SKILLED NURSING FACILITY (SNF) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON JUNE 21–22, 2016

Current as of October 2016

Question #	Question	Answer
1	Medicare secondary payer patients require Medicare assessments to report days to the common working file. Remember that Medicare can become primary at any point and reporting does not restart the schedule for the common working file (CWF.) Do these impact QRP metrics? Do discharge PPS assessments follow the NOMNC schedule since notification is required?	While the primary payer is being billed, the facility should not be submitting Prospective Payment System (PPS) assessments to CMS. The first day that Part A becomes the primary payer is Day 1 of the Part A stay, though days that Medicare is secondary do count against the 100-day benefit period if the primary payer does not make a full payment for Medicare-covered services. Starting on that day, the provider should complete and submit PPS assessments pursuant to the policies and timelines outlined in the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) manual, as long as the resident continues to qualify for and receive Part A services. Only the assessments submitted during a Part A Stay are considered for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). The Part A PPS Discharge Assessment is distinct from the Notice of Medicare Non-Coverage (NOMNC) requirements. The NOMNC rules apply regardless of the type or date of the discharge assessment.
2	Are the slides copyrighted, or may we use them to train our staff?	Training materials are publicly available and can be used to train facility staff. Please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Quality-Reporting-Program-Provider-Training-6-21-16-.zip and https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html
3	Will transcripts be accessible on the CMS Web site? If so, please provide the link.	Video recordings of the presentations given during the SNF QRP Provider Training on June 21 and 22, 2016, will be posted to the CMS YouTube site. Video recordings will include closed captioning. A transcript separate from the closed captioning will not be posted.
4	If a resident changes from Medicare PPS to a managed care, is an end-of-PPS-stay assessment required?	A Medicare Part A stay ends when payer source changes from Medicare Part A to another payer. A Part A PPS Discharge Assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility. For instructions for completing the assessment, please refer to Chapters 2 and 3 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
5	How do we address situations in which we are informed retroactively of a resident's change in payer from Medicare A to Replacement and vice versa? Thanks.	Please refer to the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. Chapter 2 of the RAI User's Manual outlines timeframes for setting the Assessment Reference Data (ARD) completion and submission of all assessment types. Read carefully through Chapter 6 for guidance on early, late, and missing PPS assessments. For specific questions related to payment, providers should contact their Medicare Administrative Contractor.
6	For a patient admitted with a pressure ulcer, what date do we enter if the date pressure ulcer developed is unknown? Do we enter dashes? Do we enter the admit date?	If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. For more information, please refer to the MDS 3.0 RAI Manual V1.14 linked here (Page M-10): https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
7	Please review the circumstances under which an MDS may be completed. In many circumstances, providers are notified of a payer's source change well after the Medicare stay has ended, at which time current restrictions prevent an MDS from being completed and providers receive no payment.	Please refer to the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. Chapter 2 of the RAI User's Manual outlines timeframes for setting the Assessment Reference Data (ARD) completion and submission of all assessment types. Read carefully through Chapter 6 for guidance on early, late, and missing PPS assessments. For specific questions related to payment, providers should contact their Medicare Administrative Contractor.

Question #	Question	Answer
8	The data collection for QRP begins October 1 and will be for one quarter. What data collection period will you use moving forward? Does this apply to all three QMs?	For the three assessment-based measures finalized in the FY 2016 SNF PPS Final Rule, Application of Percent of Patients or Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF #0678), and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631), the FY 2018 reporting year is based on one quarter of data from October 1, 2016, to December 31, 2016.This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016. Following the initial 3-month reporting period, these measures will assume a calendar year reporting schedule. Thus, FY 2019 payment determination will be based on 12 calendar months of data reporting beginning on January 1, 2017, and ending on December 31, 2017. For more information, please refer to the FY 2017 SNF PPS Final Rule (81 FR 51969) linked here: https://www.federalregister.gov/documents/2016/08/05/2016-18113/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.
9	If Local Coverage Determination (LCD) is a day prior to discharge and a fall occurs on the day of discharge (e.g., A2400 6/18, D/C on 6/19), would this exclude the resident from QRP–fall with major injury? (See 260.3.2 Claims Processing Manual.)	We interpret your question to mean that the resident is being physically discharged from the facility the day after his/her Medicare Part A stay ends, and a fall occurs on the day he/she is being physically discharged. According to the MDS 3.0 RAI Manual V1.14 (Page 2-45, https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf) "If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge Assessment and Part A PPS Discharge Assessment are both required and may be combined. When the OBRA and Part A PPS Discharge Assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000)." Therefore, in the scenario described, the fall would be captured on the discharge assessment.

