or worsened
3. Assessed and appropriately given the seasonal influenza vaccine
4. Assessed and given, appropriately, the pneumococcal vaccine** (** withdrawn 4/1/17, adjustment needed due to new CDC Immunization Guidelines, still on NHC)

More SS QMs

Visit us at AANAC.org

Visit us at AANAC.org

Questions and Answers

I do not understand why this resident triggered...

I thought this resident would be excluded....

Visit us at AANAC.org

Visit us at AANAC.org

RTI
MDS 3.0 Quality Measures
USER’S MANUAL

Effective September 1, 2016

Visit us at AANAC.org

Visit us at AANAC.org
Using the QM Manual

Chapter 1: Definitions and record selection
Chapter 2: QM Logical Specifications
Appendix D: Measures Withdrawn from NQF Submission
Appendix E: Surveyor QMs

Use the manual to answer complex questions during the exam

Long Stay MDS 3.0 QMs

1. One or more falls with major injury ★ ★
2. Self-report of moderate to severe pain ★★★
3. High-risk residents with pressure ulcers ★ ★ ★
4. Assessed and appropriately given the seasonal influenza vaccine
5. Assessed and appropriately given the pneumococcal vaccine (as noted earlier withdrawn)

★ = also used in Five-Star ★★ = in CASPER

6. Urinary tract infection ★ ★
7. Low-risk residents lose control of bowel or bladder ★
8. Catheter inserted and left in bladder ★ ★ ★
9. Physically restrained ★ ★
10. Need for help with ADLs increased ★ ★
11. Ability to move independently worsened ★ ★

★ = also used in Five-Star ★★ = in CASPER
Long Stay MDS 3.0 QMs

12. Lose too much weight
13. Depressive symptoms
14. Received an antipsychotic medication
15. Received an antianxiety or hypnotic

Prevalence QMs (Long Stay) Surveyor

- Falls
- Behavior symptoms directed toward others
- Antianxiety/hypnotic use

Possible Problems

- Off-site Preparation
- Validated Onsite
- 17 Survey/Clinical QMs
- Appendix E QM Manual

QMs for Survey Process

- Utilize the CASPER Report for survey prep
- Review MDS coding for accuracy
- Utilize QMs in the QA process as this is key to a successful survey and positive resident outcomes

QMs for Surveyors

Total 17 measures

- Available to State surveyors and facility staff through the CASPER reporting system
- Remember: these reports contain a subset of the measures we have been discussing PLUS several additional measures that are available only on the CASPER reports

Short stay (3)

- Self-reported moderate to severe pain
- New/worsened pressure ulcer
- Newly received an antipsychotic medication
### QMs for Surveyors
Total 17 measures

<table>
<thead>
<tr>
<th>QM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long stay (14)</td>
<td>+ = definition in Appendix E QM manual</td>
</tr>
<tr>
<td>Self-reported moderate/severe pain</td>
<td></td>
</tr>
<tr>
<td>High-risk pressure ulcer</td>
<td></td>
</tr>
<tr>
<td>Physical restraints</td>
<td></td>
</tr>
<tr>
<td>Falls +</td>
<td></td>
</tr>
<tr>
<td>Falls with major injury</td>
<td></td>
</tr>
<tr>
<td>Receiving antipsychotic medication</td>
<td></td>
</tr>
<tr>
<td>Antianxiety/hypnotic medication +</td>
<td></td>
</tr>
<tr>
<td>Behavior sx. affecting others +</td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td></td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td></td>
</tr>
<tr>
<td>Cath inserted/left in bladder</td>
<td></td>
</tr>
<tr>
<td>Low risk lose control B/B</td>
<td></td>
</tr>
<tr>
<td>Excess weight loss</td>
<td></td>
</tr>
<tr>
<td>Need for ADL help Increased</td>
<td></td>
</tr>
</tbody>
</table>

---

**Nursing Home Compare
CLAIMS-BASED MEASURES**

**Nursing Home compare
Claims-Based Measures**

Nursing Home Compare Claims-Based Measure Technical Specifications – September 2018

- Re-hospitalized after a NH admission
- Successfully discharged to community
- Had on Outpatient ED Visit
- Number of Hospitalizations per 1,000 Long Stay Residents Days

Publicly Reported  Based on Medicare claims and risk adjusted with claims and MDS data

---

---
Using the NHC Claims-Based Measure Technical Specifications

Percentage of short-stay residents who were re-hospitalized after a nursing home admission

- Numerator and denominator Window
  - The numerator and denominator include STAYS that started over a 12-month period. The data are updated every six months (in April and October of each year), with a lag time of nine months (i.e., the data posted in April will include stays that started 9-21 months ago).

