Take a Deep Dive into 2025 Risk Management

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ACHCA CONFERENCE 2025

BREAKOUT SESSION

Day 2

Presented by:
Leah Klusch, RN, BSN, FACHCA

Executive Director
The Alliance Training Center

- Leah is the founder and director of The Alliance Training Center and the author of numerous published articles in industry journals, periodicals, trade publications, books, video trainings, and lectures nationally on current industry topics. Leah is passionate about her work and her energy is contagious when helping clients and industry members manage Care Delivery & Clinical Competency, Wellness & Restorative Care Giving, Compliance & Risk Management, Leadership, Re-engineering & Facility Planning, Skilled Facility Operations, Payment & Reimbursement Strategies, Assessment and Assessment Documentation including the MDS Process, and Regulatory Compliance.
- Leah was named one of the "40 for 40" notable newsmakers by McKnight's, publisher of the nation's leading senior care journals McKnight's Senior Living and McKnight's Long-Term Care News. This honor, which recognizes innovative leaders to mark McKnight's 40th Anniversary, is bestowed upon Klusch for her many contributions as a nurse, speakers, educator, consultant, and leader. Leah received one of the first annual McKnight's Pinnacle Business Partner Award in 2023 for being an industry veteran who sets the standards, drives change and provides guidance and inspires.

O.I.G. Introduction of Compliance Program

A. OIG's History of Compliance Program Guidance: Commitment to Preventing Health Care Fraud and Abuse.

B. OIG's Current Compliance Guidance Approach: A Roadmap Going Forward

Strategies

1. Compliance- foundation of successful operations. Rule changes produce compliance risks and educational responsibilities.
2. Importance of data accuracy for payment and outcome documentation.
3. Competency – New Rule – New payment levels and requirements – Education – Documentation.
4. Internal Audits to confirm accuracy – Identify training and policy changes.
5. Prepare for External Audits.

Annual Healthcare Fraud and Abuse Review

-Bass, Berry & Simms

- Most FCA Allegations against healthcare defendants do not involve blatantly false statements or "obviously wrong" conduct, but instead deal with purported violations of highly complex statutory and regulatory requirements.

Strategy 1 - Compliance

- Compliance is a big picture for the entire organization – F Tag 895 rewrite (October 2022)
- Must be honest and open – review where investment is being made.
- Start with compliance related to payment – eligibility – documentation – federal coverage documents.
- Internal compliance requires audits to confirm practice and policy implementation.
- Review provider agreements – Part A Medicare – insurance, therapy, and other contracts.
- HIPPA is a new federal focus – implications for the MDS because o data use and sharing.
- Cannot cover up bad practice
- Excellent opportunity for QAPI programs and Quality Assurance focus.

Part A Medicare

- Medicare Provider Agreement must be in place for you to admit and bill for Medicare Benefits in the SNF
- What document tells you the federal rules and coverage guidelines for Part A Medicare?
- Who needs to have the specific guidelines for admission, coverage of services, documentation, and certification?
- MEDICARE BENEFIT POLICY MANUAL – CHAPTER 8 is the reference – the only reference – Who has copies and knows specific content?
- All claims denials and audit denials need to be justified from this document – have been for many years.
- WHO HAS THIS DOCUMENT IN YOUR CORPORATE COMPLIANCE OFFICE AND ON SITE IN THE FACILITIES WHERE ADMISSION AND COVERAGE DECISIONS ARE MADE?
- YOU MUST DOCUMENT THAT ADMISSIONS & SERVICES ARE COVERED TO THE PART A STANDARD and Documentation in the Medical Record.
- Use the Medicare Benefit Policy Manual (chapter 8) for orientation, in-services, documentation guidelines, coverage decisions, and certification rules.
- Document the sections of chapter 8 in your documentation notes or utilization minutes to confirm coverage.
- None of the Medicare Part A requirements change with P.D.P.M.

Essential Review MBPM – chapter 8

- Updated 10-05-2023 – Important
- Section 20.1 Three-Day Prior Hospitalization (Page 4-6)
- Section 30 Skilled Nursing Facility Level of Care (Page 14 & 15)
- Section 30.2.1 Skilled Services Defined (Page 18)
- Section 30.2.2.1 Documentation to Support Skilled Care Determinations (Page 20 & 21)
- Section 30.2.3.3 Teaching and Training Activities (Page 25 & 26)
- Section 30.3 Direct Skilled Nursing Services (Page 26 & 27)
- Section 30.4.1 Skilled Physical Therapy (Page 28 & 29)
- Section 30.5 Non-Skilled Supportive on Personal Care Services (Page 32 & 33)
- Section 40 Physician Certification and Recertification (Page 37)
- Section 40.1 Who May Sign the Certification or Recertification for Extended Care Services (Page 38)
- Section 70.4 Services Furnished Under Arrangements with Provider (Page 45&46)

Name_____

Admission Date_____

Admission Primary Diagnosis_____

M.B.P.M. Section 30 Skilled Nursing Facility Level of Care – General

Care in a SNF is covered if all of the following four factors are met:

_____The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see 30.2-30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

____The patient requires these skilled services on a daily basis (see 30.6); and

____As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See 30.7)

____The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Health Care Fraud Enforcement and Other Standards: Overview of Certain Federal Laws

A. Federal Anti-Kickback Statue

- The Federal anti-kickback statue prohibits entities involved in Federal health care program business from engaging in some practices that are common in other business sectors, such as offering or receiving gifts to reward past or future referrals. More specifically, under the Federal anti-kickback statute, it is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce, or in return for, the referral of an individual to a person for the furnishing of, or arranging for the furnishing of, any item or service reimbursable under a Federal health care program.
- For purposes of the Federal anti-kickback statue, “remuneration” includes anything of value, whether in cash, in kind, or other form. By way of example only, remuneration m ay take the form of cash, cash equivalents, cos-sharing waivers or subsidies, and opportunity to earn a fee, items, space, equipment, and services – regardless of the amount of remuneration.
- Individuals and entities should evaluate arrangements that implicate the statute and do not fit into a safe harbor by reviewing the totality of the facts and circumstances, including the intent of the parties.

Key Questions

- Nature of the relationship between the parties.

-What degree of influence do the parties have, directly or indirectly, on the generation of Federal health care program business for each other?

- Manner in which participants were selected.

-Were parties selected to participate in an arrangement in whole or in part because of their past or anticipated referrals?

- Manner in which the remuneration is determined.

-Does the remuneration take into account, either directly or indirectly, the volume or value of business generated?

-Is the remuneration conditioned in whole or in part on referrals or other business generated between the parties?

-Is the arrangement itself conditioned, either directly or indirectly, on the volume or value of Federal health care program business? Is there any service provided other than referrals?

Value of the remuneration.

- -Is the remuneration fair market value in an arm's-length transaction for legitimate, reasonable, and necessary services that are actually rendered?

-Is the entity paying an inflated rate to a potential referral source? Is the entity receiving free or below-market-rate items or services from a provider, supplier, or other entity involved in health care business?

-Is compensation tied, either directly or indirectly, to Federal health care program reimbursement?

- Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented?

Key Questions Cont.

- Federal program impact.

-Does the remuneration have the potential to affect costs to any of the Federal health care programs or their beneficiaries?

-Could the remuneration lead to overutilization or inappropriate utilization?

- Clinical decision making.

-Does the arrangement or practice have the potential to interfere with, or skew, clinical decision making?

-Does the arrangement or practice raise patient safety or quality of care concerns?