Question #	Question	Answer
10	Could you please clarify the timeframe for the look-back scan for this measure? Is it looking at only the set quarter review (i.e., October 1, 2016–December 31, 2016)? So, if a resident had three Medicare stays during the quarter and had a fall w/major injury coded on an MDS in each stay—that would be 3 toward the numerator, correct?	For the Application of Percent of Patients or Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) measure, the SNF denominator is the number of stays in the selected time window for SNF residents with a SNF PPS Part A Discharge Assessment (A0310H=1) during the selected time window, except those who meet the exclusion criteria. The SNF numerator is the number of Medicare Part A covered resident stays where the resident experienced one or more falls that resulted in major injury. A stay is defined as the time period from resident admission or reentry to the facility (identified by a 5-Day PPS Assessment) to discharge, which may be an OBRA Discharge or a SNF PPS Part A Discharge. Assessments eligible for inclusion in the look-back scan include OBRA Discharge, PPS 5-, 14-, 30-, 60-, 90-day, SNF PPS Part A Discharge Assessment or OBRA Admission, Quarterly, Annual or Significant Change Assessments. As such, if an individual had three SNF stays and a fall with major injury occurred during each stay, he or she would be counted in the numerator and the denominator three times. For more information, please refer to the Skilled Nursing Facility Quality Reporting Program–Specifications for the Quality Measures Adopted through the Fiscal Year 2016 Final Rule linked here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2015R.pdf.
11	If a resident signs on to hospice care, the section for Medicare A discharge will still be completed; however, the section GG may show decline. Will this resident be excluded, or will it flag with a decline in functional status; will this be considered an exclusion?	The function quality measure is a process measure that is an application of the quality measure, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). This quality measure reports the percent of patients/residents with an admission, a discharge functional assessment, and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident. The change in a resident's functional status is not included in the measure specifications and calculation. For more information, please refer to the Skilled Nursing Facility Quality Reporting Program–Specifications for the Quality Measures Adopted through the Fiscal Year 2016 Final Rule linked here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2015R.pdf.

Question #	Question	Answer
12	If only one Discharge Goal is required for GG, can you please clarify that use of the dash for a discharge goal will not have a negative impact (assuming there is at least one goal).	For the function measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-day PPS assessment. An SNF's Annual Payment Update will not be affected if at least one self-care or mobility goal is submitted. A dash may be entered for any other self-care or mobility that is not reported. For more information, please refer to the MDS 3.0 RAI Manual V1.14, linked here (Page GG-13): https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
13	Resident has Foley catheter and no bowel movement (BM) on Days 1–3 or admission. Would you interview family and code that? What if no family is available? Does it include care provided to perineum during personal care?	The toileting hygiene item captures the ability to maintain perineal hygiene and adjust clothes before and after the use of a commode, toilet, bedpan, or urinal and includes wiping the opening of an ostomy (but not managing equipment). A family member is not considered a "helper" in Section GG, so any assistance provided by family is not considered in coding. Coding of this item would be based on a clinical assessment soon after the admission for the SNF Part A stay. Care provided to the perineum by the helper during routine personal care is not included in this item. If the resident has an indwelling catheter and does not have a bowel movement during the 3-day assessment period, the item Toileting Hygiene would be coded 88, Activity not attempted, due to medical condition or safety concern. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
14	Is the coding of section GG the source documentation, or do we need auditable documentation in the medical record? Thank you.	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and reports from care staff and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. Federally, the resident interviews (e.g., BIMS, PHQ-9) are considered to be sole source documents, as they are direct interviews with the resident (and/or family, as in the case of Section F) and do not require additional documentation in the medical record (although some States may have more stringent documentation requirements). Information in the medical record can be documented by appropriate health care personnel, consistent with facility, Federal, and State standards.

Question #	Question	Answer
15	GG coding direction refers to "probing interviews." In WA State, "probing interviews" are challenged as NOT being appropriate data collection to code on MDS. Can you validate interview as appropriate? Also, see slide 43.	1. Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report and reports from care staff, and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. Please refer to your State Agency for State-specific documentation requirements.
16	COT on day of discharge (current RAI Chapter 2, p. 52): The provider can choose whether or not to do COT on day of discharge. 1. Choose to do when RUG up. 2. Choose NOT to do when RUG down. Result: few COT on day of discharge. Now: New Med A discharge MUST do COT if RUG change. Expect an increase in COTs which NOW cannot be combined with discharge. <1% COTs of all U.S.A. is a lot of MDS. MDS not to increase provider burden. BUT adding more and more need for assessments thereby increasing burden.	The requirement that a Change of Therapy (COT) Other Medicare Required Assessment (OMRA) is completed in cases where the resident's Medicare Part A stay ends (as documented in A2400C), and that date is on Day 7 of the COT observation period is the policy outlined on page 2-55 of the RAI manual. The only new aspect associated with this policy is that COT OMRA cannot be combined with the newly required PPS Discharge assessment and the two assessments must be completed separately.
17	Based on Anne's example: If wheelchair bound patient's admission ambulation performance score was 09 because the patient was non-ambulatory. For discharge goal -- since can't mark 09 -- should 01 be marked?	On the Admission (Start of SNF PPS Stay) Section GG assessment, assessors will indicate whether or not a resident walks in item GG0170H1. If the resident does not walk and no walking goal is clinically indicated, (i.e., GG0170H1=0, No), the assessor will not enter a walking goal and would move on to item GG0170Q1, Does the resident use a wheelchair/scooter? If the resident does not walk but a walking goal is clinically indicated, (i.e., GG0170H1=1, No), the assessor will enter a walking goal.