Short Stay Re-Hospitalized

% of residents who were re-hospitalized within 30-days of the start of a nursing home stay

- Numerator
  - The numerator includes nursing home stays for beneficiaries who:
    a) met the inclusion and exclusion criteria for the denominator; AND
    b) were admitted to a hospital for or an inpatient stay or outpatient observation stay within 30 days of entry/transfer to the nursing home, regardless of whether they were discharged from the nursing home prior to the hospital readmission. Note that inpatient hospitalizations and observation stays are identified using Medicare claims; AND
    c) the hospital readmission did not meet the definition of a planned hospital readmission (identified using principal discharge diagnoses and procedure codes on Medicare claims for the inpatient stay).

- Denominator
  - The denominator includes stays for residents who:
    a) entered or reentered the nursing home within 1 day of discharge from an inpatient hospitalization (Note that inpatient rehabilitation facility and long-term care hospitalizations are not included). These hospitalizations are identified using Medicare Part A claims; AND
    b) entered or reentered the nursing home within the target 12-month period.

COVARIATES: claims-based and MDS-based covariates (multiple pages). See Tables 2 and 3 in the Source Documents section

MDS Accuracy:

The MDS items used as covariates span multiple domains that include functional status, clinical conditions, clinical treatments, and clinical diagnoses. These MDS items are most likely to increase or decrease the likelihood of the outcome and are unrelated to the quality of care received while a resident. The resident’s clinical record should be reviewed to ensure the accuracy of items in each domain.
### Facility Characteristics

The **Numerator** indicates the number of residents with the identified characteristic and the **Denominator** indicates the number of residents in the facility.

Simple average percentages are provided for each resident characteristic among all facilities in the state and nation for the selected **Comparison Group** period.

---

### Facility Level Quality Measure Report

**Begin Date** (mm/dd/yyyy) and **End Date** (mm/dd/yyyy) dates are pre-filled for the most recent completed six-month period prior to the month the data were last calculated. May enter alternate dates in an mm/dd/yyyy format.

**Comparison Group** date range options include six-month intervals. The most recent six-month period available for reporting state and national comparison data ends three months prior to the current month.

---

### Date Range Idea

- CASPER data is updated every Monday with all current submissions through the previous week.
- You could use the date of the most recent past Monday and insert that date into the cells for BOTH the “Begin Date” and the “End Date” (Same Date as “Data was Calculated on”).

**What this will provide you with is the most recent “real time” data from the last MDS submission for every resident who is currently on your roster.**
Facility QMs

1-page report summarizing all of the QMs for a "user-defined" date range

The asterisk identifies those measures that crossed an investigative threshold (were "flagged"). QMs at or above the threshold in this column are designated with an asterisk (*). Ranking high enough that it should be investigated in survey.

The QMs for Survey: CASPER Facility

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>High</th>
<th>Average</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hx MRSA</td>
<td>2%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Hx C. diff</td>
<td>2%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Skin Pressure Ulcers</td>
<td>2%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Avoidable Pressure Ulcers</td>
<td>2%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Falling</td>
<td>6%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Falls</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Skilled Staffing</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Antipsychotic Meds</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Antianxiety Meds</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Severe AFOs</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Transfer To Hospital</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
<tr>
<td>Transfer To Skilled</td>
<td>1%</td>
<td>12%</td>
<td>74%</td>
</tr>
</tbody>
</table>

CASPER Facility Quality Measure Report

- **Observed percent:** Numerator ÷ denominator x 100
  - If QMs are not risk adjusted, this is the final score
  - The percentage of residents with the QM condition

- **Adjusted percent:** Results after a covariate is applied to the observed percent as risk adjustment
  - This is the final QM score (3 QMs only)

- **Comparison group state average:** Statewide percentage
  - The average of the QM percentages for all facilities in the state

- **Comparison group national average:** National percentage
  - The average of the QM percentages for all facilities in the nation
Improving Quality Measures – Lower the Number in the Numerator
• Identify CASPER data as one of the primary data sources in the QAPI program
• Identify triggered residents in the QM needing improvement
• Root cause analysis for each resident in the numerator
  — Early detection of early signs of problems
  — Care practices and clinical systems
  — Availability of medical resources
  — Discussion with the physician and/or physician extender
  — Content of documentation

