

# Quality Reporting Program Provider Training



**SKILLED  
NURSING  
FACILITY**

**QUALITY REPORTING  
PROGRAM**

## Changes to the RAI Manual and MDS 3.0 Item Sets

Teresa Mota, Abt Associates

May 7, 2019

# Acronyms in This Presentation

- ARD – Assessment Reference Date
- APU – Annual Payment Update
- CCN – CMS Certification Number
- CMS – Centers for Medicare & Medicaid Services
- FY – Fiscal Year
- HIPPS – Health Insurance Prospective Payment System
- IMPACT Act – Improving Medicare Post-Acute Care Transformation Act
- IPA – Interim Payment Assessment
- MDS – Minimum Data Set
- NTA – Non-Therapy Ancillary



# Acronyms in This Presentation (cont. 1)

- OBRA – Omnibus Budget Reconciliation Act
- OMRA – Other Medicare Required Assessment
- OSA – Optional State Assessment
- OT – Occupational Therapy
- OV – Observational Version
- PAC – Post-Acute Care
- PDPM – Patient Driven Payment Model
- PHQ – Patient Health Questionnaire
- PPS – Prospective Payment System
- PT – Physical Therapy



# Acronyms in This Presentation (cont. 2)

- QIES ASAP – Quality Improvement Evaluation System Assessment Submission and Processing
- QRP – Quality Reporting Program
- RAI – Resident Assessment Instrument
- RN – Registered Nurse
- RUG – Resource Utilization Group
- SB – Swing Bed
- SLP – Speech-Language Pathology
- SNF – Skilled Nursing Facility
- SPADE – Standardized Patient Assessment Data Elements

QIES ASAP  
RN  
RUG SB  
SLP  
SPADE  
QRP  
SNF  
RAI

# Objectives

- Identify the relationship between the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) and data collected for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
- List at least three Resident Assessment Instrument (RAI) Manual changes.
- Name three reasons item set changes were made.
- List at least one new, one revised, and one removed Minimum Data Set (MDS) item.

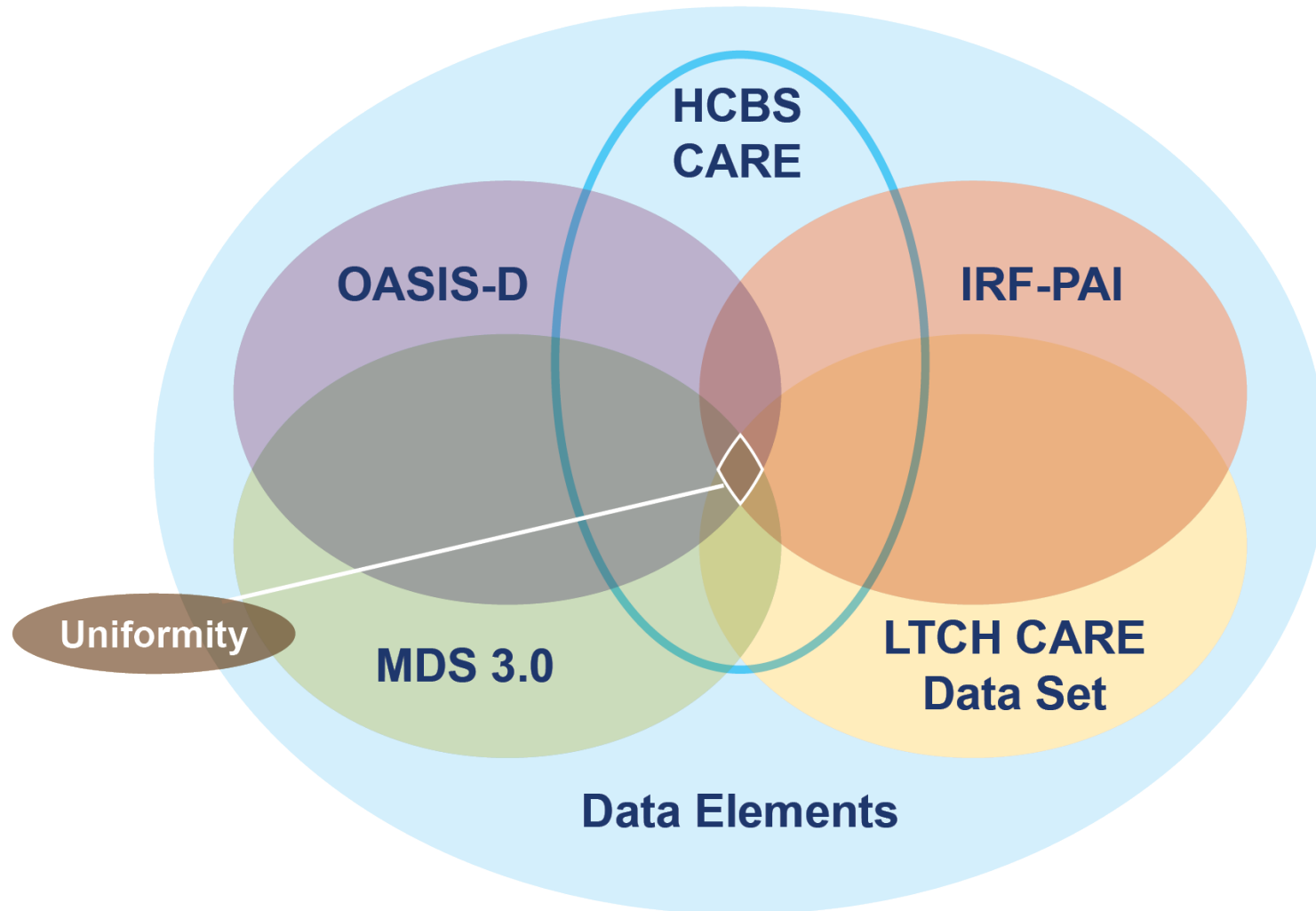


# IMPACT Act of 2014

# IMPACT Act of 2014

- Bipartisan bill passed on September 18, 2014, and signed into law on October 6, 2014.
- Requires standardized patient assessment data across post-acute care (PAC) that will enable:
  - Quality care and improved outcomes.
  - Data element uniformity.
  - Comparison of quality and data across PAC settings.
  - Improved, person-centered, goals-driven discharge planning.
  - Exchangeability of data.
  - Coordinated care.

