2018 MDS Coding Updates and the coming Patient-Driven Payment Model

DHSS
Delaware Health and Social Services

Wednesday, October 3, 2018

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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

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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

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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

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

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B0700: Makes Self Understood

- 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***

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MDS 3.0

Scripted Interviews

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

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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

The Scripted Interviews

- 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"

The Scripted Interviews (cont.)

- 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 **C**0600, **D**0500, **F**0700, **J**0700 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

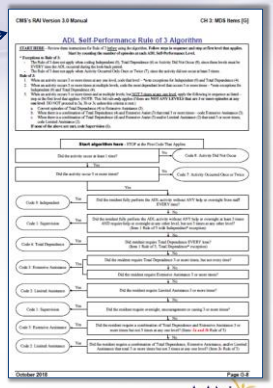
- *Stick to script and cues*
- *Same if interpreter used*

- 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 interviews, 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

FUNCTIONAL ABILITIES AND GOALS

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 illness, exacerbation, or injury

Coding:	Enter Codes in Boxes
3. **Independent** - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. **Needed Some Help** - Resident needed partial assistance from another person to complete activities. 1. **Dependent** - A helper completed the activities for the resident. 8. **Unknown.** 9. **Not Applicable.**	☐ **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.

Coding GG0100

Coding:

3. **Independent** - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Coding scale

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. Motorized wheelchair and/or scooter
- ☐ C. Mechanical lift
- ☐ D. Walker
- ☐ E. Orthotics/Prosthetics
- ☐ Z. None of the above

Same information sources as GG0100

Any – mechanical, sit-to-stand, stand assist, full body lifts

All types

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
1. Admission Performance	2. Discharge Goal	3. Discharge Performance
Enter Codes in Boxes		Enter Code
☐☐	☐☐	☐☐
☐☐	☐☐	Enter Code
		☐☐

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

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Steps for Assessment

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

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Steps for Assessment

4. Activities may be completed with or without assistive device(s)
5. Admission functional assessment, when possible, should be conducted ***prior to the person benefitting 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

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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

Code	Description
06.	**Independent:** Resident completes the activity by him/herself with no assistance from a helper
05.	**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
04.	**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

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Coding Instructions GG0130 & GG0170

code	Description
03.	**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
02.	**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
01.	**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

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

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Coding Instructions GG0130 & GG0170

If activity was not attempted, code reason	
07.	Resident refused
09.	Not applicable – Not attempted and resident did not perform prior to current illness, exacerbation, or injury
10.	Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
88.	Not attempted due to medical condition or safety concerns

CMS stated that allowing staff to use the "activity was not attempted reasons" will reduce the number of dashes used in GG

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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

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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) ✦

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✦ New 10/1/18

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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

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✦ New 10/1/18

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Section GG0170: Mobility Functional Abilities

GG0170G. Car transfer	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
GG0170I. Walk 10 feet	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)
GG0170J. Walk 50 ft w/2 turns	Once standing, the ability to walk at least 50 feet and make two 90-degree turns
GG0170K. Walk 150 feet	Once standing, the ability to walk at least 150 feet in a corridor or similar space
GG0170L. Walk 10 ft on uneven surfaces	The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel

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

New 10/1/18

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Section GG0170: Mobility Functional Abilities

GG0170M. 1 step (curb)	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
GG0170N. 4 steps	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
GG0170O. 12 steps	The ability to go up and down 12 steps with or without a rail.
GG0170P. Picking up object	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

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New 10/1/18

Section GG0170: Mobility Functional Abilities

- 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

GG0170R. Wheel 50 feet with two turns	**Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns**
GG0170R. Wheel 50 feet with two turns	Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space

Follow up question → Indicate the type of wheelchair or scooter used
☐ 1. Manual
2. Motorized

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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*

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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

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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)

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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

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Examples – Please also Check RAI Manual

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

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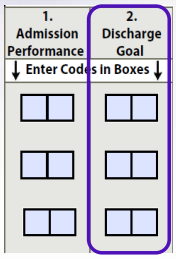
Discharge Goals for GG0130/ GG0170 Column 2



Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment

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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 residents discharge plans
- Goals should be ***established as part of the resident care plan***

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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

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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

1. Admission Performance	2. Discharge Goal
↓ Enter Codes In Boxes ↓	
0 3	0 6

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Mobility Coding Scenarios

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

Choose One

How would you code GG0170F?

04. Supervision or touching assistance
02. Substantial/maximal assistance
01. Dependent
07. resident refused

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Mobility Coding Scenarios

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

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SECTION I

ACTIVE DIAGNOSES

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I0020: Primary Medical Condition

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

I0020. Indicate the resident's primary medical condition category

Enter Code | Indicate the resident's primary medical condition category that best describes the primary reason for admission
Complete only if A0310B = 01

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions
14. Other Medical Condition If "Other Medical Condition," enter the ICD code in the boxes

I0020A.