-Could the payment structure lead to cherry-picking healthy patients or lemon-dropping patients with chronic or other potentially costly conditions to save on costs?

-If the remuneration relates to the dissemination of information, is the information complete, accurate, and not misleading?

B. Physician Self-Referral Law

The Federal physician self-referral (PSL) law, also known as the “Stark law”, prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies and it’s requirements are satisfied.

Designated health services are:

- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- prosthetics, orthotics, and prosthetic devices and supplies;
- clinical laboratory services;
- home health services;
- outpatient prescription drugs;
- inpatient and outpatient hospital services.
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- radiology and certain other imaging services; and
- radiation therapy services and supplies.

C. False Claims Act

The civil False Claims Act provides a way for the Government to recover money when an individual or entity knowingly submits or causes to be submitted false or fraudulent claims for payment to the Government. The False Claims Act, among other things, prohibits:

- knowingly presenting or causing to be presented to the Federal Government a false or fraudulent claim for payment or approval;
- knowingly making or using or causing to be made or used a false record or statement to have a false or fraudulent claim paid or approved by the Government; and
- knowingly making or using or causing to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

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D. Civil Monetary Penalty Authorities

OIG is authorized to pursue monetary penalties and exclusion through a variety of civil authorities – most notably, the Civil Monetary Penalties Law (CMPL). Under the CMPL, OIG can pursue assessments in lieu of damages, CMP's, and exclusion from participation in the Federal health care programs.

While False Claims Act cases are pursued by DOJ on behalf of HHS in Federal court, CMP cases are administrative and pursued by OIG before an HHS administrative law judge.

E. Criminal Health Care Fraud Statue

- There is a criminal health care fraud statute that makes it a criminal offense to defraud a health care benefits program. The criminal health care fraud statute prohibits knowingly and willfully executing, or attempting to execute, a scheme to either: (1) defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any money or property from any health care benefit program.
- Cases that involve violations of the criminal health care fraud statute also often involve complex money laundering, tax, and other associated financial criminal offenses. The penalties for violating the criminal health care fraud statute may include fines of up to $250,000, imprisonment of not more than 10 years, or both.

F. HIPPA Privacy and Security Rules

- HHS's OCR is responsible for administering and enforcing the HIPAA Privacy, Security, and Breach Notification Rules.
- The Privacy Rule requires appropriate safeguards to protect the privacy of PHI and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization.
- The Security Standards for the Protection of Electronic Protected Health Information, known as the Security Rule, was also promulgated pursuant to HIPAA. It specifies a series of administrative, physical, ,and technical safeguards for covered entities and their business associates to ensure, among other provisions, the confidentiality, integrity, and security of electronic PHI.

Compliance Program Infrastructure – 7 Elements of a Successful Compliance Program

1. Written Policies and Procedures
2. Compliance Leadership and Oversight
3. Training and Education
4. Effective Lines of Communication with the Compliance Officer and Disclosure Program
5. Enforcing Standards: Consequences and Incentives
6. Risk Assessment, Auditing, and Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives

What Changed on 10/1/2024?

- PHQ 2-9 – When to stop interview
- BIMS – Documentation on “0” answer codes
- GG Functional Score – More metrics
- Race and Ethnicity
- Social Determinants of Health – Will be expanding
- Diagnosis coding – CMS MAPPING
- High Risk Medications – New category

SPADES

- **Standardized Patient Assessment Data Elements**
  - Assessment data elements standardized for all PAC Providers
- Expansion of 5 new SPADES for 10/1/23 MDS 1.18.11
  - Race, ethnicity, preferred language, health literacy, social isolation
  - Outcomes can be measured regarding Health Equity
- Data collected on Admission and Discharge Assessments
- Reproducible data in the Medical Record -

CMS Framework for Health Equity 2022–2032

- **Priority 1:** Expand the **Collection**, Reporting, and Analysis of Standardized **Data**
- Priority 2: Assess Causes of **Disparities Within CMS Programs**, and Address Inequities in Policies and Operations to Close Gaps
- Priority 3: Build Capacity of Health Care Organizations and the Workforce to **Reduce Health and Health Care Disparities**
- Priority 4: Advance Language Access, Health Literacy, and the **Provision of Culturally Tailored Services**
- Priority 5: **Increase All Forms of Accessibility to Health Care Services and Coverage**

What stayed the same?

- Daily skilled documentation
- Supportive documentation for MDS coding- Reproducibility
- Staff competencies required for MDS completion- Job description (Liability)
- Signature and dating requirements
- Audits- 5-Claim to impact all SNF Providers –Part A Medicare Claims.

Operations Alert

- As new sections are added to the MDS that had not been collected previously, operations managers will likely need to consider collection, tracking, capture and eventually coding of the new data sections
- Consider policy impact
  - New
  - Revised
  - Increased liability for providers with no MDS Policies and Procedures
  - Payment Denials are increasing
  - Compliance Rules clarification – Regulatory support.

What Team Members Need to Know

- Essential to have each team member be competent with the new definitions and data formulation for each section or item on the MDS 3.0. – October 2023 Update.
- Tag 641 in the current regulatory process states, “Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.” The assessment must represent an accurate picture of the resident’s status during the assessment reference period.
- Has your facility implemented all the definitional and data formulation changes in the October 2023 update? The P.D.P.M. programs builds on those guidelines and definitions.
- Have you changed current data formulation to match October 1, 2023 changes? Final RAI Manual is now available and defines all coding instructions.

Data Formulation Policy and Procedure

- Important Part of Compliant Operations
- Begins with Regulatory Structure – TAGs
- Responsible parties – Job descriptions – Competency evaluations – Regulatory resources
- Section by Section coding responsibility and timelines for data collection- New RAI manual (October 2024)
- Structure of data base software programs – Training - Audits
- Passwords – documentation and assignment
- Timelines for assessment completion, transmission and validation – Review CASPER Reports
- Audit program and reporting – Have a format for Part A Medicare Case audits

P.D.P.M. Model – MDS Drivers by Section

- B Hearing, Speech, and Vision-SLP / Nursing
- C Cognitive Patterns-SLP / Nursing
- D Mood-Nursing
- E Behavior-Nursing
- GG Functional Abilities and Goals – PT / OT / Nursing
- H Bladder and Bowel-Nursing/N.T.A.
- I Active Diagnoses-PT/OT/SLP /Nursing / N.T.A.
- J Health Conditions-PT/OT/SLP/Nursing
- K Swallowing/Nutritional Status-SLP / Nursing / N.T.A.
- M Skin Conditions-Nursing / N.T.A.
- N Medications–Nursing
- O Special Treatments, Procedures and Programs (all while a resident) –SLP / Nursing / N.T.A.

Impact on QMs Related to 10/1/24 Changes

- Transition from G to GG
  - QM Freeze from April 2024 to January 2025 (for some)
  - Staffing ratings frozen related to transition from STRIVE studies to PDPM based acuity system
  - 5 QMS delayed in addition to staffing
    - ADLs
    - B&B
    - Improvement in Function
    - Inability to move independently worsened
    - Pressure ulcers

Documentation: Skilled or Not

- Skilled for Med a and MA-daily notes
- Custodial for Medicaid-episodic
- Both audited in most states
- Different focus for each type of audit
- Strictly following RAI definitions
  - Some asking for more than RAI for Medicaid
- Competencies for staff
  - Licensed, CNA, IDT
- Monitor documentation in lookback period, repeat if necessary

High Risk Areas for Revenue Recoupment

- Diagnostic Assignment – CMS Mapping updates
  - Primary and other
  - Importance of I 8000 codes.
- Supportive documentation- Skilled services, no hospital stay, Utilization Review notes and signatures.
- Signatures and dates
- Coding
  - MDS – Direct coding – E.M.R. Documentation
  - Claims – Triple check – HIPPS codes.