MDS Coding
• Check accuracy of the numerator for MDS items
• Risk adjustment items, such as the covariates must be coded accurately
• Double check that exclusions are coded (e.g., schizophrenia)
• Is missing data and dashes a problem?
• Discharge assessments must be completed timely
Consider

- QMs are retrospective data and methods indicate potential problems that need further review
- Concurrent methods examine actual care and clinical practices
- QMs assess performance of whole systems and parts of systems for defined episodes of care so QAPI efforts can be targeted
- Charter appropriate efforts (PIPs) to investigate, analyze, recommend, trial and evaluate results with the ultimate goal to spread successful attempts and alter trial approaches through lessons-learned

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>CASPER Reports</th>
<th>NH Compare</th>
<th>Five-Star</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHORT STAY</strong></td>
<td>4 9 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Self-report moderate to severe pain</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• New or worsened pressure ulcers</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessed &amp; given seasonal influenza vaccine</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessed &amp; given pneumococcal vaccine</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Newly received antipsychotic medication</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Made improvements in function</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Re-hospitalized after a NH admission**</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Successfully discharged to community**</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Had on Outpatient ED Visit**</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>CASPER Reports</th>
<th>NH Compare</th>
<th>Five-Star</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LONG STAY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One of more falls with major injury</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Self-report moderate to severe pain</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High-risk residents with pressure ulcers</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessed &amp; given seasonal influenza vaccine</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessed &amp; given pneumococcal vaccine</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urinary tract infection</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low-risk residents who lose control of B/B</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cather inserted and left in bladder</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physically restrained</td>
<td>X X X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Quality Measure and Reporting System

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>CASPER Reports</th>
<th>NH Compare</th>
<th>Five-Star</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LONG STAY</strong></td>
<td>16</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Need for help with ADLs increased</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ability to move independently worsened</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lose too much weight</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Received an antipsychotic medication</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Received antianxiety or hypnotic medication</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Behavior symptoms towards others</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antianxiety/hypnotic use</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Added by surveyors*

### Overview

**PATIENT-DRIVEN PAYMENT MODEL**

- Resident classifies for therapy based on amount of therapy SNF chooses to provide to a SNF resident
- Separates payment from the actual provision of services

### SNF PPS History

- 1998: RUGs-III with 44 levels
- 2006: RUGs-III with 53 levels
- 2010: RUGs-IV with 66 levels
- 2019: PDPM
CMS Predicts: PDPM Budget Neutral

CMS Cost Analysis (FY 2017 Data)

- Total Spending: $26,661,528,455
- PDPM: $26,661,528,456

Change in Payment: $1 Dollar

Therapy Payment Estimates
- RUG-IV: $10.2 Billion
- PDPM: $9.7 Billion

Change in Payment: $52 Million less in PDPM

Nursing/NTE Payment Estimates
- RUG-IV: $12 Billion
- PDPM: $12.5 Billion

Change in Payment: $520 Million more in PDPM

CMS Predicts: Winners and Losers in the PDPM

CMS Provider-Level PDPM Analysis

CMS Predicts: DE Change in Payments

CMS Provider-Level PDPM Analysis
Disclaimer: The following information is based on draft CMS documents and is subject to change.

### PDPM Payment Components

- **PT Case-Mix Group**
- **OT Case-Mix Group**
- **SLP Case-Mix Group**
- **Nursing Case-Mix Group**
- **Non-Therapy Ancillary Case-Mix Group**

**Total Per Diem Rate**

### PDPM Daily Rate

<table>
<thead>
<tr>
<th>Component</th>
<th>Base Rate</th>
<th>CMI</th>
<th>Adjustment Factor</th>
<th>Total Per Diem Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Case-Mix</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PT and OT Component Highlights

Clinical Categories
- Uses the primary reason for Med A via ICD-10 in I8000
- MDS Section J2000 Prior Surgery (items to be added)