Used for risk adjustments in SNF QRP

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I0020: Primary Medical Condition

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*

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I0020: Primary Medical Condition

- 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

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I0100 – 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 or
- No longer affected the resident's functioning or plan of care

I0100 – 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

and

– 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

I0100 – 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 assess dyspnea, tobacco use, prognosis, problem conditions, and falls

New Item 10/1/18: J2000 Prior Surgery

J2000. Prior Surgery

Enter Code	Did the resident have major surgery during the **100 days prior to admission**?
	0. **No**
	1. **Yes**
	8. **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 or 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 scar 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

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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

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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

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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

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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

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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

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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

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M0300: Current Number of Unhealed Pressure Ulcers/Injuries

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

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M0300: Current Number of Unhealed Pressure Ulcers/Injuries

- 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

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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"**

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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

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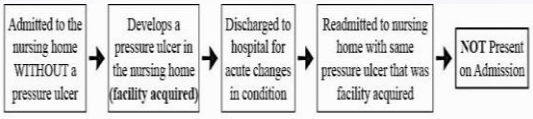
M300: Present on Admission

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



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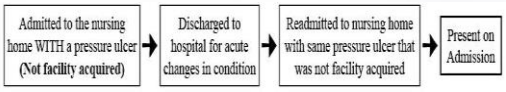
M300: Present on Admission

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



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M300: Present on Admission

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 ✔

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SECTION N

MEDICATIONS

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Section N: Drug Regimen Review (DRR)

- **N2001, N2003, and N2005 Intent**
  - 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 - *Complete only if A0310B = 01*

Enter Code	Did a complete drug regimen review identify potential clinically significant medication issues?
☐	0. No - No issues found during review 1. Yes - Issues found during review 9. NA - Resident is not taking any medications

N2003. Medication Follow-up - *Complete only if N2001 = 1*

Enter Code	Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
☐	0. No 1. Yes

N2005. Medication Intervention - *Complete only if A0310H = 1*

Enter Code	Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?
☐	0. No 1. Yes 9. NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

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

N2001: Drug Regimen Review

Completed only on the PPS 5-day Assessment (A0310B = 01)

- **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 indicate for use
     - Presence of medical condition that may warrant medication therapy
     - Omissions
     - Non-adherence (purposeful or accidental)

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N2001: Drug Regimen Review

- **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

N2001. Drug Regimen Review - Complete only if A0310B = 01	
Enter Code	**Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No** - No issues found during review 1. **Yes** - Issues found during review 9. **NA** - Resident is not taking any medications

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N2001: Drug Regimen Review

- **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

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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

N2003. Medication Follow-up - Complete only if N2001 =1

Enter Code	Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
☐	0. No 1. Yes

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

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N2005: Medication Intervention

- **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

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code	Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?
☐	0. **No** 1. **Yes** 9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

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Other RAI Changes

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

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IMPACT ACT SNF QRP

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IMPACT Act and 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

Medicare Part A beneficiaries only

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IMPACT Act

Background (continued)

- 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**

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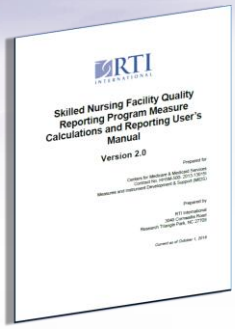
SNF QRP Resource



SNF QRP User's Manual – Eff. October 1, 2018 Version 2.0

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

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SNF QRP- FY 2019 Measures

Quality Measures: Data Collected CY 2017	2% APU Reduction
New/Worsened Pressure Ulcers – MDS 3.0 *(Retired 9/30/2018)*	FY 2019 (10/1/2018)
One or More Major Falls – MDS 3.0	
Admission / Discharge Functional Assessment and Plan of Care – MDS 3.0	
*Estimated Medicare Spending Per Beneficiary**	*not used for APU compliance calculations*
*Discharge to Community**	
*Potentially Preventable 30-Day Post-Discharge**	

** = claims based measure*

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SNF QRP FY 2020 Measures

Quality Measure	Data Collected	2% reduction to APU
One or More Major Falls	January 1 to December 31, 2018 **Full Calendar Year**	FY 2020 (10/1/2019)
Admission / Discharge Functional Assessment & POC		
Changes in Skin Integrity PAC: Pressure Ulcer/Injury *(replaced New or Worsened PU)*	October 1 - December 31, 2018 **2018 Q4 Data only**	

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SNF QRP: FY 2020 New Measures

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

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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*

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VALUE-BASED PURCHASING

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SNF Value-based Purchasing (SNF VBP)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

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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**

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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

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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.

FY2019 Program: Baseline period CY 2015

Improvement Scoring compares a SNF's performance during the performance period against it own prior performance during the baseline period.

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)

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QUALITY MEASURES

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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

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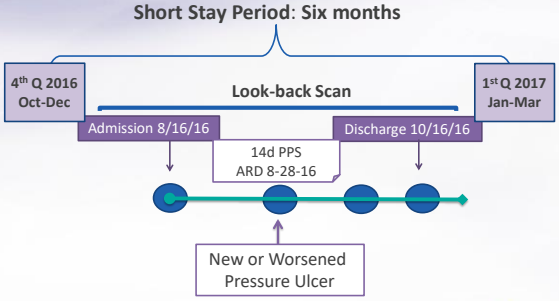
Example: Short Stay Look-Back Scan

Short Stay Period: Six months



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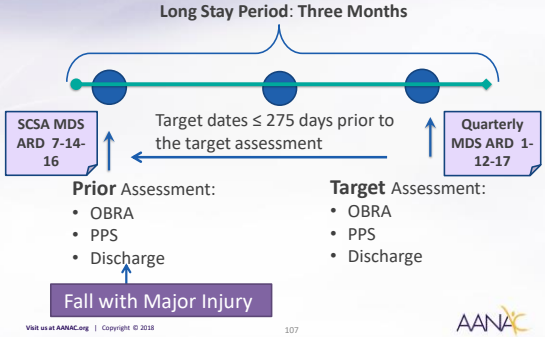
Example: Long Stay Look-Back Scan

Long Stay Period: Three Months



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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

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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

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

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Short Stay MDS 3.0 QMs (continued)

5. Newly received an antipsychotic medication ★ 👻
6. Made improvements in function ★ 👻
7. *Re-hospitalized after a NH admission (claim-based)* ★
8. *Successfully discharged to the community (claims-based)* ★
9. *Outpatient emergency department visit (claims-based)* ★

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

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Questions and Answers

I do not understand why this resident triggered..