# Data Elements: Standardization



## LEGEND

**HCBS CARE** (Home and Community Based Services Continuity Assessment Record and Evaluation)

**IRF-PAI** (Inpatient Rehabilitation Facility Patient Assessment Instrument)

**LTCH CARE Data Set** (Long Term Care Hospital Continuity Assessment Record and Evaluation Data Set)

**MDS 3.0** (Minimum Data Set Version 3.0)

**OASIS-D** (Outcome and Assessment Information Set – D).



# Standardized Data: Goals and Guiding Principles

## Goals

- ✓ Fosters seamless care transitions
- ✓ Data & Information that can follow the patient
- ✓ Evaluation of longitudinal outcomes for patients that traverse settings
- ✓ Assessment of quality across settings
- ✓ Improved outcomes, and efficiency
- ✓ Reduction in provider burden

## Data Uniformity

- ✓ Reusable
- ✓ Informative
- ✓ Increases Reliability/validity
- ✓ Facilitates patient care coordination

## Guiding Principles

## Interoperability

- ✓ Data that can communicate in the same language across settings
- ✓ Data that can be transferable forward and backward to facilitate care coordination
- ✓ Follows the individual

# SNF Quality Reporting Program

- In response to the reporting requirements under the Act, CMS established the SNF QRP and its quality reporting requirements in the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS).
- Per the statute, SNFs that do not submit the required quality measures data may receive a two-percentage-point reduction to their annual payment update (APU) for the applicable payment year.
- For more information regarding the SNF QRP, please visit our website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Overview.html>.



# Why were changes made to the MDS and RAI Manual?

- IMPACT Act – Standardized Patient Assessment Data Elements (SPADE).
- Align content of items that support cross-setting measures (e.g., pressure ulcer/injury).
- Reduce burden.
- Quality measure changes.
- Survey and certification.
- Patient Driven Payment Model (PDPM).

# RAI Manual and Item Set Revisions

# Changes by Chapter or Section

New	• Chapter 6 – 6.3 Patient Driven Payment Model – 6.3 PDPM Calculation Worksheets	
Changed	• Chapter 2 • Chapter 5 • Section A • Section C • Section D • Section GG • Section I	• Section J • Section K • Section O • Section V • Section X • Section Z
Unchanged	• Section B • Section E • Section F • Section G • Section H	• Section L • Section M • Section N • Section P • Section Q

# Global Changes

- Acronyms have been spelled out the first time they are used with the acronym to follow.
- URLs have been updated.
- Typographical and grammatical errors have been fixed.
- Where page numbers are used as reference, replaced with Section/Chapter reference.
- Standardized acronym for Quality Improvement Evaluation System Assessment Submission and Processing system, as “QIES ASAP system.”
- “Pressure ulcer” revised to “pressure ulcer/injury” where appropriate.
- Removed “mental retardation in federal regulation” when referring to “intellectual disability.”

# Global Changes (cont.)

- Guidance added throughout the manual in relation to the two new item sets have been added.
- The term, “Medicare,” revised to Prospective Payment System, “PPS,” where appropriate.
- Any and all references to the following have been removed throughout the entire RAI Manual:
  - PPS 14-, 30-, 60-, and 90-Day Assessments.
  - Other Medicare Required Assessment (OMRA) (Start, End, Start and End of Therapy, and Change of Therapy) Assessments.
  - Swing Bed (SB) Clinical Change Assessment.

# New Assessment Types/Item Sets

NEW

There are two new assessment types. Both are **optional**:

1. Interim Payment Assessment (IPA): This is the set of items active on an IPA and used for PPS payment purposes. (Item A0310B=08)
2. Optional State Assessment (OSA): This is the set of items that may be required by a State Medicaid agency to calculate the Resource Utilization Group (RUG) III or RUG IV Health Insurance Prospective Payment System (HIPPS) code. This is not a federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. (Item A0300A=1)

**NOTE**

Both are standalone assessments and may not be combined with any other assessment.



# Chapter 2:

# Assessments for the RAI

# Overall Changes in Chapter 2

- Interrupted stay definition and additional instructional text was updated related to the new interrupted stay policy.
- New item set implications on policy (i.e., IPA and Optional State Assessment (OSA)).



# Change in Ownership

Common situation updated:

- When an owner assumes the assets and liabilities of the prior owner, the new owner retains the current CMS Certification Number (CCN) number.
- The example was updated to reflect the IPA: *“If the resident is in a Part A stay, and the 5-Day PPS assessment was combined with the OBRA Admission assessment, the next PPS assessment could be an Interim Payment Assessment (IPA), if the provider so chooses to complete one, and would also be submitted under the existing provider number.”*

# 5-Day Assessment Window

- The PPS 5-Day assessment has defined days within which the Assessment Reference Date (ARD) must be set.
- The ARD must be a day within the prescribed window of days 1 through 8 of the Part A stay.
- The ARD must be set on the MDS form itself or in the facility software before this window has passed.

Assessment Reference Date (ARD)						
SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

# 5-Day Assessment Window (cont.)

- The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes *and for purposes of the variable per diem adjustment*.
- In most cases, the first day of Medicare Part A coverage is the date of admission. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date.