GG Function Score
- 10 GG items used
- 0 to 24 points assigned

PT and OT Case-Mix Groups
- 16 levels each
- Different CMYs for PT and OT

PT and OT Function Score End-Split

<table>
<thead>
<tr>
<th>Section GG Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-care: Eating (GG0130A1)</td>
<td>0-4</td>
</tr>
<tr>
<td>2. Self-care: Oral hygiene (GG0130B1)</td>
<td>0-4</td>
</tr>
<tr>
<td>3. Self-care: Toileting hygiene (GG0130C1)</td>
<td>0-4</td>
</tr>
<tr>
<td>4. Mobility: Sit to lying (GG0170E1)</td>
<td>0-4</td>
</tr>
<tr>
<td>5. Mobility: Lying to sitting on side of bed (GG0170C1)</td>
<td>0-4</td>
</tr>
<tr>
<td>6. Mobility: Sit to stand (GG0170D1)</td>
<td>0-4</td>
</tr>
<tr>
<td>7. Mobility: Chair/bench-to-chair transfer (GG0170F1)</td>
<td>0-4</td>
</tr>
<tr>
<td>8. Mobility: Toilet transfer (GG0170F1)</td>
<td>0-4</td>
</tr>
<tr>
<td>9. Mobility: Walk 50 feet with 2 turns (GG0170H1)</td>
<td>0-4</td>
</tr>
<tr>
<td>10. Mobility: Walk 150 feet (GG0170K1)</td>
<td>0-4</td>
</tr>
</tbody>
</table>

10 items Score 0-24
**PT and OT Functional Score End-split**

<table>
<thead>
<tr>
<th>Response</th>
<th>ADL Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 – Set up or 06 – Independent</td>
<td>4</td>
</tr>
<tr>
<td>04 – Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03 – Partial/moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02 – Substantial/maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>01 – Dependent</td>
<td>0</td>
</tr>
<tr>
<td>07 – Refused</td>
<td></td>
</tr>
<tr>
<td>09 – Not applicable</td>
<td></td>
</tr>
<tr>
<td>10 – Not attempted due to environmental limitations or skipped due to GG0170I (walk 10 feet coded not attempted)</td>
<td></td>
</tr>
<tr>
<td>88 – Not attempted due to medical condition or safety concerns</td>
<td></td>
</tr>
</tbody>
</table>
SLP Component

1. Acute Neurological Condition
   • Coded as primary diagnosis (first line I8000)

2. SLP-Related Comorbidity (any one)
   • CVA, TIA, or Stroke, Hemiplegia or Hemiparesis, Traumatic Brain Injury, Tracheostomy Cari (while a resident), Ventilator or Respirator (while a resident), Laryngeal Cancer, Apraxia, Dysphagia, Oral Cancers, or Speech and Language Deficits

3. Mild to Severe Cognitive Impairment
   • BIMS interview score or PDPM cognitive level

SLP End-split:
Swallowing Disorder or Mechanically Altered Diet

<table>
<thead>
<tr>
<th>BIMS Score</th>
<th>Cognitive Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 – 15</td>
<td>Cognitively Intact</td>
</tr>
<tr>
<td>8 – 12</td>
<td>Mildly Impaired</td>
</tr>
<tr>
<td>0 – 7</td>
<td>Moderately Impaired</td>
</tr>
<tr>
<td>-</td>
<td>Severely Impaired</td>
</tr>
</tbody>
</table>

If resident is not interviewable then determine cognitive level based on the Cognitive Level Score methodology for non-interviewable residents (next slide)
Nursing Case-Mix Classification

Section GG Item | Score
---|---
1. Self-care: Eating (GG0130A1) | 0-4
2. Self-care: Toileting hygiene (GG0130C1) | 0-4
3. Mobility: Sit to lying (GG0170B1) | 0-4 (average of 2 items)
4. Mobility: Lying to sitting on side of bed (GG0170C1) | 0-4 (average of 2 items)
5. Mobility: Sit to stand (GG0170D1) | 0-4 (average of 3 items)
6. Mobility: Chair/bed-to-chair transfer (GG0170E1) | 0-4 (average of 3 items)
7. Mobility: Toilet transfer (GG0170F1) | 0-4 (average of 3 items)

Uses 7 Section GG Items
Score Range 0-16
Nursing Function Score End-split

<table>
<thead>
<tr>
<th>Response</th>
<th>ADL Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 – Set up OR 06 - Independent</td>
<td>4</td>
</tr>
<tr>
<td>04 – Supervision or touching assistance</td>
<td>3</td>
</tr>
<tr>
<td>03 – Partial/moderate assistance</td>
<td>2</td>
</tr>
<tr>
<td>02 – Substantial/maximal assistance</td>
<td>1</td>
</tr>
<tr>
<td>04 – Dependent; 07 – Refused; 09 – Not applicable; 88 – Not attempted due to medical condition or safety concerns; 10 – Not attempted due to environmental limitations</td>
<td>0</td>
</tr>
</tbody>
</table>