I thought this resident would be excluded....

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Using the QM Manual

RTI INTERNATIONAL

MDS 3.0 Quality Measures

USER'S MANUAL

Effective April 1, 2017

- 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

Long Stay MDS 3.0 QMs

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

= also used in Five-Star = in CASPER

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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

Possible Problems

Off-site Preparation

Validated Onsite

17 Survey/Clinical QMs

Appendix E QM Manual

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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

more

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QMs for Surveyors
Total 17 measures

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

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Nursing Home Compare

CLAIMS-BASED MEASURES

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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

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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

Claims-based

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/reentry 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 diagnosis and procedure codes on Medicare claims for the inpatient stay)

Denominator

Included in the measure are 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

Short Stay Re-Hospitalized

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

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

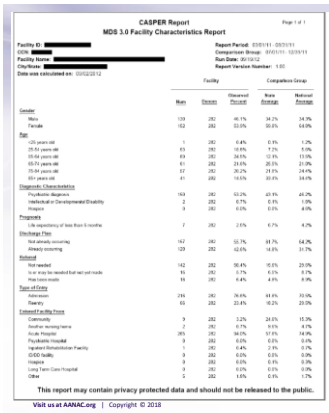
CASPER Reports

Certification and Survey Provider Enhanced Reports
Section 11

MDS 3.0 QM REPORTS

Accessing CASPER

MDS 3.0 QM Reports

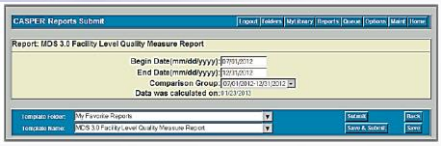

CASPER Report
MDS 3.0 Facility Characteristics Report

Facility Characteristics

The *Numerator* indicates 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 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

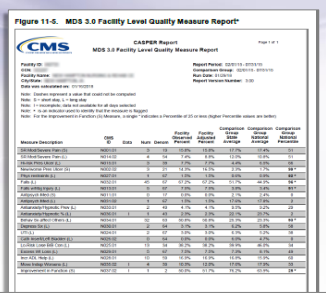


Figure 11-5. MDS 3.0 Facility Level Quality Measure Report*

CASPER Report
MDS 3.0 Facility Level Quality Measure Report

Measure Description	OBS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
SR Mod/Severe Pain (S)	N001.01	S	19	150	12.6%	13.4%	11.7%	11.4%	51
SR Mod/Severe Pain (L)	N014.02	4	54	727	7.4%	8.9%	12.0%	10.8%	11
Hi-risk Pres Ulcer (L)	N015.01	S	38	727	5.2%	7.7%	6.4%	5.5%	55
New/worse Pres Ulcer (S)	N002.02	S	21	150	14.0%	14.5%	2.3%	1.7%	99 *
Phys restraints (L)	N027.01	S	5	727	0.7%	0.8%	0.8%	0.7%	94 *
Falls (L)	N032.01	45	67	727	6.2%	47.2%	51.7%	44.9%	90 *
Falls w/Maj Injury (L)	N013.01	5	67	727	7.4%	7.0%	3.8%	3.4%	91 *
Antipsych Med (S)	N011.01	S	17	150	11.3%	8.8%	2.7%	2.3%	9
Antipsych Med (L)	N031.02	5	67	727	1.0%	1.0%	17.0%	17.0%	2
Antianxiety/Hypnotic Free (L)	N033.01	2	43	727	4.7%	4.7%	8.7%	8.2%	23
Antianxiety/Hypnotic % (L)	N033.01	1	43	727	2.3%	2.3%	23.1%	20.7%	2
Behav Sx affect Others (L)	N034.01	10	63	727	10.0%	10.8%	25.7%	22.5%	63 *
Depress Sx (L)	N030.01	2	64	727	3.1%	3.1%	6.2%	5.6%	58
UTI (L)	N024.01	2	67	727	3.0%	3.0%	5.1%	5.2%	19
Cath Insert/Left Bladder (L)	N026.02	0	67	727	0.0%	0.0%	3.2%	3.2%	0
Lo-Risk Lose B/B Con (L)	N025.01	13	34	727	38.2%	38.2%	38.9%	46.8%	34
Excess Wt Loss (L)	N029.01	3	47	727	7.0%	7.0%	7.0%	8.0%	44
Incr ADL Help (L)	N028.01	10	59	727	10.0%	10.0%	15.0%	15.9%	62
Mov Indep Wheelchr (L)	N035.02	1	4	39	10.0%	12.8%	17.0%	17.0%	35
Improvement in Function (S)	N007.02	1	1	2	50.0%	51.7%	79.2%	61.9%	28 *

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

QMs for Survey: CASPER Facility

Measure Description	OBS ID	Data	Num	Denom	Observed Percent	Adjusted Percent	State Average	National Average	National Percentile
SR Mod/Severe Pain (S)	N001.01						7.4%	16.0%	23
SR Mod/Severe Pain (L)	N014.02						7.6%	7.6%	29
Hi-risk Pres Ulcer (L)	N015.01						5.6%	6.4%	0
New/worse Pres Ulcer (S)	N002.02						1.0%	1.2%	76 *
Phys restraints (L)	N027.01						0.8%	0.7%	94 *
Falls (L)	N032.01						5.1%	45.0%	90 *
Falls w/Maj Injury (L)	N013.01						3.0%	3.4%	93 *
Antipsych Med (S)	N011.01						1.7%	2.3%	0
Antipsych Med (L)	N031.02						2.9%	16.7%	10
Antianxiety/Hypnotic (L)	N033.01						3.3%	8.8%	46
Behav Sx affect Others (L)	N034.01						2.0%	22.7%	29
Depress Sx (L)	N030.01						3.2%	5.6%	76 *
UTI (L)	N024.01						4.3%	4.8%	0
Cath Insert/Left Bladder (L)	N026.02						3.8%	3.2%	0
Lo-Risk Lose B/B Con (L)	N025.01						9.2%	46.8%	34
Excess Wt Loss (L)	N029.01						9.3%	8.0%	86 *
Incr ADL Help (L)	N028.01						4.4%	15.9%	25