# Scheduled and Unscheduled Assessments

## Scheduled and Unscheduled Assessments.

- Scheduled PPS Assessment.
  - *The PPS-required standard assessment is the 5-Day assessment, which has a predetermined time period for setting the ARD. The SNF provider must set the ARD on days 1–8 to assure compliance with the SNF PPS PDPM Requirements.*

# Scheduled and Unscheduled Assessments (cont.)

- Unscheduled PPS Assessment.
  - There are situations when a SNF provider *may* complete an assessment *after* the 5-Day assessment. *This* assessment is an *unscheduled assessment* called the *Interim Payment Assessment (IPA)*. *When deemed appropriate by the provider, this assessment may be completed to capture changes in the resident's status and condition.*

# 5-Day Assessment

## 01. 5-Day Assessment:

- ARD (*item A2300*) must be set *for Days 1 through 8* of the Part A SNF covered stay.
- Must be completed (*item Z0500B*) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment *for entire PPS* stay (*except in cases when an IPA is completed*).
- Is the first *PPS*-required assessment to be completed when the resident is first admitted for a SNF Part A stay.



# 5-Day Assessment (cont. 1)

- Is the first *PPS*-required assessment to be completed when the resident is readmitted to the facility *for a Part A stay*:
  - Following a discharge assessment—return not anticipated—OR
  - If the resident returns more than 30 days after a discharge—return anticipated.
- *A 5-Day assessment is not required at the time when a resident returns to a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption (facility discharge, resident no longer skilled, payer change, etc.).*

# 5-Day Assessment (cont. 2)

- If a resident *changes payers* from Medicare Advantage to Medicare Part A, the SNF must complete a 5-Day assessment with the ARD set for one of the days 1 through 8 of the Medicare Part A stay, with the resident's first day covered by Medicare Part A serving as Day 1, unless it is a case of an interrupted stay.

# Interim Payment Assessment (optional)

## *02. Interim Payment Assessment (optional)*

- ARD may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day.*
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).*
- Authorizes payment for remainder of the PPS stay, beginning on the ARD.*
- Must be submitted 14 days after completion (Item Z0500B) (completion + 14 days).*
- The ARD for an IPA may not precede that of the 5-Day assessment.*
- May not be combined with any other assessments (PPS or OBRA).*

# Part A PPS Discharge

## 03. Part A PPS Discharge Assessment (A0310H):

- The Part A PPS Discharge (NPE) assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility** *(unless it is an instance of an interrupted stay)*.

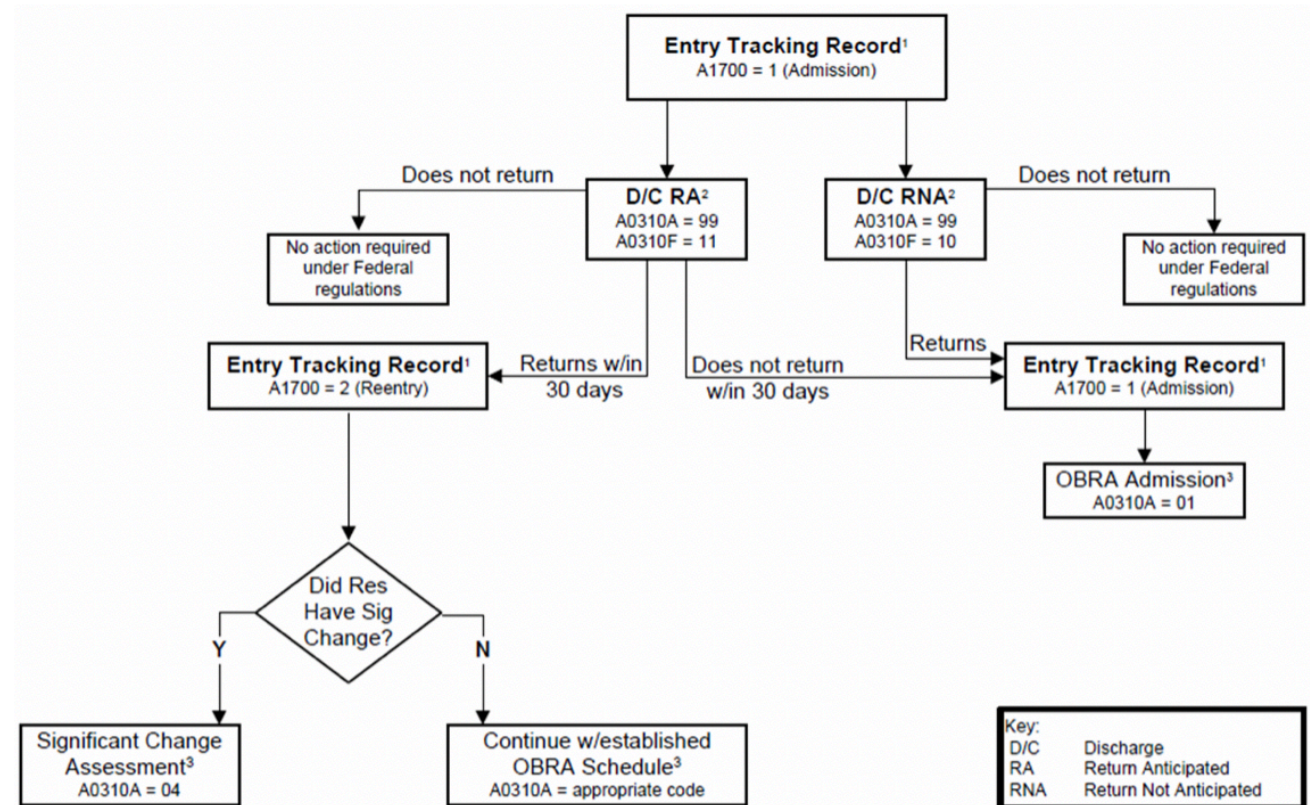
# Part A PPS Discharge (cont. 1)

- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits *do not* resume *within 3 days*, the PPS schedule starts again with a 5-Day assessment. *If the Medicare Part A stay does resume within the 3-day interruption window, then this is an interrupted stay.*
- *If the resident leaves the facility for an interrupted stay, no Part A PPS Discharge Assessment is required when the resident leaves the building at the outset of the interrupted stay; however, an OBRA Discharge record is required. If the resident returns to the facility within the interruption window, an Entry Tracking form is required; however no new 5-Day assessment is required.*

# Entry/Discharge/Reentry Algorithm and Schedule Tables

- Entry, OBRA Discharge, and Reentry Algorithm:
  - A0310C and A0310D were removed from the Entry Tracking Record footnote below the diagram.