Non-Therapy Ancillary Qualifiers

*49 MDS coded items
*HIV coded on Claim
Non-Therapy Ancillary Qualifiers

*49 MDS coded Items (Con’t)

Non-Therapy Ancillary Groups

<table>
<thead>
<tr>
<th>NTA Score Range</th>
<th>NTA Case-Mix Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>NA</td>
</tr>
<tr>
<td>9-11</td>
<td>NB</td>
</tr>
<tr>
<td>6-8</td>
<td>NC</td>
</tr>
<tr>
<td>3-5</td>
<td>ND</td>
</tr>
<tr>
<td>1-2</td>
<td>NE</td>
</tr>
<tr>
<td>0</td>
<td>NF</td>
</tr>
</tbody>
</table>
Non-Case-Mix Component

- Flat Per Diem Rate
- No change from RUG-IV non-case-mix rate

Variable Rate Adjustments

NTA Component
- Days 1 – 3 = x3
- Days 4 to end of stay = no adjustment

PT and OT Components
- Days 1 – 20 = no adjustment
- Days 21 – 100 = 2% decline every 7 days
### PPS MDS Assessment Schedule

<table>
<thead>
<tr>
<th>Medicare MDS</th>
<th>Assessment Reference Date</th>
<th>Applicable Medicare payment days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day Scheduled PPS Assessment</td>
<td>Days 1-8</td>
<td>All covered Part A days until Part A discharge (unless an IPA is completed)</td>
</tr>
<tr>
<td>Interim Payment Assessment (IPA)</td>
<td><em>Optional with no penalty</em> <em>Date facility determines to complete the IPA</em></td>
<td>ARD of the IPA through Part A discharge (unless another IPA assessment is completed) <em>Does not reset variable per diem rate</em></td>
</tr>
<tr>
<td>PPS Discharge Assessment</td>
<td>PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Therapy Requirements

- **25% combined limit for group and concurrent therapy**
- PT, OT, and SLP component levels paid regardless of whether therapy is delivered or not (However, what’s the skilled service?)

**Therapy items added to the Part A Discharge assessment**
- New “total days and total minutes” item for each therapy discipline

**CMS will continue to monitor for appropriate therapy use**
- Ensure therapy is reasonable and necessary
- Tailored to meet the resident’s unique needs

### Interrupted Stay Policy

- Resident is discharged but returns before 12 a.m. at the end of the third day-continuation of the previous stay
- If the absence exceeds this 3-day interruption window, or in any case where the resident is readmitted to a different SNF
  - The stay is considered a new stay
  - New 5-day assessment is required upon admission
  - Variable per diem restarts
PDPM Impact

Pre-admission screening and the admission process
- Obtain Dx and surgical procedures from hospital

Therapy services
- IDT collaboration based on resident unique needs

Restorative nursing
- Support and enhance resident outcome goals

Clinical systems
- Nursing models of care
- Chronic care management and specialties
- Med A qualifiers

Medicare A: Skilled Services Review

Resident requires skilled services on a daily basis
- Nursing: 7 days a week
- Rehabilitation: ≥5 days a week (§30.6) for at least 15 minutes per day
- Restorative Nursing: at least 6 days a week
Direct Skilled Nursing Services

- IV or IM injections and IV feeding
- Enteral feeding with ≥ 26% of calories and ≥ 501 ml fluid per day
- Nasopharyngeal and tracheostomy suctioning
  - Not oral suctioning
  - Insertion, sterile irrigation and replacement of suprapubic catheters
  - Not routine maintenance of stable indwelling bladder catheters, including emptying and cleaning containers and clamping the tubing

Direct Skilled Nursing Services

- Application of dressings involving prescription medication and aseptic techniques
  - Not changes of dressings for uninfected post-operative or chronic conditions
- Treatment of decubitus ulcers, Stage 3 or worse, or a widespread skin disorder
- Heat treatments ordered by MD as part of active treatment which require observation by nurses to adequately evaluate the patient’s progress

Direct Skilled Nursing Services

- Rehab nursing procedures
  - For example, bowel/bladder programs
  - When skilled status is based solely on a restorative nursing program, there must be documented medical evidence to justify the services
    - "In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration" (§30.6)
Direct Skilled Nursing Services