Question #	Question	Answer
18	How is "usual performance" defined? What if the usual performance fluctuates during the course of the day? Example: Dementia resident is supervision with toilet hygiene in a.m. and dependent in p.m.	Usual status is defined on page GG-18 in Section GG of the MDS 3.0 RAI Manual V1.14 (https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf): "A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's admission or discharge 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." The functional assessment should be completed soon after admission within the 3-day assessment period and prior to the start of therapeutic interventions, so that a usual/baseline status is captured. The discharge assessment period includes the day of discharge and the 2 days prior. The discharge functional assessment should occur close to the time of discharge within the 3-day assessment period.
19	How do you code an item in Section GG if a family member is the person who helps **every** time during the observation period?	For Section GG, the activities (items) are codes based on a clinical assessment soon after the admission for the SNF Part A stay. 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). Therefore, a family member is not considered a "helper" in Section GG, so any assistance provided by family is not considered in coding. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
20	What source document is required to support to Section GG? How many entries do you need during the 1-3 assessment window?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report and reports from care staff, and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. Federally, the resident interviews (e.g., BIMS, PHQ-9) are considered to be sole source documents, as they are direct interviews with the resident (and/or family, as in the case of Section F) and do not require additional documentation in the medical record (although some States may have more stringent documentation requirements). Information in the medical record can be documented by appropriate health care personnel, consistent with facility, Federal, and State standards. Section GG is based on a functional assessment of the resident's usual status. There are no requirements to count the number of times an activity occurs in order to determine usual status.
22	If QRP starts September 1, 2016, and Section GG doesn't start until October 1, how is this going to happen, or does GG go into effect on September 1?	The implementation date of SNF QRP was October 1, 2018. The FY 2018 APU determination is based on one quarter of data from October 1, 2016– December 31, 2016. This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016. The Assessment Reference Date (ARD) coded in item A2300 will determine the version of the MDS 3.0 that providers are to complete and submit to CMS. Specifically, if the ARD is on or after October 1, 2016, providers should use MDS 3.0 version 1.14.1 and submit section GG items.

Question #	Question	Answer
23	Day Two: % of LTCH with Admission and D/C. Self-Care Section GG. Slides 48-77. 1. Please clarify why all examples reference and code assessment findings include nursing/CNA observations but the actual Coding Scenario for Self-Care used **only** the OT evaluation information to score Section GG. The reliability and validity of studies in the User Manual (p. 36 and p. 43) indicate more than one clinician assessed the patient and there was a need to allow for fluctuation in patient abilities. Based on these studies, why are only the OT or PT evals used to score?	1. Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and reports from care staff and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. Examples included in the training are intended to give attendees insights into coding Section GG. When coding resident's discharge goals, all sources of information available should be considered.
24	A resident prior level of function was ambulating. Admitted to SNF after hospitalization and for the first 3 days resident is unable to ambulate. He was readmitted to hospital after 14 days and during that time not ambulating. Upon readmit for mobility section GG item J, would it be coded 09 = non-applicable or 88?	In the example provided, the resident was walking prior to the current illness, exacerbation, or injury, Code 88, Not attempted due to medical condition or safety concerns is the correct code to use for GG0170J and K in this instance. Note, if a walking goal is not clinically indicated (GG0170H1 = 0), these items will be skipped.
27	Care Plan: Can you clarify what do you mean by care plan for Section GG? (1) Are you referring to the nursing care plan? or (2) Is it the therapy plan of care?	For the function quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, documentation of a goal for one of the function items reflects that the patient's/resident's care plan addresses function. It is up to the facility to determine how the plan of care that included function is documented.

Question #	Question	Answer
28	In cases when the resident is too sick to start rehabilitation and on the 5-day MDS therapy has not been initiated and functional goals are not yet established and then later on the Part A Stay, PT and OT starts and functional goals are established: (1) Do we modify the 5-day MDS to reflect the current functional goals for the resident? (2) Can we use the prior level of function as the initial goal?	Section GG should reflect the resident's goals as of the 3-day assessment period. Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family, and the clinician's consideration of expected treatments, and resident motivation to improve. Goals can be established by RNs as well as OTs, PTs. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
29	The RAI draft manual does not provide the definition of turns as 90 degrees. Will the manual be updated to include definition of all turns as 90 degrees?	For the definition of turns as 90 degrees, please refer to Page GG-20 of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. "The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (e.g., cane, wheelchair)."
30	The RAI draft manual does not explain that toileting hygiene is broken down by three tasks. Will the RAI manual be updated with a better description of the toileting hygiene?	Toileting hygiene is defined as (1) adjustment of clothes before using the toilet, commode, bedpan, or urinal; (2) the ability to maintain perineal hygiene; and (3) adjustment of clothes after using the toilet, commode, bedpan, or urinal. For more instructions and guidance, please refer to coding examples in Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
31	1. Can CMS provide us with a flowsheet that we can use for CNA teaching? Is there an algorithm to calculate the Section GG, since it is only 3 days, or does the Rule of 3 still apply?	1. CMS does not provide documentation tools to support coding the MDS. Providers may wish to work with their software vendors to facilitate development of tools for documentation of function and self-care items, or refer to the various companies that create such documentation tools. The coding instructions for Section GG should not be confused with the coding instructions for Section G, Item G0110, Activities of Daily Living (ADL) Assistance. The Rule of 3 does not apply to Section GG. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
32	An accurate discharge goal requires input from the entire interdisciplinary team. The MDS completion typically triggers this discussion. MDS 5-day completion is required by 14 days after the ARD. Are you suggesting discharge goals be set without input from the entire team? Unilateral goals may not be accurate.	Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan. Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family, the clinician's consideration of expected treatments, and resident motivation to improve. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
33	Walking/Wheeling: Do we code for completion of distance, then turns (sequential) or distance with turns?	The distance required for the items GG0170J and GG0170R is walking or wheeling distance with two turns. In other words, the total distance, including the two turns must be 50 feet. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
34	How do we code eating if the resident does not use utensils but is independent using his/her hands?	Facilities may code the eating item using the appropriate response codes if the resident eats using his/her hands vs. using utensils (e.g., can feed him/herself using finger foods). If the resident eats finger foods with his/her hands independently, the resident would be coded as 06, independent.