October 2023 PHQ2 vs. PHQ9 (Changes to Resident Interview only)

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

D0600. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

Reimbursement Impact

PHQ 2-9

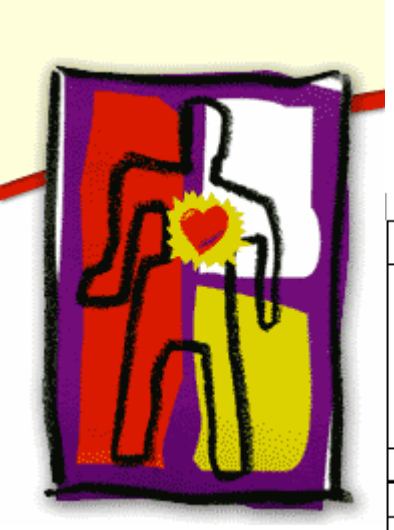
- Scripted interview
  - You Tube videos
- Signatures and dating compliance, date of interview, Notes during interview
- 14-day lookback period
  - Multiple interviews in the lookback window –Documentation Form
- More difficult to score 10+ with new system for interview
- Documentation in medical record to support staff assessment
- Coding interview directly into MDS data set- Question- What is in the EMR substantiating the interview?
- 14 day look back – Pre interview Preparation

Section D- PHQ2 vs. PHQ9

Determine whether to ask the remaining seven questions (D0150C to D0150I) of the Resident Mood Interview (PHQ-2 to 9©).
If **BOTH** D0150A1 and D0150B1 (symptom Response) are coded 9 (no response)

OR

BOTH D0150A2 and D0150B2 are coded 0 (Never or 1 Day) or (2 to 6 Days)
END the PHQ interview – New directions and examples in October 1, 2023 RAI Manual
Retraining essential – Structure of Documentation necessary



14 DAY LOOK-BACK DOCUMENTATION RECORD
Documentation Example

Day 7	Day 6	Day 5	Day 4	Day 3	Day 2	Day 1
Hospital	Hospital	SNF	SNF	SNF	SNF	Date Of Interview SNF
Date: 11-23-2023	Date: 11-24-2023	Date: 11-25-2023	Date: 11-26-2023	Date: 11-27-2023	Date: 11-28-2023	Date: 11-29-2023
Day 14	Day 13	Day 12	Day 11	Day 10	Day 9	Day 8
Hospital	Hospital	Home	Home	Hospital	Hospital	Hospital
Date: 11-16-2023	Date: 11-17-2023	Date: 11-18-2023	Date: 11-19-2023	Date: 11-20-2023	Date: 11-21-2023	Date: 11-22-2023

Patient Name:	John Doe
Date of Mood Interview:	11-29-2023
Staff Completing Interview:	Sally Smith LSW
Calendar Date Range:	14 day look back 11-16-2023
Notes:	

BIMS Test

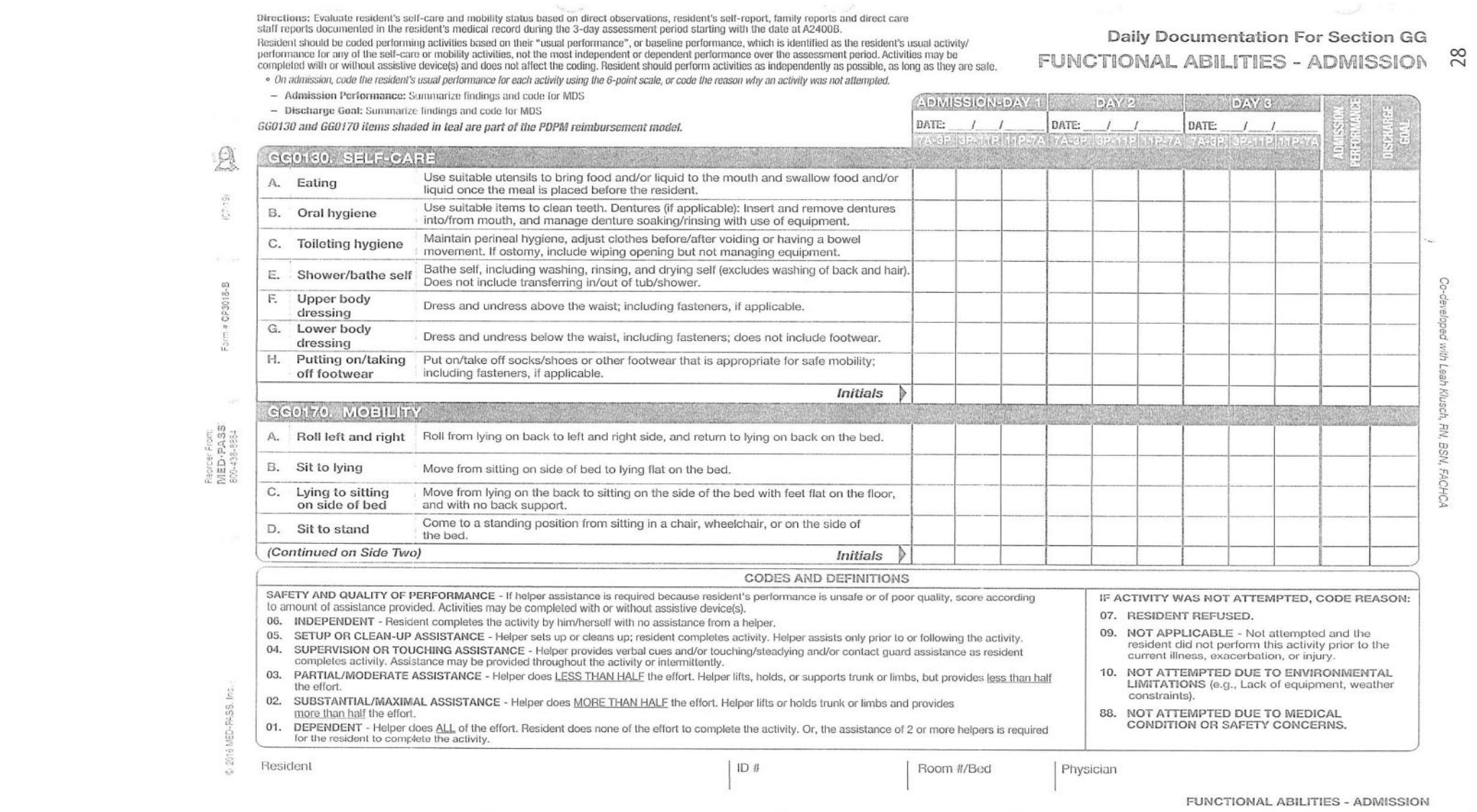
- SCRIPTED interview
  - You Tube videos
- Read the Steps for the Assessment in RAI
- Signatures and dating compliance
- 7-day lookback period
  - Multiple interviews in the lookback window – (Everyone follows the steps for assessment)
- Documentation in medical record to support staff assessment -
- Medicaid CMI auditors looking for staff training on wandering and Cognitive performance
- Where is BIMS, interview and score documentation in Medical Record?

Interviews vs. Assessment

- Must attempt to interview **all residents unless the resident is rarely or never understood.**
- Allowed to conduct interview anytime in the 7 Day look-back period
  - CMS would prefer **interview as close to ARD as possible**
- ***Cannot* be conducted after the ARD**
- Must have a system to ensure that the Interview is completed timely and documented in the Medical Record with comments and additional responses by the resident.