Entry, OBRA Discharge, and Reentry Algorithms



¹A0310A = 99 A0310B = 99 A0310E = 0 A0310F = 01

²A0310B – E = appropriate code

³A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

# Combining PPS and OBRA Assessments

## 2.10 Combining *PPS* Assessments and OBRA Assessments.

- This section is basically the same with the exception of the additional information related to the IPA, which cannot be combined with any other assessment.
- One caveat: Be careful in selecting the ARD for an OBRA Admission assessment combined with a 5-Day assessment. For the OBRA Admission, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For the 5-Day, the ARD must be set for days 1 through 8.
- Avoid a late assessment by choosing an ARD between days 1 through 8.

# Combining PPS and OBRA Assessments (cont.1 )

- Item Sets by Assessment Type of Skilled Nursing Facilities and Item Sets by Assessment Type for Swing Bed Providers tables were updated to include the IPA and Swing Bed Discharge and updated types of combination assessments.
- Tracking records (Entry and Death in Facility) *and the Interim Payment Assessment* can never be combined with other assessments.



# Combining PPS and OBRA Assessments (cont. 2)

2.11 *PPS* and OBRA Assessment Combinations for the following assessments have been revised for combinations of the 5-Day and the:

OBRA Admission Assessment.

Significant Correction to Prior Comprehensive.

OBRA Quarterly Assessment.

Significant Correction to Prior Quarterly.

Annual Assessment.

OBRA Discharge Assessment.

Significant Change in Status Assessment.

Part A PPS Discharge Assessment.

# Factors Impacting SNF PPS Assessment Scheduling

## 2.12 Factors Impacting SNF PPS Assessment Scheduling.

- Resident is Admitted to an Acute Care Facility and Returns:
  - A new 5-Day assessment is required, *unless it is an instance of an interrupted stay.*
  - *If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form.*
    - *An IPA may be completed, if deemed appropriate.*

# Factors Impacting SNF PPS Assessment Scheduling (cont. 1)

- Resident Is Sent to Acute Care Facility, Not in SNF over Midnight and is Not Admitted to Acute Care Facility:
  - If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, *a new 5-day PPS assessment is not required, though an IPA may be completed, if deemed appropriate.*
  - Payment implications: The day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day pursuant to the “midnight rule.”

# Factors Impacting SNF PPS Assessment Scheduling (cont. 2)

- Resident Takes a Leave of Absence from the SNF:
  - If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2–13 in this chapter, *there may be payment implications*.
  - For example, if a resident leaves a SNF at 6 p.m. on Wednesday, which is Day 27 of the resident's stay, and returns to the SNF on Thursday at 9 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

# Factors Impacting SNF PPS Assessment Scheduling (cont. 3)

- Resident Discharged from Part A Skilled Services and From the Facility and Returns to SNF Part A Skilled Level Services:
  - In the situation when a beneficiary is discharged from Medicare Part A and is physically discharged from the facility but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and may be combined.

# Factors Impacting SNF PPS Assessment Scheduling (cont. 4)

- On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new 5-Day and Entry Tracking Record must be completed. If the resident was discharged return not anticipated, the facility must also complete a new OBRA Admission assessment.
- In the case of an interrupted stay, only an OBRA Discharge is required. An Entry Tracking Record is required on reentry, but no 5-Day is required. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.

# Factors Impacting SNF PPS Assessment Scheduling (cont. 5)

- Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility
  - In the situation when a resident's Medicare Part A stay ends, but the resident is not physically discharged from the facility, remaining in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item *A1900*) and must also complete a Part A PPS Discharge assessment.

# Factors Impacting SNF PPS Assessment Scheduling (cont. 6)

- If the Part A benefits resume, there is no reason to change the OBRA schedule; the *PPS* schedule would start again with a 5-Day assessment, MDS *item* A0310B = 01, ***unless*** it is a case of an interrupted stay – that is, if the resident is discharged from Part A, remains in the facility and resumes Part A within the 3-day interruption window, no *PPS Discharge* is completed, nor is a 5-Day required when Part A resumes.



# Factors Impacting SNF PPS Assessment Scheduling (cont. 7)

- Non-Compliance with the PPS Assessment Schedule:
  - Frequent late assessment scheduling practices *or missed assessments* may result in *additional* review.
  - The default rate takes the place of the otherwise applicable Federal rate.
  - This rate is equal to the rate paid for the *Health Insurance Prospective Payment System (HIPPS)* code reflecting the lowest acuity level *for each PDPM component*, and be lower than the Medicare rate payable if the SNF had submitted an assessment on time.



# Factors Impacting SNF PPS Assessment Scheduling (cont. 8)

- Late PPS Assessment:
  - *The SNF will bill the default rate for the number of days that the assessment is out of compliance.*
  - This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD).
  - **The SNF would then bill the HIPPS code established by the late assessment for the *remainder of the SNF stay, unless the SNF chooses to complete an IPA.***

# Expected Order of MDS Records and ISC Tables

- 2.13 Expected Order of MDS Records and 2.14 Nursing Home and Swing Bed Item Set Code Reference tables were updated to include the IPA and remove retired PPS assessments.
- Two items sets are not included in the tables:
  - Inactivation record, ISC code XX.
  - Other State Assessment, ISC code OSA indicated by coding item A0300 as 1, Yes.