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

Figure 11-7. MDS 3.0 Resident Level Quality Measure Report*

CASPER Report
MDS 3.0 Resident Level Quality Measure Report

Page 1 of 6

Facility ID:
Facility Name:
CCN:
City/State:
Data was calculated on: 01/08/2018

Report Period: 07/01/17 - 12/31/17
Run Date: 01/11/18
Report Version Number: 3.00

Note: **S** = short stay, **L** = long stay, **X** = triggered, **0** = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected

Residents

Resident Name	Resident ID	A0310A/B/F	Q4 Hospitalized Freq (3)	Q4 Hospitalized Flag (1)	Stage Pressure Ulcer (1)	Moderate Pain Level (0)	Pain Freq (1)	Pain Flag (1)	Fall Freq (1)	Fall Flag (1)	Antipsych Meds (0)	Antipsych Meds Flag (1)	Antianxiety/Hypnotic Freq (1)	Antianxiety/Hypnotic Flag (1)	Bladder Or Bowel Incont (1)	Depress Dx (4)	UTI (1)	Catheter Inserted Freq (1)	UTI Flag Level 3B2 (Type 3)	Excess Wt Loss (1)	Inc Wt Freq (1)	Inc Wt Flag (Series 5)	Improvement Flag (Series 5)	Quality Measure Count
Date			G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G
Active Residents																								
	2804706B	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	1305489S	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	2607219S	01/18/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	0846143	05/18/99	S	X	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	1
	201409	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	1304034S	02/16/99	S	S	S	S	S	X	S	S	S	X	S	X	X	S	S	S	S	S	S	S	S	4
	1703165I	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	1804H3	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0
	1307J7	02/16/99	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	0

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

* Fictitious, sample data are depicted.

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 (**PIP**s) to investigate, analyze, recommend, trial and evaluate results with the ultimate goal to spread successful attempts and alter trial approaches through lessons-learned

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Quality Measure and Reporting System

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

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** CLAIMS BASED

137

Quality Measure and Reporting System

Quality Measure	CASPER Reports	NH Compare	Five-Star
LONG STAY			
• One of more falls with major injury	X	X	X
• Self-report moderate to severe pain	X	X	X
• High-risk residents with pressure ulcers	X	X	X
• Assessed & given seasonal influenza vaccine		X	
• Assessed & given pneumococcal vaccine		X	
• Urinary tract infection	X	X	X
• Low-risk residents who lose control of B/B	X	X	
• Cather inserted and left in bladder	X	X	X
• Physically restrained	X	X	X

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Quality Measure and Reporting System

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

Added by surveyors

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Overview

PATIENT-DRIVEN PAYMENT MODEL

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SNF PPS History

- 1998: RUGs-III with 44 levels
- 2006: RUGs-III with 53 levels
- 2010: RUGs-IV with 66 levels
- 2019: PDPM

RUGs: Resident classifies for therapy based on amount of therapy SNF chooses to provide to a SNF resident

PDPM: Separates payment from the actual provision of services

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CMS Predicts: PDPM Budget Neutral

26.6 Billion!

CMS Cost Analysis (FY 2017 Data)		
Total Spending	RUG-IV	$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	$502 Million less in PDPM
Nursing/NTE Payment Estimates	RUG-IV	$12 Billion
	PDPM	$12.5 Billion
	Change in Payment	$520 Million more in PDPM

PDPM includes: $17.6 Million less non-case mix payments

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CMS Predicts: Winners and Losers in the PDPM

RUGs .55 Therapy CMI

RUGs 1.69 Therapy CMI

City	State	RUG-IV Total Payments ($)	PDPM Total Payments ($)	Change in Revenue RUG-IV to PDPM
San Francisco	CA	3,228,343	5,194,026	1,965,683
Miami	FL	5,644,401	6,912,534	1,268,133
Port Huron	MI	4,523,907	5,616,725	1,092,817
Washington	DC	3,774,348	4,843,094	1,068,746
Miami	FL	7,327,235	8,393,375	1,066,140
New Rochelle	NY	3,632,339	4,683,955	1,051,616
Manahawkin	NJ	3,947,548	4,947,867	1,000,319
New York	NY	44,042,060	38,693,054	-5,349,005
Brooklyn	NY	31,192,346	27,203,960	-3,988,386
East Islip	NY	17,802,317	15,370,382	-2,431,935
Brooklyn	NY	18,574,380	16,189,261	-2,385,119
New York	NY	15,113,617	13,024,185	-2,089,433
Wellington	FL	16,763,638	14,721,513	-2,042,125
New York	NY	12,657,757	10,650,137	-2,007,620
St James	NY	17,007,892	15,066,067	-1,941,825

CMS Provider-Level PDPM Analysis

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CMS Predicts: DE Change in Payments