Operations Alert

- Update ADL flowsheets
  - EMR software will likely have a solution built in
  - Make sure the system generated reports are also updated to pull the new information as opposed to the old information based on Section G
    - Determine who you want the data collected by CNA, Nursing, Rehab, Combo
  - Integrate what CNA is doing under old Section G (ADLs) with the new tasks assigned from Section GG (Functional Score)
  - Already seeing denials from Managed Care on GG data collection
  - May impact:
    - Policies
    - Process
    - Care plan



Directions: Evaluate resident's self-care and mobility status based on direct observations, resident's self-report, family reports and direct care staff reports documented in the resident's medical record during the 3-day assessment period starting with the date at A2400B.

Resident should be coded performing activities based on their "usual performance", or baseline performance, which is identified as the resident's usual activity/ performance for any of the self-care or mobility activities, not the most independent or dependent performance over the assessment period. Activities may be completed with or without assistive device(s) and does not affect the coding. Resident should perform activities as independently as possible, as long as they are safe.

- *On admission, code the resident's usual performance for each activity using the 6-point scale, or code the reason why an activity was not attempted.*
  - **Admission Performance:** Summarize findings and code for MDS
  - **Discharge Goal:** Summarize findings and code for MDS

GG0130 and GG0170 items shaded in teal are part of the PDPM reimbursement model.

Daily Documentation For Section GG

FUNCTIONAL ABILITIES - ADMISSION

28

			ADMISSION-DAY 1 DATE: / /			DAY 2 DATE: / /			DAY 3 DATE: / /			ADMISSION PERFORMANCE	DISCHARGE GOAL
			7A-3P	3P-11P	11P-7A	7A-3P	3P-11P	11P-7A	7A-3P	3P-11P	11P-7A		
GG0130. SELF-CARE													
A.	Eating	Use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.											
B.	Oral hygiene	Use suitable items to clean teeth. Dentures (if applicable): Insert and remove dentures into/from mouth, and manage denture soaking/rinsing with use of equipment.											
C.	Toileting hygiene	Maintain perineal hygiene, adjust clothes before/after voiding or having a bowel movement. If ostomy, include wiping opening but not managing equipment.											
E.	Shower/bathe self	Bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.											
F.	Upper body dressing	Dress and undress above the waist; including fasteners, if applicable.											
G.	Lower body dressing	Dress and undress below the waist, including fasteners; does not include footwear.											
H.	Putting on/taking off footwear	Put on/take off socks/shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.											
		Initials											
GG0170. MOBILITY													
A.	Roll left and right	Roll from lying on back to left and right side, and return to lying on back on the bed.											
B.	Sit to lying	Move from sitting on side of bed to lying flat on the bed.											
C.	Lying to sitting on side of bed	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.											
D.	Sit to stand	Come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.											
		(Continued on Side Two) *Initials*											

CODES AND DEFINITIONS

SAFETY AND QUALITY OF PERFORMANCE - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive device(s).

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.
04. **SUPERVISION OR TOUCHING ASSISTANCE** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **PARTIAL/MODERATE ASSISTANCE** - 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** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **DEPENDENT** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

IF ACTIVITY WAS NOT ATTEMPTED, CODE REASON:

07. **RESIDENT REFUSED.**
09. **NOT APPLICABLE** - Not attempted and the resident did not perform this activity prior to the 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.**

Resident | ID # | Room #/Bed | Physician

FUNCTIONAL ABILITIES - ADMISSION

Co-developed with Leah Klusch, RN, BSN, FACHCA

Form # CP3018-B (07-19)

Pearcer From: MED-PASS 800-438-8884

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FUNCTIONAL ABILITIES - ADMISSION

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GG0170. MOBILITY (Continued from Side One)			ADMISSION DAY 1 DATE: ___/___/___ 7A-8P	8P-11P	11P-7A	DAY 2 DATE: ___/___/___ 7A-8P	8P-11P	11P-7A	DAY 3 DATE: ___/___/___ 7A-8P	8P-11P	11P-7A	ADMISSION PERFORMANCE	DISCHARGE GOAL
E.	Chair/bed-to-chair transfer	Transfer to and from a bed to a chair (or wheelchair).											
F.	Toilet transfer	Get on and off a toilet or commode.											
G.	Car transfer	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.											
I.	Walk 10 feet	Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. **If admission performance is coded 07, 09, 10, or 88 skip to GG0170M,** *1 step (curb).*											
J.	Walk 50 feet with two turns	Once standing, the ability to walk at least 50 feet and make two turns.											
K.	Walk 150 feet	Once standing, the ability to walk at least 150 feet in a corridor or similar space.											
L.	Walking 10 feet on uneven surfaces	Walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.											
M.	1 step (curb)	Go up and down a curb and/or up and down one step. **If admission performance is coded 07, 09, 10, or 88 - Skip to P,** *Picking up object.*											
N.	4 steps	Go up and down four steps with or without a rail. **If admission performance is coded 07, 09, 10, or 88 - Skip to P,** *Picking up object.*											
O.	12 steps	Go up and down 12 steps with or without a rail.											
P.	Picking up object	Bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.											
	Q1. Does the resident use a ☐ **wheelchair or** ☐ **scooter?** ☐ **Yes, continue to R.** ☐ **No,** the form is **COMPLETED.**												
R.	Wheel 50 feet with two turns	Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. ☐ **Manual** ☐ **Motorized**											
S.	Wheel 150 feet	Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. ☐ **Manual** ☐ **Motorized**											
		Initials											

CODES AND DEFINITIONS

SAFETY AND QUALITY OF PERFORMANCE - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive device(s).

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.
04. SUPERVISION OR TOUCHING ASSISTANCE - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. PARTIAL/MODERATE ASSISTANCE - 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 - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. DEPENDENT - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

IF ACTIVITY WAS NOT ATTEMPTED, CODE REASON:

07. RESIDENT REFUSED.
09. NOT APPLICABLE - Not attempted and the resident did not perform this activity prior to the 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.

Resident | ID # | Room #/Bed | Physician

FUNCTIONAL ABILITIES - ADMISSION

29

Co-developed with Leah Klusch, RN, BSN, FACHCA

GG-Functional Performance Score

- Teaching Staff requirements – New items and new scoring
- Schedule for documentation
- Data collection format
- Understanding definitions and instructions
- Calculate the FPS for both Nursing and Rehab to monitor for errors – RAI Manual Chapter 6-16, 17, 18
- Requires an additional step the Section G did not
  - (Assessment must be performed by qualified clinicians for GG.)

G Data Elements That Have Been Added to Section GG

- G0400 Functional Limitation in ROM is now GG0115
- G0600 Mobility Devices is now GG0120
- G0110J Personal Hygiene is now G01301
- G0120 Bathing
- The tub/shower transfer is now GG0170FF. Tub/Shower Transfer

Best Practice for Managing GG-FPS

- Check nursing documentation daily during the 3-day lookback periods. Note any variations or concerns & discuss/clarify with nursing staff during the 3-day documentation period.
- Develop a routine in discussing nursing & therapy documentation of admission performance & DC goals during meetings with Therapy Manager. Know your therapy short & long term goals on eval.
- Goals should be periodically reviewed throughout the stay to determine progress toward the goal. If a goal is determined to need revision based on resident needs or changes, the plan of care should be updated.
- Once the Usual Performance on admit & DC goals are determined, add this information to your weekly Medicare meeting.