**D0350. and D0650.**

# Safety Notification

# D0350.– D0650.: Safety Notification – PHQ9<sup>©</sup> and PHQ9-OV<sup>©</sup>

- Items removed:
  - These items were completed when a responsible staff member or provider was informed there was a potential for resident self-harm.

D0350. Safety Notification - Complete only if D020011 = 1 indicating possibility of resident self harm	
Enter Code <input type="checkbox"/>	Was responsible staff or provider informed that there is a potential for resident self harm? 0. No 1. Yes

D0650. Safety Notification - Complete only if D050011 = 1 indicating possibility of resident self harm	
Enter Code <input type="checkbox"/>	Was responsible staff or provider informed that there is a potential for resident self harm? 0. No 1. Yes

**K0510. and K0710.**

# Nutritional Approaches

## Percent Intake by Artificial Route

# K0510.– K0710.: Nutritional Approaches and Percent Intake by Artificial Route

- Items removed from both K0510 and K0710.
- Removed references to potential State requirements for completion of items no longer collected by CMS.
- Removed text within Section K (and elsewhere in the manual) regarding items no longer collected by CMS.

# K0510. Nutritional Approaches

## K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days

OLD

	1. While NOT a Resident	2. While a Resident
<b>1. While NOT a Resident</b> Performed <b>while NOT a resident</b> of this facility and within the <b>last 7 days</b> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank		
<b>2. While a Resident</b> Performed <b>while a resident</b> of this facility and within the <b>last 7 days</b>	↓ Check all that apply ↓	↓ Check all that apply ↓
<b>A. Parenteral/IV feeding</b>	<input type="checkbox"/>	<input type="checkbox"/>

- B. Feeding tube** - nasogastric or abdominal
- C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- Z. None of the above**

## K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days

NEW

	1. While NOT a Resident	2. While a Resident
<b>1. While NOT a Resident</b> Performed <b>while NOT a resident</b> of this facility and within the <b>last 7 days</b> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank		
<b>2. While a Resident</b> Performed <b>while a resident</b> of this facility and within the <b>last 7 days</b>	↓ Check all that apply ↓	↓ Check all that apply ↓
<b>A. Parenteral/IV feeding</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Feeding tube</b> - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Mechanically altered diet</b> - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Therapeutic diet</b> (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Z. None of the above</b>	<input type="checkbox"/>	<input type="checkbox"/>

Removed items  
K0510C and D from  
Column 1. While NOT  
a Resident.



# K0710. Percent Intake by Artificial Route

**K0710. Percent Intake by Artificial Route** - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

<b>1. While NOT a Resident</b> Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank  <b>2. While a Resident</b> Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>  <b>3. During Entire 7 Days</b> Performed during the entire <i>last 7 days</i>	<div style="border: 2px solid blue; border-radius: 50%; width: 60px; height: 60px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">OLD</div>	
	While NOT a Resident	2. While a Resident
	3. During Entire 7 Days	
	↓ Enter Codes ↓	
<b>A. Proportion of total calories the resident received through parenteral or tube feeding</b> 1. 25% or less 2. 26-50% 3. 51% or more	<input type="checkbox"/>	<input type="checkbox"/>

Removed Column 1.  
While NOT a Resident.

**K0710. Percent Intake by Artificial Route** - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

<b>B. Average fluid</b> 1. 500 cc/day 2. 501 cc/day	<div style="border: 2px solid yellow; border-radius: 50%; width: 60px; height: 60px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">NEW</div>	
	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓	
<b>2. While a Resident</b> Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>  <b>3. During Entire 7 Days</b> Performed during the entire <i>last 7 days</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>A. Proportion of total calories the resident received through parenteral or tube feeding</b> 1. 25% or less 2. 26-50% 3. 51% or more	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Average fluid intake per day by IV or tube feeding</b> 1. 500 cc/day or less 2. 501 cc/day or more	<input type="checkbox"/>	<input type="checkbox"/>

**00100L.**

## Respite Care

# O0100L. Respite Care

O0100. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that were performed during the last 14 days	
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 14 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank	2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i>
<b>Cancer Treatments</b>	
A. Chemotherapy	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>
<b>Respiratory Treatments</b>	
C. Oxygen therapy	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>
F. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	<input type="checkbox"/>
<b>Other</b>	
H. IV medications	<input type="checkbox"/>
I. Transfusions	<input type="checkbox"/>
J. Dialysis	<input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>
L. Respite care	<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>
<b>None of the Above</b>	
Z. None of the above	<input type="checkbox"/>

OLD

Removed O0100L. Respite Care from Column 1. While NOT a Resident.

O0100. Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that were performed during the last 14 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 14 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank	2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i>	
<b>Cancer Treatments</b>		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
F. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>	<input type="checkbox"/>
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>		
H. IV medications	<input type="checkbox"/>	<input type="checkbox"/>
I. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
J. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/>
<b>None of the Above</b>		
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

NEW

**V0100.**

Items from the Most Recent Prior OBRA or  
Scheduled PPS Assessment

# V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment	
Complete only if A0310E = 0 and if the following is true for the <b>prior assessment</b> : A0310A = 01- 06 or A0310B = 01- 05	
Enter Code <input type="text"/> <input type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment</b> (A0310A value from prior assessment) 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. None of the above
Enter Code <input type="text"/> <input type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment</b> (A0310B value from prior assessment) 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment 07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant co 99. None of the above
Enter Score <input type="text"/> <input type="text"/>	<b>C. Prior Assessment Reference Date</b> (A2300 value from prior assessment) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Enter Score <input type="text"/> <input type="text"/>	<b>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score</b> (C0500 value from pr
Enter Score <input type="text"/> <input type="text"/>	<b>E. Prior Assessment Resident Mood Interview (PHQ-9®) Total Severity Score</b> (D0300 value from pr
Enter Score <input type="text"/> <input type="text"/>	<b>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score</b> (D0600 v

OLD

Removed Retired PPS Assessment Response Codes from V0100B and Added Response Code 08 for IPA.