RUGs .87 Therapy CMI

RUGs 1.66 Therapy CMI

City	State	Facility Type	Ownership	Location	RUG-IV Total Payments ($)	PDPM Total Payments ($)	Change in Revenue RUG-IV to PDPM
Newark	DE	Freestan	For profit	Urban	4,375,253	4,865,087	489,834
Seaford	DE	Freestan	For profit	Urban	2,487,473	2,860,960	373,487
Middletown	DE	Freestan	For profit	Urban	6,278,942	6,526,751	247,809
Wilmington	DE	Freestan	For profit	Urban	2,967,402	3,178,346	210,944
Milford	DE	Freestan	For profit	Urban	3,703,935	3,889,354	185,419
Seaford	DE	Freestan	Non-profit	Urban	847,216	1,030,024	182,808
Wilmington	DE	Freestan	For profit	Urban	11,939,399	11,053,655	-885,745
Wilmington	DE	Freestan	For profit	Urban	8,377,140	8,144,078	-233,062
Millsboro	DE	Freestan	For profit	Urban	7,348,925	7,123,965	-224,960
Wilmington	DE	Freestan	For profit	Urban	5,744,056	5,552,371	-191,685
Dover	DE	Freestan	For profit	Urban	5,112,766	4,944,076	-168,690
Millsboro	DE	Freestan	For profit	Urban	5,433,874	5,283,343	-150,531
Smyrna	DE	Freestan	For profit	Urban	4,756,928	4,619,900	-137,028
Dover	DE	Freestan	Non-profit	Urban	3,602,379	3,470,610	-131,769

CMS Provider-Level PDPM Analysis

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PDPM Clock is Ticking!

Begins Oct. 1, 2019

Disclaimer: The following information is based on draft CMS documents and is subject to change.

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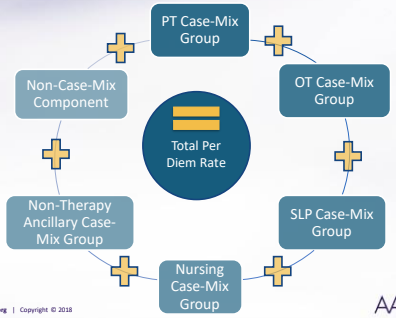
PDPM Payment Components



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PDPM Daily Rate

PT	Base Rate	X	CMI	X	Adjustment Factor	
+						
OT	Base Rate	X	CMI	X	Adjustment Factor	
+						
SLP	Base Rate	X	CMI			
+						
Nursing	Base Rate	X	CMI			
+						
NTA	Base Rate	X	CMI	X	Adjustment Factor	
+						
Non-Case-Mix	Base Rate					

Total Per Diem Rate

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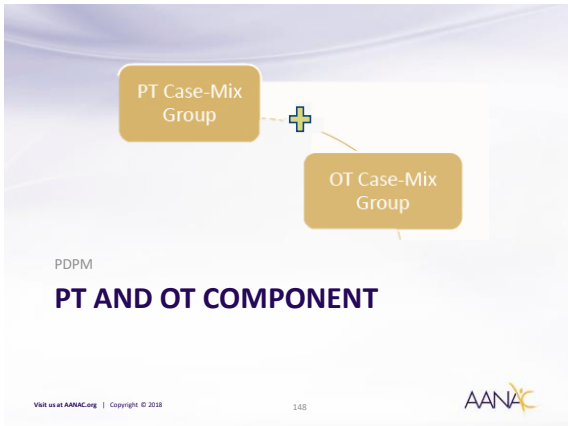

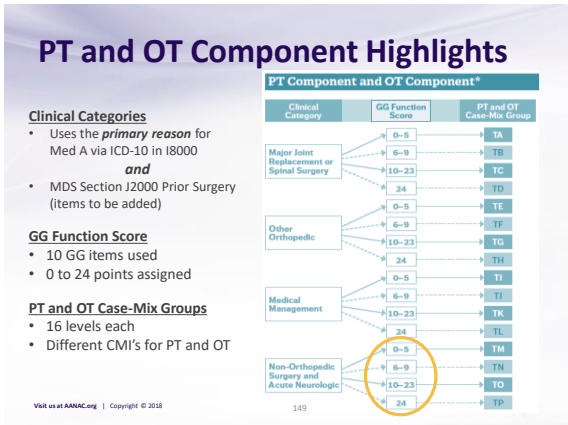

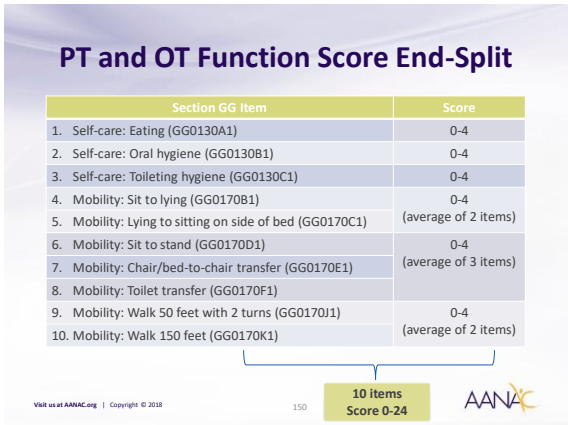

PT and OT Function Score End-Split

Section GG Item	Score
1. Self-care: Eating (GG0130A1)	0-4
2. Self-care: Oral hygiene (GG0130B1)	0-4
3. Self-care: Toileting hygiene (GG0130C1)	0-4
4. Mobility: Sit to lying (GG0170B1)	0-4 (average of 2 items)
5. Mobility: Lying to sitting on side of bed (GG0170C1)	
6. Mobility: Sit to stand (GG0170D1)	0-4 (average of 3 items)
7. Mobility: Chair/bed-to-chair transfer (GG0170E1)	
8. Mobility: Toilet transfer (GG0170F1)	
9. Mobility: Walk 50 feet with 2 turns (GG0170J1)	0-4 (average of 2 items)
10. Mobility: Walk 150 feet (GG0170K1)	

10 items
Score 0-24

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PT and OT Functional Score End-split