Question #	Question	Answer
35	Example: A patient comes in to facility. PT, OT, and ST are ordered. Your examples suggested to use rehab goal(s) to code goal(s) in "GG." Would it be fair to say that patients in rehab who have rehab goals that are included in GG, those are the goals that you would want to code in "GG"?	Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan. Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family, the clinician's consideration of expected treatments, and resident motivation to improve. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
36	Please define "clean-up assistance." Please give examples of this for each of the Section GG ADL activities. (Examples of questions from providers: Is removing tray after meal "clean-up"? Is putting away oral hygiene items after use "clean-up"?)	Clean-up assistance includes putting away the supplies or items used to complete the activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices. Once a resident is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
37	Will there be some regulatory relief for the need/requirement for physician orders for therapy for assessing a patient since therapy will need to be involved in the admission MDS?	Currently, the MDS should be completed using an interdisciplinary process and should already be including the input of therapists throughout the resident's stay.

Question #	Question	Answer
38	Is effort defined as the amount of time the helper spends doing a task or as the amount of physical assistance the helper exerts? RAI examples vary between these definitions.	In assessing functional activity, "effort" is related to the amount of assistance the helper provides to complete the entire activity, not the amount of time the helper spends with the resident to complete the activity. This assistance, as noted in the six-point scale definitions, can be setup/cleanup; touching and/or verbal cueing; and lifting, holding, or supporting the trunk or limbs—and whether (for the latter) the helper is providing less or more than 50 percent of the effort required to assist the resident in completing the entire activity. The assessor should refer to and become proficient in understanding the definitions associated with the six-point scale and activity not attempted codes, as well as the Admission and Discharge Performance Coding Instructions to guide their coding of Section GG items.
39	Scenario: Patient sets him/herself up for an activity and completes the activity independently. Patient leaves the items needed for the ADL out, and staff clean up those items. Is coding a 5, set up/clean up?	Code 05, Setup or clean-up assistance is used if the helper SETS UP or CLEANS UP and the resident completes the activity by him/herself. The helper assists only prior to or following the activity, but not during the activity. In the example provided, the patient sets him/herself up, completes the activity, but does not clean up after the activity has been completed. Therefore, this scenario would be coded as 05, Setup or cleanup. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
40	Patient's usual performance for toileting is to NOT USE the toilet, commode, bedpan, urinal. Patient is totally incontinent and chooses not to transfer to toilet, commode bedpan, or urinal. Do we code 09, not applicable because she does not use toilet, commode, etc.? Do we code based on assistance and hygiene post incontinence.	If a resident refuses to complete the activity by not choosing to transfer to a toilet or use a commode, bedpan, or urinal, it should be coded 07, resident refused. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
41	"If we don't address a goal (because maintaining functionality noted at admission is the goal), my understanding is that we should use a dash. If we don't address a goal, we should use a dash. However, since you assessed and decided not to address, why would you not just code goal at current level at start of care. For example: eating is a "03," and we don't anticipate improvement, so should we code this item as "03" or dash?	Goals can reflect an improvement goal, a maintenance goal, or an expected decline. In any of these cases, the Discharge Goal should reflect the expected level of performance at the end of the Part A stay. Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family, the clinician's consideration of expected treatments, and resident motivation to improve. For more information, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
42	When gathering data for functional tasks in section GG, there are many options to making coding decisions (e.g., observation, report, therapist). When coding admission and discharge, do we have to be consistent with means of data gathering (e.g., on admission, code task based on observation of performance with CNA on unit; on discharge, coded task based on usual performance with therapy department)? Is this okay?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and family/caregiver input as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. Information in the medical record can be documented by appropriate health care personnel, consistent with facility, Federal, and State standards.

Question #	Question	Answer
43	Is there a deadline or suggested timeline for coding Section GG after the 3-day period? If resident receives a tube feeding 90% of the time, and is given food for pleasure 10% of the time, how would this be coded?	1. The Admission assessment of Section GG must be completed within 3 calendar days (Days 1 through 3 of the Medicare Part A stay), starting with the date in A2400B, Start of most recent Medicare stay and the following 2 days, ending at 11:59 p.m. on Day 3. The assessment should occur prior to the start of therapeutic intervention in order to capture the resident's true admission baseline status. The Discharge assessment of Section GG must be completed within the last 3 calendar days of the resident's stay, which includes the day of discharge and the 2 days prior to the day of discharge. The assessment period for Section GG is different from the actual completion date required for the entire 5-Day PPS assessment, which must be completed no later than the 14th calendar day of the resident's admission and the completion date for the Part A PPS Discharge assessment, which must be completed within 14 days after the End Date of Most Recent Medicare Stay. For more information, please refer to the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. Assistance with G-tube feedings is not considered when coding GG0130A Eating. The assessor should only consider the resident's usual performance with food and/or fluids taken by mouth.