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment	
Complete only if A0310E = 0 and if the following is true for the <b>prior assessment</b> : A0310A = 01- 06 or A0310B = 01	
Enter Code <input type="text"/> <input type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment</b> (A0310A value from prior assessment) 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. None of the above
Enter Code <input type="text"/> <input type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment</b> (A0310B value from prior assessment) 01. <b>5-day</b> scheduled assessment 08. <b>IPA</b> - Interim Payment Assessment 99. None of the above
Enter Score <input type="text"/> <input type="text"/>	<b>C. Prior Assessment Reference Date</b> (A2300 value from prior assessment) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Enter Score <input type="text"/> <input type="text"/>	<b>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score</b> (C0500 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	<b>E. Prior Assessment Resident Mood Interview (PHQ-9®) Total Severity Score</b> (D0300 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	<b>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score</b> (D0600 value from prior assessment)

NEW

## **X0570A. and X0570B**

# Correction Record: Optional State Assessment

# X0570. Optional State Assessment

X0570. Optional State Assessment (A0300A/B on existing record to be modified/inactivated)	
Enter Code <input type="checkbox"/>	<b>A. Is this assessment for state payment purposes only?</b> 0. No 1. Yes
Enter Code <input type="checkbox"/>	<b>B. Assessment type</b> 1. <b>Start of therapy</b> assessment 2. <b>End of therapy</b> assessment 3. <b>Both Start and End of therapy</b> assessment 4. <b>Change of therapy</b> assessment 5. <b>Other payment</b> assessment

# X0570. Optional State Assessment (cont. 1)

- **Item Rationale:**
  - This item contains the reasons for assessment from the prior erroneous OSA record to be modified/inactivated.
- **Coding Instructions for X0570A, Is this assessment for state payment purposes only?:**
  - Fill in the box with the state payment purpose code exactly as submitted for item A0300A “**Is this assessment for state payment purposes only?**” on the prior erroneous record to be modified/inactivated.
  - The state payment purpose code in X0570A must match the current value of A0300A on the modification request.



# X0570. Optional State Assessment (cont. 2)

## Coding Instructions for X0570B, Assessment Type:

- Fill in the box with the assessment type code exactly as submitted for item A0300B “**Assessment Type**” on the prior erroneous record to be modified/inactivated.
- Note that the assessment type code in X0570B must match the current value of A0300B on the modification request.

**X0600.**

## Type of Assessment/Tracking

# X0600. Type of Assessment/Tracking

## X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>B. PPS Assessment</b> <b>PPS Scheduled Assessments for a Medicare Part A Stay</b> 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment <b>PPS Unscheduled Assessments for a Medicare Part A Stay</b> 07. <b>Unscheduled assessment used for PPS (OMRA, significant or clinic</b> <b>Not PPS Assessment</b> 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. <b>No</b> 1. <b>Start of therapy</b> assessment 2. <b>End of therapy</b> assessment 3. <b>Both Start and End of therapy</b> assessment 4. <b>Change of therapy</b> assessment
<b>X0600. Type of Assessment - Continued</b>	
Enter Code <input type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if X0150 = 2 0. <b>No</b> 1. <b>Yes</b>
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment-return not anticipated 11. <b>Discharge</b> assessment-return anticipated 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>H. Is this a SNF Part A PPS Discharge Assessment?</b> 0. <b>No</b> 1. <b>Yes</b>

OLD

Removed  
Retired PPS  
Assessment  
Response Codes  
from X0600B  
and removed  
X0600C and D.

## X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>B. PPS Assessment</b> <b>PPS Scheduled Assessment for a Medicare Part A Stay</b> 01. <b>5-day</b> scheduled assessment <b>PPS Unscheduled Assessment for a Medicare Part A Stay</b> 08. <b>IPA - Interim Payment Assessment</b> <b>Not PPS Assessment</b> 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment-return not anticipated 11. <b>Discharge</b> assessment-return anticipated 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>
Enter Code <input type="text"/>	<b>H. Is this a SNF Part A PPS Discharge Assessment?</b> 0. <b>No</b> 1. <b>Yes</b>

NEW

Added  
IPA.

# X0600. Type of Assessment/Tracking (cont.)

- These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated (A0310 on existing record to be modified/inactivated).
- Items X0600 B, C, and D removed due to various retired PPS assessments and to add the IPA.
- Language in the manual related to these items also removed.

**X0900.**

## Reasons for Modification

# X0900. Reasons for Modification

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)	
↓ Check all that apply	
<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	E. End of Therapy - Resumption (EOT-R) date
<input type="checkbox"/>	Z. Other error requiring modification If "Other" checked, please specify: _____

**OLD**

Removed Retired PPS  
Assessment Response Code  
X0900E. End of Therapy-  
Resumption (EOT) date.

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)	
↓ Check all that apply	
<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	Z. Other error requiring modification If "Other" checked, please specify: _____

**NEW**

# Z0100.

## Medicare Part A Billing

# Z0100. Medicare Part A Billing

Z0100. Medicare Part A Billing	
Enter Code <input type="checkbox"/>	A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	B. RUG version code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	C. Is this a Medicare Short Stay assessment? 0. No 1. Yes

OLD

Z0100. Medicare Part A Billing	
	A. Medicare Part A HIPPS code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	B. Version code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

NEW





# Z0100. Item Rationale

- Used to capture the *PDPM case mix version code* followed by the HIPPS modifier based on the type of assessment.