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

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PT and OT Case-mix Groups

TABLE 21: PT and OT Case-mix Classification Groups

Clinical Category	Section GG Function Score	PT OT Case-Mix Group	PT Case-Mix Index	OT Case-Mix Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

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PDPM

SPEECH LANGUAGE PATHOLOGY COMPONENT

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SLP Component

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

2. SLP-Related Comorbidity (any one)
- CVA, TIA, or Stoke, Hemiplegia or Hemiparesis, Traumatic Brain Injury, Tracheostomy Care (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

All three | Any two | Any one | None

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SLP End-split: Swallowing Disorder *or* Mechanically Altered Diet

1

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder
Check all that apply

- A. Loss of liquids/solids from mouth when eating or drinking
- B. Holding food in mouth/cheeks or residual food in mouth after meals
- C. Coughing or choking during meals or when swallowing medications
- D. Complaints of difficulty or pain with swallowing
- Z. None of the above

2

K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last **7 days**

- C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)

Neither | Either | Both

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SLP Component

Cognitive Level Based on BIMS Score

Level	BIMS Score
Cognitively Intact	13 – 15
Mildly Impaired	8 – 12
Moderately Impaired	0 – 7
Severely Impaired	-

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

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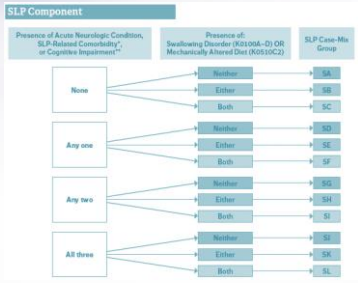
American Association of Directors of Nursing Services

Resident Cognitive Level Determination

Step A – Severely Impaired			
MDS Item	**MDS Score**	**Yes**	**No**
Option 1: Comatose (B0100) = 1 ***and*** all following Section GG items apply Self-Care Items 1. Eating (GG0130A1) 2. Toileting hygiene (GG0130C1) Mobility Items 3. Sit to lying (GG0170B1) 4. Lying to sitting on side of bed (GG0170C1) 5. Sit to stand (GG0170D1) 6. Chair/bed-to-chair transfer (GG0170E1) Toilet transfer (GG0170F1) ***Option 2:*** 1. Cognitive skills for daily decision making	B0100 = (1) **And** Resident completely dependent or activity did not occur for ALL seven (7) Section GG items of the MDS **MDS Coding Equals one of the following:** (01) Dependent (09) Not Applicable – (Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury) (88) Not attempted due to medical condition or safety concerns C1000 = (3)	If "yes" to either option #1 or #2 stop here [Res Qualifies for SLP Cognitive Impairment]	If all "no" to both option #1 and #2 proceed to step B
Step B1 – Basic Impairment Count			
MDS Item	**MDS Score**	**Yes**	**No**
a. Cognitive Skills for Daily Decision Making (C1000)	1 or 2		
b. Makes Self Understood (B0700)	1, 2, or 3		
c. Short-term Memory OK (C0700)	1		
	Sum of a., b., and c. count		
Step B2 – Severe Impairment Count			
MDS Item	**MDS Score**	**Yes**	**No**
a. Cognitive Skills for Daily Decision Making (C1000)	2		
b. Makes Self Understood (B070)	2 or 3		
	Sum of a. and b.		
	Check "yes" if Basic Impairment Count (B1) is 2 or 3 AND Severe Impairment Count (B2) is 1 or 2		

SLP Component



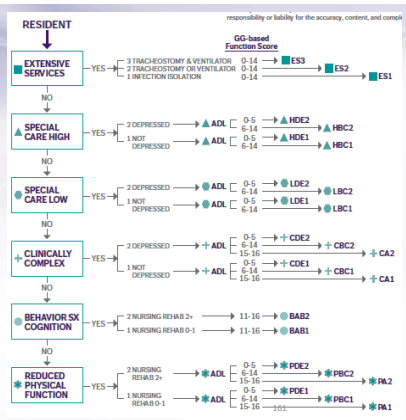
SLP Component CMI

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	SLP Case-Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

12 Levels

PDPM

NURSING CASE-MIX CLASSIFICATION



Nursing Function Score End-Split

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)	
5. Mobility: Sit to stand (GG0170D1)	0-4 (average of 3 items)
6. Mobility: Chair/bed-to-chair transfer (GG0170E1)	
7. Mobility: Toilet transfer (GG0170F1)	

Uses 7 Section GG Items
Score Range 0-16

Nursing Function Score End-split

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

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PDPM

NON-THERAPY ANCILLARY COMPONENT

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Non-Therapy Ancillary Qualifiers

HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV Feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I6200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis—Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1

*49 MDS coded Items
*HIV coded on Claim

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Non-Therapy Ancillary Qualifiers

Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer—Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code (M1040B)	MDS Item M1040A, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I8000	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy—Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnosis: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity—Except: RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

*49 MDS coded Items (Con't)

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Non-Therapy Ancillary Groups

NTA Score Range	NTA Case-Mix Group
12+	NA
9-11	NB
6-8	NC
3-5	ND
1-2	NE
0	NF

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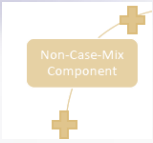

PDPM

NON-CASE-MIX COMPONENT

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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