Question #	Question	Answer
44	1. Sit to stand: How would you code if a sit-to-stand lift is utilized? If resident does not complete two turns while utilizing a wheelchair or scooter, how would 0170R be coded: 07, 09, or 88? The resident only goes left with no turns demonstrated.	1. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity. The score should be coded according to the amount of assistance provide by a helper. For more coding instruction for Section GG, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf. The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (e.g., cane, wheelchair). Therefore, if the resident only makes two turns to the left, it can still be coded. For more coding instruction for Section GG, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
45	Can you provide a more concrete definition of "usual" (e.g., four out of seven episodes, etc.) and a more concrete definition of "effort" for us to teach CNAs which of these self-care and mobility tasks are broken down into components (e.g., toilet hygiene is three components).	1. Usual status is defined on page GG-18 in Section GG of the MDS 3.0 RAI Manual V1.14 (https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf): "A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's admission or discharge 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 patient's usual performance." There are no requirements to count the number of times an activity occurs in order to determine usual status. Remember that the instructions for Section G do not apply to Section GG and should not be considered at all when completing these items. In assessing functional activity, "effort" is related to the amount of actual assistance the helper provides to complete the entire activity, not the amount of time the helper spends with the resident to complete the entire activity. This assistance, as noted in the six-point scale definitions, can be setup/cleanup; touching and/or verbal cueing; and lifting, holding, or supporting the trunk or limbs—and whether (for the latter) the helper is providing less or more than 50 percent of the effort required to assist the resident in completing the entire activity. The assessor should refer to and become proficient in understanding the definitions associated with the six-point scale and activity not attempted codes, as well as the Admission and or Discharge Performance Coding Instructions to guide their coding of Section GG items.
46	Are these only looking at functional activities, or can "practice in rehab" be considered for the coding?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and reports from care staff and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period. With regard to "practice in rehabilitation," the code is to reflect the resident's status performing the activity such as bed mobility in a bed, if the resident sleeps in a bed.

Question #	Question	Answer
47	If a resident comes in Med Adv. Plan- No PPS MDS are completed then several months later it is determined they are FFS. Facility is able to bill Medicare using Admit OBRA MDS for the first 2 billing periods. No PPS end of stay DIC MDS is completed- are these folks excluded from the QM calculations?	There would have been no 5-Day PPS Assessment or Part A PPS Discharge completed for the resident; therefore, this SNF stay would not be included in the measure calculation.
48	If a resident doesn't use the toilet and only has incontinent care, is this a scenario where 07 09 or 88 would be used?	It should be coded 88.
49	No criterion has been discussed about supportive or supplemental documentation to support coding of section GG. If it is the usual performance over 3 days, what (if any) documentation aside from therapy evaluations are required?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and reports from care staff and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period.
50	How would you score toilet transfer or toilet hygiene when the resident has a Foley catheter?	Care of a catheter is not considered when coding Toilet hygiene (GG0130C) or Toilet transfer (GG0170F). Coding toilet hygiene and toilet transfer in this instance would reflect the resident's function associated with instances of moving his or her bowels.
51	If there is no goal, how is this indicated in #2 discharge goal?	In the FY 2016 SNF PPS Final Rule, three quality measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP. The Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) is one of the three measures. For the function quality measure, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment. Coding instructions for Discharge Goals are available in Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
53	Discharge goal: if 1 admit performance is coded 7-9-88, will 2 discharge goal be a skip pattern?	Using the Activity Not Attempted codes for coding the Self-Performance items for self-care and/or mobility does not mean that the assessor skips the establishment of a Discharge goal for these items. The SNF QRP requires the submission of at least one self-care or mobility goal; as long as a Discharge Goal for at least one self-care or mobility item is established, the rest may have dashes entered (unless the SNF wants to submit more than the one discharge goal required). Use of the dash in this instance does not affect annual payment update determination. There is one exception related to the walking items (GG0170J and GG0170K) in the case where the assessor responds to GG0170H1 as, 0. No, and walking goals is not clinically indicated. In such a case, the walking items would be skipped per the established skip pattern. For coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
54	How do you code if the resident used both types of wheelchair—manual or unit-motorized off unit?	The code is based on the wheelchair they usually use for the particular wheeling activity. For example, if the resident performed both activities using both wheelchairs but usually used his or her motorized wheelchair and only sporadically used the manual wheelchair, the motorized wheelchair would be coded.
55	How would you code: On first day, CNA reports that resident performs less than half the effort. However, on the second day, the CNA reports on 2nd day support required to stand is more than half… What is “usual”?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report and reports from care staff, and family/caregivers as documented in the resident’s medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident’s functional assessment as reported in the resident’s medical record during the 3-day assessment period. Usual status is defined on page GG-18 in Section GG of the MDS 3.0 RAI Manual V1.14 (https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf): “A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status. If the resident’s admission or discharge 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.”