Initial phases of treatment involving administration of medical gases
• Not routine administration of oxygen after therapy has been established

Care of a colostomy during the early post-operative period in the presence of associated complications
• Not general maintenance care of colostomy and ileostomy

IMPACT ON MDS CODING HOURS

MDS hours Comparison
**PDPM Impact**

**MDS assessment process**
- Accuracy
- Diagnoses
- More items to code
- Fewer assessments
- Section GG coding by nurses and therapist
- Care planning
- Case management
- Monitor for IPA and payment

---

**12 Months and Counting**

<table>
<thead>
<tr>
<th>Anticipated CMS Action (could change)</th>
<th>Recommended Facility Action</th>
</tr>
</thead>
</table>
| Fall/Winter 2018 – Technical Specs on MEDS changes posted | • Shore up ICD-10 Coding  
  • Invest in restorative nursing programs  
  • Improve Medicare A charting  
  • Evaluate PDPM rates vs. RUG-IV rates (using CMS Grouper Tool based on 2017) |
| April 2019 – SNF PPS Proposed Rule (with potential PDPM refinements) |  |
| July 2019 – SNF PPS Final Rule | • Evaluate PDPM rates vs. RUG-IV rates (base on new information)  
  • Train teams on MDS changes  
  • Create transition plan and prepare teams |
| Summer 2019 – CMS conducts provider training?? |  |
| September 2019 – CMS Posts RAI User’s Manual ?? |  |
RUG-IV vs. PDPM: Gather Information

**STEP 1: Determine Coding for these items**

- Primary Diagnosis
- Extensive Services
- RUG-IV Function Score - Section G Based ADL Score
- PDPM Function Score - Section GG Based Score
- Cognitive Impairment
- Swallowing Disorder
- Mechanically Altered Diet
- SLP Comorbidity
- Intr Comorbidity Score
- Depression
- Nursing Category
- Restorative/Nursing Services
- Therapy Minutes
- Facility Location

RUG-IV vs. PDPM: Primary Diagnosis

**Step 2: Determine Clinical Category of Primary Diagnosis**
**Step 3: Determine NTA Count**

Mapping of Comorbidities Included in the Proposed PDPM NTA Component to ICD-10-CM Codes

**Step 4: Complete CMS PDPM Grouper Tool exercise**

**RUG-IV vs. PDPM: Check Accuracy**

- Primary Diagnosis and Surgical Procedures
- Extensive Services
- RUG-IV Function Score - Section G-Based ADL Score
- PDPM Function Score - Section G-Based Score
- Cognitive Impairment
- Swallowing Disorder
- Mechanically Altered Diet
- SLP Comorbidity
- NTA Comorbidity Score
- Depression
- Nursing Category
- Restorative/Nursing Services
- Therapy Minutes
- Facility Location

More on these items

Prior Surgery Items to be added to MDS
QUESTIONS?

Thank You!

Follow me on Twitter: @JudiK_AANAC
Contact me via email: jkulus@aanac.org

Reminder: The information provided is based on draft CMS documents and is subject to change.

We provide the building blocks to help you succeed in your role.

AANAC offers educational tools and resources to help you in your long-term care journey.

Visit AANAC.org/LTC-Tools-and-Resources for an additional FREE tool related to this session’s topic.

Resources

• AANAC: www.AANAC.org
• CMS MDS 3.0 Information Site: www.cms.gov/NursingHomeQualityInitiatives/25_NHQIMDS30.asp
• CMS Website – PPS: www.cms.hhs.gov/SNFPPS/01_overview.asp
Resources

• IMPACT Act Web Page:
• USP Pharmacological Classification of Drugs,
• Medline Plus,

Resources

• PDPM Cognitive Worksheet:
  – https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
  – https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Clinical_Category_Mapping.zip

Resources

• https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Grouper_Tool_20180613.zip
• https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MDS_Manual_Ch6_PDPM_508_corrected.pdf
Resources

- MDS 3.0 Quality Measures User’s Manual v11.1:
- Nursing Home Compare Quality Technical Specification (October 1, 2018)
- AANAC website. At-a-Glance QM, QRP, and VBP Measures
  https://www.aanac.org/Information/Tools
- SNF VBP
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
- SNF QRP Manual
- NHC Claims-Based Measure Tech Specs