PDPM

MEDICARE A
MDS ASSESSMENT SCHEDULE

PPS MDS Assessment Schedule

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

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

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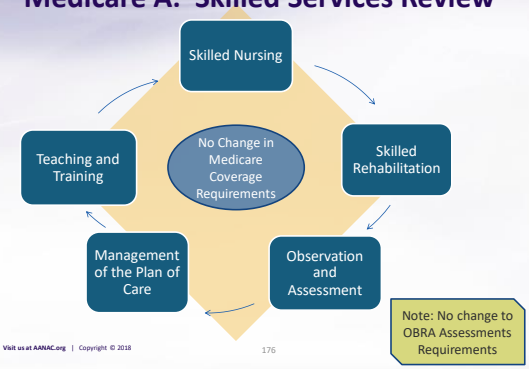
Medicare A: Skilled Services Review



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Medicare A: Daily Skilled Services

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

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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*

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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

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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)

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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*

PDPM

IMPACT ON MDS CODING HOURS

Handout

MDS hours Comparison

AANAC 2017 Work Study Averages:	Comprehensive (e.g., 5 hrs.)		Quarterly (e.g., 1 hr.)		Discharge (e.g., 0.5 hr.)		PPS (e.g., 1 hr.)		OMRA (EOT, SOT, EOT) (e.g., 0.5 hr.)		Tracking Forms Entry/Death in Facility (e.g., 10 min/ 17)		Managed Care Assessments (e.g., 1 hr.)		Validated Submission (e.g., 0.25 hours per batch)		Baseline Care Plan (e.g., 0.5 min per unit)		QRPP/ QM average mins	Non-assessment Time	Total Monthly Hours	Converted FTEs Needed
AANAC 2017 time Study Averages →	5		1		0.5		1		0.5		0.17		1		0.4		0.5		0	109.50		
Date	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# batches / wk.	Hrs.	# Medicare Advances Hrs.	Hours per Advances	Average hours per Month	See Chart below		
RUG-IV Oct-Dec																						
Oct	16	80	16	16	7	3.5	16	16	4	2	10	2.94	5	5	2	3.2	4	2	0	109.5	247.14	1.4
Nov	10	50	9	9	11	5.5	9	9	6	4	10	1.7	6	6	2	3.2	6	3	0	109.5	248.9	1.2
Dec	16	80	16	16	7	3.5	16	16	3.5	2	10	2.94	5	5	2	3.2	5	2.5	0	109.5	243.57	1.4

AANAC FY19 RUG-IV	Comprehensive (e.g., 5 hrs.)		Comprehensive + 5-day (e.g., 5.5 hrs.)		Quarterly, Scheduled 14-, 30-, 60-, 90-day PPS		5-day PPS stand alone (e.g., 1.25 hr.)		Unscheduled PPS OMRA, Discharges (EOTA, MPE)		Tracking Forms Entry/Death in Facility (e.g., 10 min/ 17)		Managed Care Assessments (e.g., 1 hr.)		Validated Submission (e.g., 0.5 hrs. per batch)		Baseline Care Plan		QRPP/ QM average mins	Non-assessment Time	Total	Total MDS FTEs Needed
Estimated FY19 daily average →	5.15		5.5		1		1.25		0.5		0.17		1		0.4		0.5		0	109.50		
Date	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# batches / wk.	Hrs.	# Medicare Advances Hrs.	Hrs. per week	Hrs. per week	see below		
RUG-IV Oct-Dec																						
Oct	11	56.65	6	27.5	22	22	4	5	9	5.5	10	2.94	5	5	2	3.2	4	2	0	109.5	240.34	1.4
Nov	4	20.6	6	33	20	20	1	1.25	16	9.5	10	1.7	6	6	2	3.2	6	3	0	109.5	238.75	1.3
Dec	6	30.9	10	55	21	21	2	2.5	10	5.5	8	1.37	4	4	2	3.2	5	2.5	0	109.5	264.47	1.5

Estimated FY20 PDPM	Comprehensive (e.g., 5 hrs.)		Comprehensive + 5-day (e.g., 5.5 hours)		Quarterly (e.g., 1 hr.)		5-day PPS stand alone (e.g., 1.25 hr.)		Discharge Assessments (OASIS, PPS or combined)		Tracking Forms Entry/Death in Facility (e.g., 10 min/ 17)		Managed Care Assessments (e.g., 1 hr.)		Validated Submission (e.g. 0.5 hrs. per batch)		Baseline Care Plan		QRPP/ QM average mins	Non-assessment Time	Total	Total MDS FTEs Needed
Estimated Daily average under PDPM →	5.15		5.5		1		1.25		0.5		0.17		1		0.4		0.5		0	109.50		
Date	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# MDSs	Hrs.	# batches / wk.	Hrs.	# Medicare Advances Hrs.	Hrs. per week	Hrs. per week	see below		
PDPM																						
Oct	11	56.65	6	27.5	10	10	4	5	11	5.5	10	2.94	5	5	2	3.2	4	2	0	109.5	242.34	1.5
Nov	4	20.6	6	33	10	10	1	1.25	10	5.5	10	1.7	6	6	2	3.2	6	3	0	109.5	243.95	1.3
Dec	6	30.9	10	55	11	11	2	2.5	10	5.5	8	1.37	4	4	2	3.2	5	2.5	0	109.5	263.97	1.5

AANAC MDS hours Comparison

2017 Work Study

- Average FTE 1.33 or 53.2 hours per week
- Time spent for assessment completion and meetings from work study

FY2019 RUG-IV Estimates

- Average FTE 1.36 or 54.4 hours per week
- Increase number of MDS items for QRP
  - I0020
  - J2000
  - GG
  - N2001, N2003, N2005

FY2020 PDPM Estimates

- Average FTE 1.36 or 54.4 hours per week
- Decrease number of PPS assessments
- Increased focus and accuracy of ICD-10
- Increased time with monitoring charting and case management

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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