  Continue through 30-day window.

Operations Alert

- Update ADL flowsheets
  - EMR software may still track both G and GG
  - Make sure the system generated reports are also updated to pull the new information as opposed to the old information based on Section G
    - Determine who you want the data collected by CNA, Nursing, Rehab, Combo
  - Integrate what CNA is doing under old Section G (ADLs) with the new tasks assigned from Section GG (Functional Score)
  - Already seeing significant denials on GG data
  - High impact on :
    - Policies
    - Process
    - Payment

Important Definitions

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 and do not record the resident's worst performance, but rather record the resident's usual performance.

Qualified Clinician – Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

Helper – For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" 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. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.

GG Definitions

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

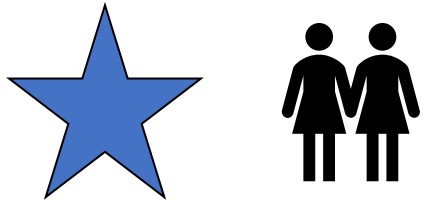
Activities may be completed with or without assistive devices.

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.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - 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** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the 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**

REMINDER: If two or more helpers are required to assist the resident in completing the activity, code as **01, Dependent.**



GG	Rehab	Section G
Independent – High Numbers	Independent	Independent – Low Numbers
Setup or clean-up assistance	Independent/Modified Independence	Set Up only
Supervision or touching assistance	Supervision	Supervision
Supervision or touching assistance	Contact Guard	Limited
Partial/moderate assistance	Min-Mod Assist	Extensive
Substantial/maximal assistance:	Mod to Max Assist	Extensive
Dependent – Low Numbers	Dependent	Dependent – High Numbers

Diagnosis Coding and Sequencing

- Primary diagnosis
  - 2-step process now
    - Diagnosed by practitioner (assigned or renewed) within last 60-days
    - Active in the last 7 days
  - One of the highest areas for recoupment/ PDPM adjustment
  - Should be the reason for skilled services under Med A, not highest reimbursement
    - Conflict between bulk of services being provided between IDT clinicians and focus of care.
    - Accurate DX in UR process.

Section I: Active Diagnoses

- The items in this section are intended to code diseases that have a direct relationship to the resident's –
  - Current functional status, cognitive status, mood/behavior status,
  - Medical treatments,
  - Nursing monitoring,
  - Risk of death.
    - Diagnosis **identification**: (Step 1) is a 60-day look-back period.
    - Diagnosis **status**: Active or Inactive (Step 2) is a 7-day look-back period (except UTIs, which use a 30-day look-back period).

Other

I8000. Additional active diagnoses

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

Documenting Completion Date

- Sign the date the interview was complete for interview items
- Sign separately for those items requiring completion after the ARD (e.g.E)

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			

PT & OT

Clinical Category	Section GG F.P.S.	PT CMI	Urban	Rural	PT CMG	OT CMI	Urban	Rural	OT CMG
Major Joint Replacement or Spinal Surgery	0-5	1.49	$98.43	$112.20	TA	1.45	$97.77	$100.28	TA
Major Joint Replacement or Spinal Surgery	6-9	1.65	$109.00	$124.25	TB	1.59	$98.77	$109.96	TB
Major Joint Replacement or Spinal Surgery	10-23	1.83	$120.89	$137.80	TC	1.64	$97.77	$113.42	TC
Major Joint Replacement or Spinal Surgery	24	1.87	$123.53	$140.81	TD	1.49	$100.80	$103.05	TD
Other Orthopedic	0-5	1.38	$91.16	$103.91	TE	1.37	$91.62	$94.75	TE
Other Orthopedic	6-9	1.57	$103.71	$118.22	TF	1.56	$84.24	$107.89	TF
Other Orthopedic	10-23	1.62	$107.02	$121.99	TG	1.60	$98.38	$110.66	TG
Other Orthopedic	24	1.13	$74.65	$85.09	TH	1.12	$68.87	$77.46	TH

PT & OT

Clinical Category	Section GG F.P.S.	PT CMI	Urban	Rural	PT CMG	OT CMI	Urban	Rural	OT CMG
Medical Management	0-5	1.10	$72.67	$82.83	TI	1.45	$97.77	$100.28	TI
Medical Management	6-9	1.38	$91.16	$103.91	TJ	1.59	$98.77	$109.96	TJ
Medical Management	10-23	1.48	$97.77	$111.44	TK	1.64	$97.77	$113.42	TK
Medical Management	24	1.06	$70.02	$79.82	TL	1.49	$100.80	$103.05	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	1.24	$81.91	$93.37	TM	1.37	$91.62	$94.75	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	1.44	$95.13	$108.43	TN	1.56	$84.24	$107.89	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	1.51	$99.75	$113.70	TO	1.60	$98.38	$110.66	TO
Non-Orthopedic Surgery and Acute Neurologic	24	1.05	$69.36	$79.07	TP	1.12	$68.87	$77.46	TP

NURSING CASE-MIX CLASSIFICATION GROUPS

RUG-IV Nursing RUG	Clinical Condition	Depression	GG- Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
ES1	Infection		0-14	ES1	2.85	$328.18	$313.56	C
HE2/HD2	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	Yes	0-5	HDE2	2.33	$268.30	$256.35	D
HE1/HD1	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	No	0-5	HDE1	1.94	$223.39	$213.49	E
HC2/HB2	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	Yes	6-14	HBC2	2.18	$251.03	$239.84	F
HC1/HB1	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	No	6-14	HBC1	1.81	$208.42	$199.14	G
LE2/LD2	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	Yes	0-5	LDE2	2.02	$232.60	$222.24	H
LE1/LD1	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	No	0-5	LDE1	1.68	$193.45	$184.83	I
LC2/LB2	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	Yes	6-14	LBC2	1.67	$192.30	$183.73	J

NURSING CASE-MIX CLASSIFICATION GROUPS CONT.

RUG-IV Nursing RUG	Clinical Condition	Depression	GG-Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
LC1/LB1	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	No	6-14	LBC1	1.39	$160.06	$152.93	K
CE2/CD2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	0-5	CDE2	1.82	$209.57	$200.24	L
CE1/CD1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	0-5	CDE1	1.58	$181.94	$173.83	M
CC2/CB2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	6-14	CBC2	1.51	$173.88	$166.13	N
CA2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	15-16	CA2	1.06	$122.06	$116.62	O
CC1/CB1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	6-14	CBC1	1.30	$149.70	$143.03	P
CA1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	15-16	CA1	0.91	$104.79	$100.12	Q

NURSING CASE-MIX CLASSIFICATION GROUPS CONT.