Question #	Question	Answer
56	The description for sit to stand specifies the ability to safely come to a standing position from sitting in a chair or on the side of the bed. Does this item exclude a wheelchair? As I see in the next item, chair/bed-to-chair transfer indicates a chair would include wheelchair.	Sit to stand includes coming to a standing position from a wheelchair.
57	Specifically for walking in GG0170J & K, does the total distance of 50 feet or 150 feet have to be completed consecutively, or can it be a total of 50 or 150 feet over the course of the day? For example, resident ambulates 20 then turns and ambulates an additional 10, but due to fatigue, he stops and an hour later ambulates 30 with a turn. Does this count as completing 50 feet with two turns?	GG0170J, Walk 50 feet with two turns and GG0170K, Walk 150 feet assess the resident's performance walking these distances in a single occurrence of the respective activity. For example, the resident must walk 50 feet with two turns all at once, not 20 feet in one occurrence and 30 feet in another.
58	Please define usual in the following situation. A resident is admitted and refuses to get up and walk Days 1 & 2. On Day 3, the resident agreed to walk for 20 feet with max. Assist. How would you code this scenario? If a resident refused to perform sit to stand day 1 & 2 and on Day 3 max Assist. How do you code this?	If a resident refuses to complete an activity over the 3-day assessment period, it should be coded 07. However, if a usual status can be identified, even if the resident had only a few episodes of compliance, that is what should be coded.
59	Does it matter if the two turns are done at the beginning, middle, or end of the 50 feet? If the assistance is greater turning than just walking, do we weigh those amounts equally?	For the walking and wheelchair items that require two turns, the two turns may occur any time during the 50 feet. The score should be coded according to the amount of assistance provide by a helper. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
60	The therapist attempts to assess "walks 150." The patient starts out well but fatigues with distance. By 100 feet, the patient is dependent. Do we code "dependent 01" or "activity not attempted due to med condition/safety" 88 since if would not be clinically appropriate to continue with the last 50 feet?	If there are safety concerns or the resident's medical condition does not allow for completion of the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For the example provided where the safety concerns would warrant not attempting the activity, code 88.
61	Will the coding in Section GG have an effect on RUG levels?	Section GG is not included in the RUG Classification system. For more information on items included in the RUG Classification system, please refer to Chapter 6 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
63	J: If the resident walks 50+ feet and completes a 180-degree turn at the end of the hall to turn around and walk back for part of that distance, does this count as two 90-degree turns since significantly more efforts and skills are required? Or would the 180-degree turn count as a single turn? How would this be coded? R: Similarly, if the resident wheels 50+ feet including one 180-degree turn, how would this be coded? Thank you!	The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
64	(1) How would Section GG be coded if the resident is on Part A stay for nursing services and is not receiving any rehabilitation services at the beginning of Part A stay, so no goals are set? (2) Therapy later starts during Part A Stay and Start of Therapy (SOT) is completed. Is there any way to now capture goals so that this can be captured in QRP measure?	For the function measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment. Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan. For more information , please refer to the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
65	J and K: When coding levels of independence with walking, please give examples and clarification of a case when the nurse, CNA, or therapist would need to hold on to the resident's gait belt while assisting him/her to walk. Is this defined to be more than steadying (since the therapists/CNA's hand needs to fully be around the gait belt, rather than just touching/steadying it)? Thank you!	If the assessor determines that the helper usually provides more than steadying assistance when coding walking items in GG0170, the assessor should determine if the helper usually provides more than or less than half the effort and code 02, Substantial/maximal assistance or 03, Partial/moderate assistance. If only steadying assistance is provided, 04, Supervision or touching assistance should be coded. The presence of a gait belt is not what determines the performance level; rather, it is the amount of assistance the helper provides.
66	A patient is assessed over 3 days and has not ambulated or transferred to the toilet. Upon questioning, the team records indicate the patient requires maximal assistance with chair to bed and sit to stand. The team determines she is unable to ambulate because she would be dependent, and therefore functionally it is not appropriate to attempt it. Would it be appropriate to code ambulated as (01)/dependent rather than (88)/not attempted? If not, why? Rationale: Applying clinical/functional logic to our assessment would seem appropriate. Based on patient performance of lower level activities would inform the decision to score the patient dependent.	If there are safety concerns or the resident's medical condition does not allow for completion of the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For the example provided where the resident's medical condition or safety concerns would warrant not attempting the activity, code 88.

Question #	Question	Answer
68	If the resident has a catheter but has bowel movements, then we code toilet hygiene based on the resident having a bowel movement, right? Maybe if the resident has a Foley catheter and a rectal tube, is it a code of 88 or 09 for admission performance?	If the resident has a catheter but has bowel movements, coding should reflect the resident's function associated with instances of moving his or her bowels. If the resident has a catheter and a rectal tube, the assessor will need to determine the status prior to the current illness, exacerbation, or injury and code 09 or 88 depending on the status immediately prior to the current illness, exacerbation, or injury. Code 09, Not applicable, is used if the patient did not perform this activity prior to the current illness, exacerbation, or injury. Code 88, Not attempted due to medical condition or safety concerns, is used if the activity was not attempted due to medical condition or safety concerns.
69	A patient with a history of moderate cognitive impairment has been readmitted after a 4-day hospitalization. The patient requires partial assistance to move his/her trunk to come to sitting but also requires 100-percent verbal cues and visual cues to sequence the task. Even though the patient only required partial physical assistance, would the item be appropriately scored maximal assist, given the patient required maximum verbal cues to complete the task? Rationale: Instructions indicate safety and quality of performance should be considered in the assessment, by the examples given in training did not appear to consider this until the (04)/(05) levels. Would this type of assistance be considered as "adding to" the level at 02/03 level too?	Code 03, Partial/moderate assistance is used if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort. The assessor would code the most appropriate choice for the activity. The assessor should not try to combine aspects from one response choice with another to arrive at the appropriate response. Examples included in the training are intended to give attendees insights into coding the MDS Section GG and do not cover every type of assistance or scenario. For more coding instructions, please refer to Chapter 3 Section GG of the MDS 3.0 RAI Manual V1.14, linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
70	When collecting medical record documentation for self care and mobility for Days 1 through 3, can CNA documentation of ADLs be used to complete MDS items? As an assessment coordinator, if I am completing a 5-day assessment on Day 8 of admission, is it expected that I complete the measures of observation, data collection, interviewing on Days 1 through 3?	Information coded on the MDS should be based on clinical assessment, direct observation, resident self-report, and reports from care staff and family/caregivers as documented in the resident's medical record. In this aspect, coding for Section GG is no different and should be consistent with the resident's functional assessment as reported in the resident's medical record during the 3-day assessment period.
71	These new assessments and section GG are going to require additional labor time in both therapy and nursing. Did CMS do a study related to additional labor (cost) to the SNF? Where is this published?	For related information, please refer to the FY 2017 SNF PPS Final Rule linked here: https://www.federalregister.gov/articles/2016/08/05/2016-18113/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.
75	What happens if the discharge assessment from IRF or LTAC doesn't match SNF Admission Assessment?	An individual's functional status on the discharge assessment from another PAC setting is not being compared to the functional status on the SNF 5-Day PPS assessment as part of the SNF QRP.
76	1. What item set is used for Short Stay PPS patients? There doesn't appear to be an item set with admission and discharge for GG. 2. Is there going to be a change in Assessment Indicator types for the new combination discharge assessments?	1. For a Medicare Part A stay, the 5-day PPS Assessment (or combined OBRA Admission and 5-Day PPS Assessment) and the Medicare Part A PPS Discharge Assessment (or combined Medicare Part A PPS Discharge and OBRA Discharge Assessment) will be used for SNF QRP measure calculation. Section GG is collected at the start of a Medicare Part A stay on the 5-Day PPS Assessment and is also collected at the end of the Medicare Part A stay on the Part A PPS Discharge Assessment. For more information, please refer to Chapter 2 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf). 2. For information about combining Medicare Assessment and OBRA Assessments, please refer to Chapter 2.11 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
77	Penalties are assessed for late, missed PPS scheduled, and unscheduled assessments. How would compliance with PPS assessment timing and scheduling be factored in QRPs?	Compliance with the PPS assessment timing and scheduling requirements does not impact the SNF QRP. For the SNF QRP, there are specific deadlines that are used for measure calculation and data reporting compliance. For related information, please refer to the SNF PPS 2017 Final Rule linked here: https://www.federalregister.gov/documents/2016/08/05/2016-18113/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.
78	When a notice of noncompliance is sent to the SNF, how will it be sent (email, USPS…?) and from whom will it be sent (MAC or …)? How far into the following compliance (year) will the facility receive the notice of noncompliance?	Notifications of noncompliance and any subsequent notifications from CMS would be sent via a traceable delivery method, such as certified U.S. mail or registered U.S. mail, or through other practicable notification processes, such as a report from CMS to the provider as a Certification and Survey Provider Enhanced Reports (CASPER) report, that will provide information pertaining to the provider's compliance with the reporting requirements for the given reporting cycle. CMS will also work with Medicare Administrative Contractors (MACs) to deliver the noncompliance report in the future.
79	Will CMS look at aligning the measurements to have the same definition from 5 star to VBP to QRP? This will be very significant for consumers.	While measures are aligned as much as possible across the programs, CMS must also account for variation in episode construction and measure calculation that may arise from differences in available data, risk adjustment (where applicable), inclusion and exclusion criteria to ensure the accuracy of the measure for each program.