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12 Months and Counting

Anticipated CMS Action (could change)	Recommended Facility Action
Fall/Winter 2018 – Technical Specs on MDS changes posted April 2019 – SNF PPS Proposed Rule (with potential PDPM refinements)	• 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)
July 2019 – SNF PPS Final Rule Summer 2019 – CMS conducts provider training?? September 2019 – CMS Posts RAI User's Manual ??	• Evaluate PDPM rates vs. RUG-IV rates (base on new information) • Train teams on MDS changes • Create transition plan and prepare teams

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CMS PDPM Grouper Tool

RUGS-IV VS. PDPM PAYMENT ANALYSIS PROCESS

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
- NTA 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

Mapping: PDPM Clinical Categories to ICD-10 Diagnosis Codes for FY2019

Overview

ICD-10-CM Code	Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
M84472P	Pathological fracture, left ankle, subsequent encounter for fracture with malunion	Non-Surgical	N/A
M84472S	Pathological fracture, left ankle, sequela	Non-Surgical	N/A
M84473A	Pathological fracture, unspecified ankle, initial encounter for fracture	Return to Provider	N/A
M84473D	Pathological fracture, unspecified ankle, subsequent encounter for fracture with routine	Return to Provider	N/A
M84473G	Pathological fracture, unspecified ankle, subsequent encounter for fracture with delayed	Return to Provider	N/A
M84473K	Pathological fracture, unspecified ankle, subsequent encounter for fracture with	Return to Provider	N/A
M84473P	Pathological fracture, unspecified ankle, subsequent encounter for fracture with	Return to Provider	N/A
M84473S	Pathological fracture, unspecified ankle, sequela	Return to Provider	N/A
M84474A	Pathological fracture, right foot, initial encounter for fracture	Medical Management	N/A
M84474D	Pathological fracture, right foot, subsequent encounter for fracture with routine healing	Medical Management	May be Eligible for One of the Two Orthopedic Surgery Categories
M84474G	Pathological fracture, right foot, subsequent encounter for fracture with delayed healing	Medical Management	May be Eligible for One of the Two Orthopedic Surgery Categories

RUG-IV vs. PDPM: NTA Categories

Step 3: Determine NTA Count

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

Overview

The following mapping of CCs and RxCCs to ICD-10-CM codes is based on the 2017 Risk Adjustment model software found at https://www.cms.gov/Medicare/Health-Plans/Medica

Sort Order	Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
1	HIV/AIDS	B20	Human immunodeficiency virus [HIV] disease
65	RxCC5: Opportunistic Infections	A072	Cryptosporidiosis
66	RxCC5: Opportunistic Infections	A310	Pulmonary mycobacterial infection
67	RxCC5: Opportunistic Infections	A312	Disseminated mycobacterium avium-intracellulare complex (DMAC)
68	RxCC5: Opportunistic Infections	B250	Cytomegaloviral pneumonitis
69	RxCC5: Opportunistic Infections	B251	Cytomegaloviral hepatitis
70	RxCC5: Opportunistic Infections	B252	Cytomegaloviral pancreatitis
71	RxCC5: Opportunistic Infections	B258	Other cytimegaloviral diseases
72	RxCC5: Opportunistic Infections	B259	Cytomegaloviral disease, unspecified
73	RxCC5: Opportunistic Infections	B371	Pulmonary candidiasis
74	RxCC5: Opportunistic Infections	B377	Candidal sepsis
75	RxCC5: Opportunistic Infections	B37581	Candidal esophagitis
76	RxCC5: Opportunistic Infections	B440	Invasive pulmonary aspergillosis
77	RxCC5: Opportunistic Infections	B441	Other pulmonary aspergillosis
78	RxCC5: Opportunistic Infections	B442	Tonsillar aspergillosis
79	RxCC5: Opportunistic Infections	B447	Disseminated aspergillosis
80	RxCC5: Opportunistic Infections	B4489	Other forms of aspergillosis
81	RxCC5: Opportunistic Infections	B449	Aspergillosis, unspecified
82	RxCC5: Opportunistic Infections	B458	Pulmonary cryptococcosis

RUG-IV vs. PDPM: Fill in Grouper Data

Step 4: Complete CMS PDPM Grouper Tool exercise

Grouper Interactive Tool - Simulating Resident Classifications and Per Diem Payments under RUG-IV and the Proposed PDPM

Per Diem Payment Comparison (Based on FY 2019 Base Rates)

RUG-IV Payment	$632.88
PDPM Payment	$604.41

RUG-IV vs. PDPM: Check Accuracy

More on these items

- Primary Diagnosis and Surgical Procedures
- 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
- NTA Comorbidity Score
- Depression
- Nursing Category
- Restorative Nursing Services
- Therapy Minutes
- Facility Location

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: ww.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- CMS Website – PPS: www.cms.hhs.gov/SNFPPS/01_overview.asp
- QIES Technical Support – MDS 3.0 Information: https://www.qtso.com/mds30.html

Resources

- **IMPACT Act Web Page:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html
- **GlobalRPh Drug Reference**, http://globalrph.com/drug-A.htm
- **USP Pharmacological Classification of Drugs**, http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines
- **Medline Plus**, https://www.nlm.nih.gov/medlineplus/druginformation.html

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Resources

- PDPM Cognitive Worksheet:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MDS_Manual_Ch_6_PDPM_508.pdf
  - 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

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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

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Resources

- MDS 3.0 Quality Measures User's Manual v11.1: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/NursingHomeQualityInits/NHQIQualityMeasures.html
- Nursing Home Compare Quality Technical Specification (October 1, 2018) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

Resources

- 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
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Calculations-and-Reporting-Users-Manual-V20.pdf
- NHC Claims-Based Measure Tech Specs
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Nursing-Home-Compare-Claims-based-Measures-Technical-Specifications.pdf