# Definition HIPPS Code

- The HIPPS code is comprised of the *PDPM case mix code*, which is *calculated from the assessment data*. The first four positions of the HIPPS code contain the *PDPM classification codes for each PDPM component to be billed for Medicare reimbursement*, followed by an indicator of the type of assessment that was completed.

# Z0100A. Medicare Part A HIPPS Code

## Coding Instructions:

- The HIPPS code under SNF Part A is still a five-position billing code where the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator.
- If your software does not calculate this code, you can use the worksheets in Chapter 6 of the RAI Manual to determine the appropriate HIPPS code and assessment type indicator.
- Like the RUG version code, the HIPPS code takes into account all MDS items used in the PDPM logic; however, it does NOT include the values in items O0400 (Therapies).



# Z0100B. Version Code

- Typically the software data entry product will calculate this value.
- If the value for Z0100B is not automatically calculated by the software data entry product, enter the PDPM version code in the spaces provided.

**Z0150.**

# Medicare Part A Non-Therapy Billing

# Z0150. Medicare Part A Non-Therapy Billing

This item was removed because it is not needed under PDPM.

Z0150. Medicare Part A Non-Therapy Billing											
	<p><b>A. Medicare Part A non-therapy HIPPS code</b> (RUG group followed by assessment type indicator):</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
	<p><b>B. RUG version code:</b></p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										



**Z0200. and Z0250.**

# State Medicaid Billing and Alternate State Medicaid Billing

# Z0200. and Z0500.: State Medicaid Billing and Alternate State Medicaid Billing

Z0200 and Z0250 were updated to remove the term “RUG”

Z0200. State Medicaid Billing (if required by the state)		OLD
A. RUG Case Mix group:	<input type="text"/>	<b>Z0200. State Medicaid Billing (if required by the state)</b>
B. RUG version code:	<input type="text"/>	
Enter Code <input type="checkbox"/>		
		<b>NEW</b>
		A. Case Mix group:
		<input type="text"/>
		B. Version code:
		<input type="text"/>
		C. Is this a Short Stay assessment?
		0. No
		1. Yes

Z0250. Alternate State Medicaid Billing (if required by the state)		OLD
A. RUG Case Mix group:	<input type="text"/>	<b>Z0250. Alternate State Medicaid Billing (if required by the state)</b>
B. RUG version code:	<input type="text"/>	
Enter Code <input type="checkbox"/>		
		<b>NEW</b>
		A. Case Mix group:
		<input type="text"/>
		B. Version code:
		<input type="text"/>



**Z0300.**

## Insurance Billing

# Z0300. Insurance Billing

Z0300 was updated to remove the term “RUG”

Z0300. Insurance Billing									
	A. RUG billing code:								
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	B. RUG billing version:								
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

OLD

Z0300. Insurance Billing									
	A. Billing code:								
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	B. Billing version:								
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

NEW



**Z0500B.**

**Signature of RN Assessment Coordinator  
Verifying Assessment Completion**

# Z0500B. Signature of RN Assessment Coordinator Verifying Assessment Completion

## Coding Instructions for Z0500B:

- Use the actual date that the MDS was completed, reviewed, and signed as complete by the Registered Nurse (RN) assessment coordinator. This date *must be equal to the latest date at Z0400* or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.
- If the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion																					
<b>A. Signature:</b>  	<b>B. Date RN Assessment Coordinator signed assessment as complete:</b> <table border="1"><tr><td></td><td></td><td>–</td><td></td><td></td><td>–</td><td></td><td></td><td></td><td></td></tr><tr><td colspan="2">Month</td><td></td><td colspan="2">Day</td><td></td><td colspan="4">Year</td></tr></table>			–			–					Month			Day			Year			
		–			–																
Month			Day			Year															

# Chapter 5: Submission and Correction of the MDS Assessments

# 5.7 Correcting Errors in MDS Records That Have Been Accepted Into the QIES ASAP System

- Facilities should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within **2** years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