Question #	Question	Answer
80	What measures impact payment determining the three QRP measures and readmissions VBP?	In the FY 2016 SNF PPS Final Rule, three quality measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP. These measures are Application of Percent of Patients or Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF #0678), and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). For more information, please refer to the FY 2016 SNF PPS Final Rule linked here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2015R.pdf. The question related to the SNF VBP is out of scope for the SNF QRP, and we refer readers to the SNF PPS 2016 Final Rule and 2017 Final Rule linked here: https://www.federalregister.gov/documents/2016/08/05/2016-18113/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.
81	There are situations where patients come off Medicare and stay in facility for reasons other than completing a stay. Examples might be (1) patient chooses to discharge on day 21 to avoid paying co-pay (even though we feel he/she could still benefit from skilled level of care), (2) patient chooses to switch to hospice, and (3) long-term care resident who was skilled following 3-day stay chooses to transfer to non-certified bed to be with former roommate. In such scenarios, is PPS discharge assessment warranted?	A Part A PPS Discharge Assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility. For instructions for completing the assessment, please refer to Chapters 2 and 3 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
82	Since these quality measures focus on Medicare admissions on and after October 1, should the PPS discharge MDS only be completed for residents admitted after October 1? Ex. Admitted on 9/29/16; d/c from PPS 11/1 - should a PPS D/C MDS be completed?	The FY 2018 Annual Payment Update (APU) determination is based on one quarter of data from October 1, 2016, to December 31, 2016.This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016. In terms of assessment types and item responses, this would mean that a 5-Day PPS with an Admission Date (A1900) and/or Start Date of Most Recent Medicare Stay (A2400B) of October 1, 2016, would be included, and Part A PPS Discharge or OBRA/Part A PPS Discharge with a Discharge Date (A2000) and/or End Date of Most Recent Medicare Stay (A2400C) of December 31, 2016, would be included. The ARD coded in item A2300 will determine the version of the MDS 3.0 that providers are to complete and submit to CMS. Specifically, if the ARD is on or after October 1, 2016, providers should use MDS 3.0 version 1.14.1. Version 1.14.1 is the version that has all of the items required for submission for the SNF QRP, including a Section new to the MDS 3.0, Section GG. We recognize that if the resident is admitted in September and discharged on or after October 1, 2016, the SNF would submit a discharge record with GG data. In this case, SNF can voluntarily complete and submit Section GG but be assured that any assessments that have September admission and start of Medicare Part A stay dates during the assessment period will not be taken into account for the calculation of the measure, nor will CMS penalize anyone for dashing out the entire Section GG in this circumstance.