RUG-IV Nursing RUG	Clinical Condition	GG-Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
BB2/BA2	Behavioral or Cognitive Symptoms	11-16	BAB2	1.01	$116.30	$102.57	R
BB1/BA1	Behavioral or Cognitive Symptoms	11-16	BAB1	0.96	$110.54	$97.33	S
PE2/PD2	Assistance with Daily Living and General Supervision	0-5	PDE2	1.53	$176.18	$154.90	T
PE1/PD1	Assistance with Daily Living and General Supervision	0-5	PDE1	1.43	$164.66	$144.43	U
PC2/PB2	Assistance with Daily Living and General Supervision	6-14	PBC2	1.19	$137.03	$120.36	V
PA2	Assistance with Daily Living and General Supervision	15-16	PA2	0.69	$79.45	$70.12	W
PC1/PB1	Assistance with Daily Living and General Supervision	6-14	PBC1	1.10	$126.67	$100.94	X
PA1	Assistance with Daily Living and General Supervision	15-16	PA1	0.64	$73.70	$64.89	Y

SLP CASE-MIX CLASSIFICATION GROUPS

SLP Case-Mix Classification Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mech. Alt. Diet or Swallowing Disorder	SLP Case-mix Index	Urban	Rural	SLP CMG	
None	Neither	0.68	$15.01	$18.92	SA	
None	Either	1.82	$40.12	$50.55	SB	
None	Both	2.67	$58.88	$74.20	SC	
Any one	Neither	1.46	$32.14	$40.50	SD	
Any one	Either	2.34	$51.61	$65.03	SE	
Any one	Both	2.98	$65.69	$82.77	SF	
Any two	Neither	2.04	$45.04	$56.76	SG	
Any two	Either	2.86	$63.11	$79.52	SH	
Any two	Both	3.53	$77.89	$98.14	SI	
All three	Neither	2.99	$65.92	$83.06	SJ	
All three	Either	3.70	$81.64	$102.87	SK	
All three	Both	4.21	$92.90	$117.06	SL	

Table 16: NTA Comorbidity Score Calculation

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	N/A (SNF claim)	8
Parenteral IV Feeding: Level High	K0520A3, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0110H1b	5
Special Treatments/Programs: Invasive Mechanical Ventilator or Respirator Post-admit Code	O0110F1b	4
Parenteral IV Feeding: Level Low	K0520A3, K0710A2, K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0110I1b	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	O0110E1b	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0110M1b	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0110B1b	1
Stage 4 Unhealed Pressure Ulcer Currently Present[1]	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1

Condition/Extensive Service	MDS Item	Points
Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Code	M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0110D1b	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0520B3	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

[1] If the number of Stage 4 Unhealed Pressure Ulcers is recorded as greater than 0, it will add one point to the NTA comorbidity score calculation. Only the presence, not the count, of Stage 4 Unhealed Pressure Ulcers affects the PDPM NTA comorbidity score calculation.

STEP #2

Calculate the resident's total NTA score using the table above. To calculate the total NTA score, sum the points corresponding to each condition or service present. If none of these conditions or services is present, the resident's score is 0.

NTA Score: _____

N.T.A. Case-Mix Classification Groups

N.T.A. Score range	N.T.A. case-mix index	Urban	Rural	NTA CMG	
12+	3.24	$252.05	$240.83	NA	
9-11	2.53	$196.68	$187.92	NB	
6-8	1.84	$142.97	$136.60	NC	
3-5	1.33	$103.30	$98.70	ND	
1-2	0.96	$74.38	$71.06	NE	
0	0.72	$56.20	$53.69	NF	

October 1, 2021

Request for Information: Update to PDPM NTA Component

- Updates to Conditions and Extensive Services Used for NTA Classification (cont.)

RFI 16 NTA Removal Considerations	RFI 17 NTA Addition Considerations
Bladder and Bowel Appliances: Ostomy, Active Diagnoses: Malnutrition Code, Immune Disorders, End-Stage Liver Disease, Proliferative Diabetic Retinopathy and Vitreous Hemorrhage, Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage, Aseptic Necrosis of Bone, Cardio-Respiratory Failure and Shock, Systemic Lupus Erythematosus, Other Connective Tissue Disorders, Inflammatory Spondylopathies, Severe Skin Burn or Condition, Intractable Epilepsy, Respiratory Arrest, Pulmonary Fibrosis and Other Chronic Lung Disorders, Nutritional Approaches While a Resident: Feeding Tube, Special Treatments/Programs: Tracheostomy Post-admit Code, Special Treatments/Programs: Radiation Post-admit Code, Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Codes M1040A, M1040C.	B0100: Comatose, GG0120D: Mobility Devices: Limb prosthesis, I0600: Active Diagnoses: Heart Failure, I5700: Active Diagnoses: Anxiety Disorder, I5900: Active Diagnoses: Bipolar Disorder, I6100: Active Diagnoses: Post Traumatic Stress Disorder, I6300: Active Diagnoses: Respiratory Failure, RxCC: Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis, RxCC: Venous Thromboembolism, RxCC: Atrial Arrhythmias, RxCC: Sickle Cell Anemia, RxCC: Rheumatoid Arthritis and Other Inflammatory Polyarthropathy, RxCC: Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease - Except: CC: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease, RxCC: Aplastic Anemia and Other Significant Blood Disorders, RxCC: Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders, RxCC: Chronic Viral Hepatitis, Except Hepatitis C, M1040E: Other Skin Problems: Surgical Wound(s) Code

In this revision, 9 retained NTAs have decreased in point values, some significantly.
For example:
Special Treatments/Programs: Ventilator or Respirator Post-admit Code is would be revised from 4 points to 1 point **and**
Section K: Parenteral IV Feeding: Level High would be revised from 7 points to 5.

Conversely, there are 4 items with point values that have increased as well.
For example:
Lung Transplant Status is would be revised from 3 points to 5 and
Cystic Fibrosis wouldbe revised from 1 point to 3.

Operations Alert

- Recommendations for best practice
  - Review current applications for admission and make changes as needed
  - Assess current referral forms and determine if the additional data can be obtained, or if changes will be needed
  - Add data collection items to current tools to include the additional section questions
  - Alert team members as to where the data will be kept and how to access

Managed Care Audits

- Least lenient
- Misinterpretation of RAI manual
- Making up payment rules not included in contracts, manuals, or RAI/MBPM/MCPM
- No appeal process for ‘payment audits’
  - Mainly OON
  - Must pay at PDPM rate
- Many current ‘levels’ below default or Medicaid rates

UPCOMING CHANGES TO QUALITY MEASURES

Current Measure: Percent of Residents Who Made Improvements in Function (SS) (CMS ID: N037.03)	**GG Equivalent Measure:** Discharge Function Score (CMS ID: S042.02)
Measure Description: This measure reports the percentage of short-stay residents who were discharged from the nursing home that gained more independence in transfer, locomotion, and walking during their episodes of care.	**Measure Description:** This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge function score.
Numerator Short-stay residents who: 1. Have a change in performance score that is negative ([valid discharge assessment] - [valid preceding PPS 5-Day assessment or OBRA Admission assessment] < [0]). Performance is calculated as the sum of G0110B1 (transfer: self-performance), G0110E1 (locomotion on unit: self-performance), and G0110D1 (walk in corridor: self-performance), with 7's (activity occurred only once or twice) and 8's (activity did not occur) recoded to 4's (total dependence). **Denominator** Short-stay residents who: Meet all of the following conditions, except those with exclusions: 1. Have a valid discharge assessment (A0310F = [10]), and Have a valid preceding PPS 5-Day assessment (A0310B = [01]) or OBRA Admission assessment (A0310A = [01]).	**Numerator** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with an observed discharge function score that is equal to or greater than the calculated expected discharge function score. **Denominator** The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria. **GG Function items used for discharge function score calculations:** • GG0130A3. Eating • GG0130B3. Oral hygiene • GG0130C3. Toileting hygiene • GG0170A3. Roll left and right • GG0170C3. Lying to sitting on side of bed • GG0170D3. Sit to stand • GG0170E3. Chair/bed-to-chair transfer • GG0170F3. Toilet transfer • GG0170I3: Walk 10 Feet* • GG0170J3: Walk 50 Feet with 2 Turns* • GG0170R3. Wheel 50 feet with 2 Turns*
Exclusions Residents satisfying any of the following conditions: **1.1.** Comatose (B0100 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM. **1.2** Life expectancy of less than 6 months (J1400 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM. **1.3** Hospice (O0100K2 = [1]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM.	**Exclusions** Medicare Part A SNF stays are excluded if: **1.** The Medicare Part A SNF stay is an incomplete stay: Unplanned discharge - Discharge to acute hospital, psychiatric hospital, long-term care hospital indicated - SNF PPS Part A stay less than 3 days - The resident died during the SNF stay **2.** The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment): Coma, persistent vegetative state, complete tetraplegia, severe brain