# Chapter 5: Submission and Correction of the MDS Assessments

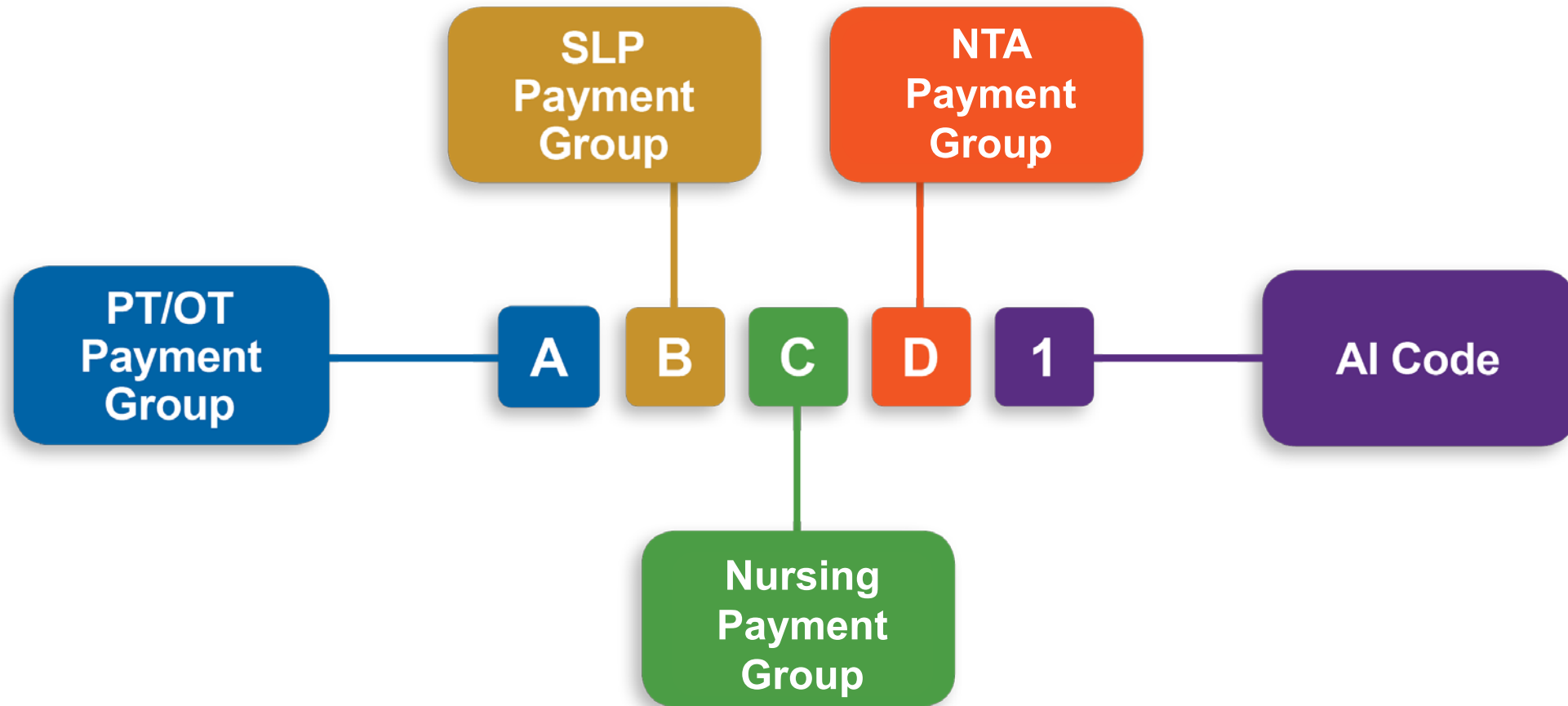
- Submission Time Frame for MDS Records Table:
  - Updated to include IPA under A0310B.
- Fatal Record Error information updated:
  - Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted, *unless the Fatal Error is due to submission of a duplicate assessment.*

# Chapter 5: Submission and Correction of the MDS Assessments (cont. 1)

- HIPPS Code information updated.
- The HIPPS code consists of five positions.
  1. Physical Therapy/Occupational Therapy (PT/OT) Payment Group
  2. Speech Language Pathology (SLP) Payment Group
  3. Nursing Payment Group
  4. Non-therapy Ancillary (NTA) Payment Group
  5. Assessment Indicator (AI) code indicating which type of assessment was completed.



# Chapter 5: Submission and Correction of the MDS Assessments (cont. 2)



# Chapter 5: Submission and Correction of the MDS Assessments (cont. 3)

- Grouper language updated:
  - The standard grouper uses MDS 3.0 items to determine both the *PDPM* group and the Assessment Indicator (AI) code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the *PDPM* group and AI code. Detailed logic for determining the *PDPM* group and AI code is provided in Chapter 6.

# Chapter 5: Submission and Correction of the MDS Assessments (cont. 4)

- The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes.
  - The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The PDPM version code in Item Z0100B documents which version of PDPM was used to determine the PDPM payment groups represented in the Medicare Part A HIPPS code.

# Chapter 6: Medicare SNF PPS

# Chapter 6: Medicare SNF PPS

- This chapter was extensively revised due to the change in the payment system.
- Highlights related to the PDPM:
  - Changes to HIPPS code.
  - Classification categories: Clinical and Functional (based on Section GG).
  - PDPM Component tables for PT/OT, SLP, Nursing, and NTA.
  - AI codes for the IPA and 5-Day.
  - Interrupted Stay Policy.
  - Noncompliance with SNF PPS (late, missed assessments).



# Chapter 6: Medicare SNF PPS (cont. 1)

- 6.3 – Patient Driven Payment Model
  - PDPM adjusts payment for each major element of a resident's SNF care, specifically for PT, OT, SLP, nursing, and NTA. In Section 6.6 of the RAI manual we provide a PDPM calculation worksheet.
  - The calculation worksheets were developed to provide clinical staff with a better understanding of how PDPM works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system.



# Chapter 6: Medicare SNF PPS (cont. 2)

- 6.6 PDPM Calculation Worksheets for SNFs
  - Calculation of Cognitive Level.
  - Worksheets guide providers through steps to identify:
    - Primary Diagnosis, Clinical Category, Function Score, Case-Mix Groups, and Payment Component tables for PT, OT, SLP, Nursing, and NTA.
    - Calculation of Variable Per Diem Adjustment.
    - Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate.

# Appendices



# Appendix A

Added definitions:	Added acronyms:
Interrupted Stay	IPA – Interim Payment Assessment
Payment Driven Payment Model	NTA – Non-Therapy Ancillary
	OSA – Optional State Assessment
	PDPM – Patient Driven Payment Model
	PHQ-9-OV – Patient Health Questionnaire-9 Observational Version
	SNF QRP – Skilled Nursing Facility Quality Reporting Program
	SSN – Social Security Number
	TPN – Total Parenteral Nutrition

# Appendixes C and G

Appendix C:	Appendix G:
Changed Pressure ulcers (M0300) to Pressure ulcers/ <i>injuries</i> (M0300).	Updated URL for CMS MDS 3.0 Provider User's Guide.
Updated URL to the Alzheimer's Association Resource web page.	

# Summary



In this lesson you learned:

- The relationship between IMPACT Act and data collected for the SNF QRP.
- About the RAI Manual and item set changes and why they were made.

# Record Your Action Plan Ideas



Join at  
**slido.com**  
**#Econometrica**



# Questions?