Question #	Question	Answer
83	In last year's Final Rule it stated, "pressure ulcers found during interim assessments that healed before discharge are not included in the measure calculation." However, specs say will trigger if worsened PU triggered on any assessment. To my knowledge, IRF and LTAC do not do interim assessments although SNFs do. This seems to put SNFs at disadvantage. 1. Do PU worsened on interim assessments figure into stats? 2. How does this compare to IRF/LTAC rules?	The SNF Pressure Ulcer measure has been recently updated. Please find the updated measure specifications, Skilled Nursing Facility Quality Reporting Program–Specifications for Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (NQF #0678) (August 2016), here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2016_updated-PU.docx.The Updated time window for the SNF Pressure Ulcer measure will be a rolling 12 months of data.
84	Please provide specific definitions for the terms "stay" and "episode" as they relate to SNF QRP. Also, if a stay is admission thru PPS discharge, is an episode a series of PPS stays by a resident, or how does a "stay" compare to an "episode"? Specific examples would help. Since this is different from the way it is defined for CASPER, it is a bit more confusing for folks.	For the SNF QRP QMs, a Medicare Part A stay includes consecutive time in the facility starting with the Medicare Part A Admission record (PPS 5-Day assessment with A0310B=[01]) through the Medicare Part A Discharge record with A0310H=[1] and all intervening assessments. "Episode" is not related to SNF QRP.
85	Please explain the differences between "application of" and the actual Quality measure.	Generally, the term "application" pertains to the use of a measure for a different population, or a variation of an endorsed or non-endorsed measure for the same or a different population. For example, The long-stay falls measure, Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674), is currently publicly reported on Nursing Home Compare and applies to nursing home residents who have stayed in the nursing home for 101 or more days. The SNF QRP measure is a modification of that long-stay measure, where the specifications have been modified to apply to the SNF Medicare Part A population. Therefore, the measure is called an "Application of Percent of Residents Experiencing One or More Falls with Major Injury."

Question #	Question	Answer
86	I understand that QRP re function use 12 months of data calculated quarterly. Pressure ulcer's measure uses 6 months of data calculated quarterly. What assessment window is used for falls measure? Specs just say "selected time window."	The SNF Pressure Ulcer measure has been recently updated. Please find the updated measure specifications, Skilled Nursing Facility Quality Reporting Program–Specifications for Percent of Residents or Patients with Pressure Ulcers That are New or Worsened (NQF #0678) (August, 2016), here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_August-2016_updated-PU.docx. The time window for the SNF Pressure Ulcer measure and Falls with Major Injury measure is a rolling 12 months of data.
87	In situations where the SNF was not made aware in a timely manner that the beneficiary disenrolled from a Medicare Advantage Program, no PPS assessment was completed, and the conditions that would trigger a QRP QM were present during that time, what will happen?	There would have been no 5-Day PPS Assessment or Part A PPS Discharge completed for the resident, so this SNF stay would not be included in the measure calculation.
88	Will providers be able to access these data through CASPER reports for any of these QRP measures?	Providers will be able to access the data for any of the QRP measures through CASPER.
89	How would you code if half of the task is performed by staff and exactly half is performed by the resident?	If the patient performs half of the effort, code the item 03, Partial/moderate assistance.
92	Do you anticipate pressure ulcers to be called pressure wounds?	CMS is reviewing the new National Pressure Ulcer Advisory Panel (NPUAP) guidance and has not made any determinations regarding updating language as of this time.
94	Can you clarify the definition of required reporting of data? Are there thresholds for dashes, etc.?	Beginning with the FY 2018 payment determination, any SNF that does not meet the requirement that 80 percent of all MDS assessments submitted contain 100 percent of all data items necessary to calculate the SNF QRP measures would be subject to a reduction of 2 percentage points to its FY 2018 market basket percentage. For more information, please refer to the FY 2016 SNF PPS Final Rule linked here: https://www.federalregister.gov/documents/2015/08/04/2015-18950/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

Question #	Question	Answer
95	Can you please re-explain why the incomplete stays are part of the numerator calculation (Step 4)?	For patients/residents who have an incomplete stay, discharge data are not required to be reported. Patients/residents who have incomplete stays are defined as those patients/residents (1) with incomplete stays due to a medical emergency, (2) who leave the SNF against medical advice, or (3) who die while in the SNF. Discharge functional status data are not required to be reported for these patients/residents because these data might not be feasible to collect at the time of the medical emergency if the patient/resident dies or if the patient/resident leaves against medical advice. The following are required for the patients/residents who have an incomplete stay to be counted in the numerator: (1) a valid numeric score indicating the patient's/resident's functional status, or a valid code indicating the activity was not attempted or could not be assessed for each of the functional assessment items on the admission assessment and (2) a valid numeric score, which is a discharge goal indicating the patient's/resident's expected level of independence, for at least one self-care or mobility item on the admission assessment.
96	Is there a minimum number of PPS assessments submitted in order to calculate the SNF QRP QMs (e.g., when a SNF has a very small Part A census)? Is a Part A PPS discharge assessment required if a resident transitions payers to a Medicare Advantage plan?	There is no minimum number of Medicare Part A SNF stays required for SNF QRP QM calculation. However, for public reporting of the SNF QRP QMs, there will be minimum denominator sizes applied, which means that the measures score will not be publicly reported for providers with fewer than the minimum number of Medicare Part A SNF stays for a given SNF QRP measure. A Medicare Part A stay ends when payer source changes from Medicare Part A to another payer. A Part A PPS Discharge Assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility. For instructions for completing the assessment, please refer to Chapters 2 and 3 of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

Question #	Question	Answer
97	If facility is using Electronic Medical Record (EMR) to gather ADL data, i.e., Caretracker that integrates into MDS—this system is different coding than rest of MDS—how will that work? These codes are not going to be consistent with Section G.	The facility should contact its EMR vendor and discuss potential direction related to integration of Section GG. It is true that Section GG and Section G are different and, therefore, not consistent, which makes it even more important that the facility consult with its EMR vendor if the same functionality is desired.