G to GG QM Changes Compare Table

1.4 Information on Transfer: self-performance, walk in corridor: self-performance, or locomotion on unit: self-performance is missing on any of the assessments used to calculate the QM (G0110B1, G0110D1, or G0110E1 = [-]) (i.e., valid discharge assessment, and PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM). **1.5** Residents with no impairment (sum of G0110B1, G0110D1 and G0110E1 = [0]) on the PPS 5-Day assessment or OBRA Admission assessment, whichever was used in the QM. **1.6.** Residents with an unplanned discharge on any assessment during the care episode (A0310G = [2])	damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain. **3.** The resident is younger than age 18: **4.** The resident is discharged to hospice or received hospice while a resident:
Covariates **1.** Age on the PPS 5-Day assessment **2.** Gender **3.** Severe cognitive impairment **4.** Long Form ADL (LFADL) Scale (G0110A1 + G0110B1 + G0110E1 + G0110G1 + G0110H1 + G0110I1 + G0110J1). If any (G0110A1, G0110B1, G0110E1, G0110G1, G0110H1, G0110I1, G0110J1) = [7, 8], recode the item to equal [4].	**Covariates** **1.** Age group **2.** Admission function – continuous form **3.** Admission function – squared form **4.** Primary medical condition category **5.** Interaction between admission function and primary medical condition category **6.** Prior surgery **7.** Prior functioning: self-care **8.** Prior functioning: indoor mobility (ambulation) **9.** Prior functioning: stairs **10.** Prior functioning: functional cognition **11.** Prior mobility device use **12.** Stage 2 pressure ulcer/injury **13.** Stage 3, 4, or unstageable pressure ulcer/injury **14.** Cognitive abilities **15.** Communication impairment **16.** Urinary Continence **17.** Bowel Continence **18.** History of falls **19.** Nutritional approaches **20.** High BMI **21.** Low BMI **22.** Comorbidities **23.** No physical or occupational therapy at the time of admission

G to GG QM Changes Compare Table

Current Measure: Percent of Residents Whose Ability to Move Independently Worsened (LS) (CMS ID: N035.03)	**GG Equivalent Measure:** Percent of Residents Whose Ability to Walk Independently Worsened (LS) (CMS ID: N035.05)
Measure Description: This measure reports the percent of long-stay residents who experienced a decline in independence of locomotion during the target period.	**Measure Description:** This measure reports the percent of long-stay residents who experienced a decline in independence of locomotion during the target period.
Numerator Long-stay residents with a selected target assessment and at least one qualifying prior assessment who have a decline in locomotion when comparing their target assessment with the prior assessment. Decline identified by: **1.** Recoding all values (G0110E1 = [7, 8]) to (G0110E1 = [4]). **2.** An increase of one or more points on the "locomotion on unit: self-performance" item between the target assessment and prior assessment (G0110E1 on target assessment – G0110E1 on prior assessment ≥1) **Denominator** Long-stay residents who have a qualifying MDS 3.0 target assessment and at least one qualifying prior assessment, except those with exclusions.	**Numerator** Long-stay residents with a selected target assessment and at least one qualifying prior assessment who have a decline in locomotion when comparing their target assessment with the prior assessment. Decline identified by: **1.** Recoding all values (GG0170I = [07, 09, 10, 88]) to (GG0170I = [01]). **2.** A decrease of one or more points on the "Walk 10 feet" item between the target assessment and prior assessment (GG0170I on target assessment – GG0170I on prior assessment ≤ -1) **Denominator** Long-stay residents who have a qualifying target assessment and at least one qualifying prior assessment, except those with exclusions.
Exclusions (Any of the following) **1.** Comatose or missing data on comatose at the prior assessment. **2.** Prognosis of less than 6 months at the prior assessment as **3.** Resident totally dependent during locomotion on prior assessment **4.** Missing data on locomotion on target or prior assessment **5.** Prior assessment is a discharge with or without return anticipated **6.** No prior assessment is available to assess prior function.	**Exclusions (Any of the following)** **1.** Comatose or missing data on comatose at the prior assessment. **2.** Prognosis of less than 6 months at the prior assessment **3.** Resident dependent or activity was not attempted during locomotion on prior assessment **4.** Missing data on locomotion on target or prior assessment **5.** Prior assessment is a discharge with or without return anticipated **6.** No prior assessment is available to assess prior function. **7.** Prior or target assessment dates before 10/01/2023
Covariates **1.** Eating (self-performance) from prior assessment **2.** Toileting (self-performance) from prior assessment **3.** Transfer (self-performance) from prior assessment **4.** Walking in Corridor (self-performance) from prior assessment **5.** Severe cognitive impairment from prior assessment **6.** Linear Age	**Covariates** **1.** Eating from prior assessment **2.** Toilet Transfer from prior assessment **3.** Sit to Stand from prior assessment **4.** Walk 10 Feet from prior assessment **5.** Severe cognitive impairment from prior assessment **6.** Linear Age
7. Gender **8.** Vision **9.** Oxygen use **10.** All covariates are missing if no prior assessment is available.	**7.** Gender. **8.** Vision. **9.** Oxygen use. **10.** All covariates are missing if no prior assessment is available.

G to GG QM Changes Compare Table

Current Measure: Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (CMS ID: N028.02)	**GG Equivalent Measure:** Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (CMS ID: N028.04)
Measure Description: This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.	**Measure Description:** This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.
Numerator Long-stay residents with selected target and prior assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared. The four late-loss ADL items are self-performance bed mobility (G0110A1), self-performance transfer (G0110B1), self-performance eating (G0110H1), and self-performance toileting (G0110I1). An increase is defined as: - an increase in two or more coding points in one late-loss ADL item or - one point increase in coding points in two or more late-loss ADL items. **Note** that for each of these four ADL items, if the value is equal to [7, 8] on either the target or prior assessment, then recode the item to equal [4] to allow appropriate comparison. **Denominator** All long-stay residents with a selected target and prior assessment, except those with exclusions.	**Numerator** Long-stay residents with selected target and prior assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared. The four late-loss ADL items are Sit to Lying (GG0170B), Sit to Stand (GG0170D), Eating (GG0130A), and Toilet Transfer (GG0170F). An increase in need for help is defined as: - a decrease in two or more coding points in one late-loss ADL item or - one point decrease in coding points in two or more late-loss ADL items. **Note** that for each of these four ADL items, if the value is equal to [07, 09, 10, 88] on either the target or prior assessment, then recode the item to equal [01] to allow appropriate comparison. **Denominator** All long-stay residents with a selected target and prior assessment, except those with exclusions.
Exclusions **1.** All four of the late-loss ADL items indicate total dependence, activity occurred only once or twice, or activity did not occur on the prior assessment **2.** Three of the late-loss ADLs indicate total dependence on the prior assessment, as in #1 AND the fourth late-loss ADL indicates extensive assistance on the prior assessment. **3.** If resident is comatose missing data on comatose on the target assessment. **4.** Prognosis of life expectancy is less than 6 months on the target assessment. **5.** Hospice care on the target assessment. **6.** The resident is not in the numerator and data is missing for the four late loss ADLs on the prior or target assessment.	**Exclusions** **1.** All four of the late-loss ADL items indicate dependence or activity was not attempted on the prior assessment **2.** Three of the late-loss ADLs indicate dependence or activity was not attempted on the prior assessment, as in exclusion 1 AND the fourth late-loss ADL indicates substantial/maximal assistance on the prior assessment. **3.** Comatose or missing data on comatose (B0100 = [1, -]) on the target assessment. **4.** Prognosis of life expectancy is less than 6 months on the target assessment. **5.** Hospice care on the target assessment. **6.** The resident is not in the numerator and data is missing for the four late loss ADLs on the prior or target assessment. **7.** No prior assessment is available to assess prior function. **8.** Prior or target assessment date before 10/01/2023.18
Covariates: Not Applicable	**Covariates:** Not Applicable

G to GG QM Changes Compare Table

Current Measure: Percent of High-Risk Residents With Pressure Ulcers (LS)24 (CMS ID: N015.03)	**GG Equivalent Measure:** Percent of Residents With Pressure Ulcers (LS) (CMS ID: N045.02)
Measure Description: This measure captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers	**Measure Description:** This measure captures the percentage of long-stay residents with Stage II-IV or unstageable pressure ulcers.
Numerator All long-stay residents with a selected target assessment that indicates Stage II-IV or unstageable pressure ulcers are present. **Denominator** All long-stay residents with a selected target assessment that meet the definition of high risk, except those with exclusions. Residents are defined as high-risk if they meet one or more of the following three criteria on the target assessment: **1.** Impaired bed mobility or transfer **2.** Comatose **3.** Malnutrition or at risk of malnutrition	**Numerator** All long-stay residents with a selected target assessment that indicates Stage II-IV or unstageable pressure ulcers are present. **Denominator** All long-stay residents with a selected target assessment except those with exclusions.
Exclusions **1.** Target assessment is an OBRA Admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]) **2.** If the resident is not included in the numerator (the resident did not meet the pressure ulcer conditions for the numerator) and no data is available for the Stage II-IV or unstageable pressure ulcers items on the target assessment	**Exclusions** **1.** Target assessment is an ORBA Admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]) **2.** If the resident is not included in the numerator and no data is available for the Stage II-IV or unstageable pressure ulcers items on the target assessment **3.** Assessments with target dates before 10/01/2023.
Covariates: Not Applicable	**Covariates** **1.** Impaired Functional Mobility: Lying to Sitting on Side of Bed on target assessment **2.** Bowel Incontinence on target assessment. **3.** Diabetes Mellitus, Peripheral Vascular Disease or Peripheral Arterial Disease on target assessment. **2.** Indicator of low body mass index based on height (K0200A) and weight (K0200B) on target assessment. **3.** Malnutrition or at risk of malnutrition on target assessment. **4.** Dehydrated on target assessment. **5.** Infections: Septicemia, Pneumonia, Urinary Tract Infection or Multidrug-Resistant Organism on target assessment. **6.** Moisture Associated Skin Damage on target assessment.
	7. Hospice Care on target assessment.

G to GG QM Changes Compare Table

Current Measure: Percent of Low-Risk Residents Who Lose Control of Their Bowel or Bladder (LS) (CMS ID: N025.02)	**GG Equivalent Measure:** Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS) (CMS ID: N046.02)
Measure Description: The measure reports the percent of long-stay residents who frequently lose control of their bowel or bladder.	**Measure Description:** This measure reports the percent of long-stay residents with new or worsened bowel or bladder incontinence between the prior assessment and target assessment.
Numerator Long-stay residents with a selected target assessment that indicates frequently or always incontinence of the bladder **Denominator** All long-stay residents with a selected target assessment, except those with exclusions.	**Numerator** Long-stay residents with selected target and prior assessments that indicate a new or worsened case of bowel or bladder incontinence has occurred when the selected assessments are compared. Residents meet the definition of new or worsened bowel or bladder incontinence if any of the following conditions are true: **Condition A:** A new case of bowel incontinence is defined as an increase in one or more coding points on the bowel continence item (H0400) from always continent to either occasionally, frequently, or always incontinent. **Condition B:** A worsened case of bowel incontinence is defined as an increase in one or two coding points on the bowel continence item (H0400) from occasionally incontinent to frequently or always incontinent or from frequently incontinent to always incontinent. **Condition C:** A new case of bladder incontinence is defined as an increase in one or more coding points on the bladder continence item from always continent or occasionally incontinent to frequently or always incontinent. **Condition D:** A worsened case of bladder incontinence is defined as an increase in one coding point on the bladder continence item (H0300) from frequently incontinent to always incontinent.

G to GG QM Changes Compare Table

	Denominator All long-stay residents with a selected target and prior assessment, except those with exclusions.
Exclusions **1.** Target assessment is an admission assessment or a PPS 5-Day assessment **2.** Resident is not in numerator and data is missing for the incontinence items. **3.** Residents who have any of the following high-risk conditions: 3.1. Severe cognitive impairment on the target assessment 3.2. Totally dependent in bed mobility self-performance 3.3. Totally dependent in transfer self-performance 3.4. Totally dependent in locomotion on unit self-performance **4.** Resident does not qualify as high risk and both of the following two conditions are true for the target assessment: 4.1. BIMS summary score is missing and 4.2. Short term memory data is missing **5.** Resident does not qualify as high risk and any of the following three conditions are true: 5.1. Data for bed mobility is missing 5.2. Data for transfers is missing 5.3. Data for locomotion on unit is missing 6. Resident is comatose or comatose status is missing on the target assessment. 7. Resident has an indwelling catheter or indwelling catheter status is missing on the target assessment. 8. Resident has an ostomy or ostomy status is missing on the target assessment.	**Exclusions** 1. Target assessment is an admission assessment or a PPS 5-Day assessment 2. Resident is not in numerator and data is missing for the incontinence items on the prior assessment or on the target assessment. 3. Resident is comatose or comatose status is missing on the prior assessment, or on the target assessment. 4. Resident has an indwelling catheter or indwelling catheter status is missing on the prior assessment, or on the target assessment. 5. Resident has an ostomy or ostomy status is missing on the prior assessment, or on the target assessment. 6. No prior assessment is available to assess prior function. 7. Prior or target assessments with dates before 10/01/2023.
Covariates Not Applicable	**Covariates** 1. Severe cognitive impairment on target assessment. 2. Sit to Lying on prior assessment. 3. Sit to Stand on prior assessment.

Resources Links

- Med Pass-RAI Manual- Two Versions
- L3RA11 – Long-Term Care Facility Resident Assessment Instrument 3.0 Essential MDS User Manual w/Flash Drive – No Updates: https://www.med-pass.com/index.php/ltcf-rai-3-0-essential-mds-user-s-manual-with-usb-flash-drive.html
- L3RA33 - Long-Term Care Facility Resident Assessment Instrument 3.0 Enhanced MDS User Manual w/Flash Drive – Receives 1 year of Updates - https://www.med-pass.com/index.php/ltcf-rai-3-0-enhanced-mds-user-s-manual-with-usb-flash-drive.html?___SID=U
- MDS Form- Med Pass (Item Number CP911911)
- MDS 3.0 Resident Interview Cue Cards (Item number CP301C-18).
- MDS 3.0 1.19.11 item sets V6 https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual
- https://www.cms.gov/files/document/mds30finalitemmatrixv1191foroct12024.pdf
- https://padona.com/news/mds-version-1-19-11-effective-october-1-2024-2/