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

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON AUGUST 24, 2016

Current as of December 2016

#	Question	Answer
Assessment Type		
1	How does CMS define an unplanned discharge?	An unplanned discharge includes, for example: • Acute care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine whether an acute care admission is required based on emergency department evaluation. • Resident unexpectedly leaving the facility against medical advice. • Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting). 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	Could you clarify the issue of a “planned” versus an "unplanned" discharge definition and its impact on the type of discharge assessment needed?	Per current requirements, the Omnibus Budget Reconciliation Act (OBRA) Discharge assessment is used any time a resident is physically discharged from the facility, regardless of whether the discharge was planned or unplanned discharge. When a resident’s Medicare Part A stay ends but the resident remains in the facility, the Part A PPS Discharge assessment would be completed. 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 Prospective Payment System (PPS) Discharge assessment are both required and may be combined. For more instructions, 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.

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3	Often a resident will have their level of care at home change, and the SNF plans a discharge in the future, but a family member steps in and offers to take place of that "need" for care in a SNF. They then demand that the resident discharge. Because the family member is now discharging safely, this is not against medical advice, but we typically cannot get our information needed for the discharge assessment because they leave within hours and the MD has agreed to it. Is this coded as "Unplanned" even though it is not considered as AMA?	The facility should use its judgment based on the situation as to how to "categorize" the type of discharge based on individual circumstances. If it is determined that the discharge is an unplanned discharge, then the facility should comply with the instructions provided in the RAI Manual for unplanned discharges and the end of the Part A stay. The facility would be wise to document the reasons for the unplanned discharge in the medical record.
4	Regarding the Part A PPS Discharge assessment slides, can the last bullet of page 7 be clarified, "If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required"?	Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends but the resident remains in the facility. The Part A PPS Discharge assessment can also be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs on the day of or 1 day after the End Date of Most Recent Medicare Stay (A2400C) because, in this instance, both the OBRA and Part A PPS Discharge assessments would be required. 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.
5	How about a 5-day and planned discharge?	We interpret your question to be, "Can a PPS 5-Day be combined with a 'planned' discharge?" The answer to this is yes. Please refer to Chapter 2 of the RAI Manual for allowed assessment combinations, https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

#	Question	Answer
6	If the resident did not start on Medicare Part A the day of admission, does the 3-day assessment period start on the start day of admission even if the start day was a week later? What if you did not know the resident was Part A admission and did not find out until after the 3-day lookback period?	1. The 3-day assessment period for the admission assessment includes 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. 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. 2. Chapter 2 of the RAI User's Manual outlines timeframes for setting the Assessment Reference Data (ARD) completion and submission of all assessment types. Please read carefully through Chapter 6 for guidance on early, late, and missing PPS assessments.
Data Submission Timeline		
7	How can the three claims-based QRP measure timeframes overlap? The collection period is CY 2017 with a payment determination of FY 2018. The payment would begin October 1, 2017, but data will still be collected through December 31, 2017.	In the FY 2017 SNF PPS final rule, three claims-based quality measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP, including Discharge to Community – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), and Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure. These measures will be calculated using Medicare fee-for-service claims and, thus, will require no additional data collection on the part of providers. For more information about the specifications for these three measures, please refer to the two linked documents: Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule and Measure Specifications: Medicare Spending Per Beneficiary.
8	The FY 2018 2-percent payment update that is based on data collected October 1 through December 31, 2016 is clear. The question is, for subsequent years payment update, will new data be collected each year to determine subsequent payment determinations, or is this one-time data collection period October–December 2016 going to determine all future years payment update?	The FY 2018 payment determination 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. For the FY 2019 payment determination and the subsequent years, SNF QRP will assume a full calendar year reporting schedule. The 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 (that is, data from January 1, 2017, up to and including 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.

#	Question	Answer
MDS 3.0 – Section A		
9	Would the date on 2400C be last covered day on Medicare A, date of SNF Advance Beneficiary Notice (SNFABN)?	The end of Medicare date (A2400C) is coded as follows, whichever occurs first: • Date SNF benefit exhausts (100th day of the benefit); or • Date of last day covered as recorded on the effective date from the Notice of Medicare Non-Coverage (NOMNC); or • The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or • Date the resident was discharged from the facility (see Item A2000, Discharge Date). For more coding instruction, 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. For information regarding the SNF Beneficiary Liability Notifications, please refer to Chapter 30, Financial Liability Protections, Section 70 of the Medicare Claims Processing Manual linked here: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html.
10	Would we code this (A0310H) yes if a resident exhaust their days and stays in facility?	The Part A PPS Discharge assessment must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility). The end of Medicare date (A2400C) is coded as follows, whichever occurs first: • Date SNF benefit exhausts (100th day of the benefit); or • Date of last day covered as recorded on the effective date from the NOMNC; or • The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or • Date the resident was discharged from the facility (see Item A2000, Discharge Date). Therefore, if the resident has exhausted his/her SNF benefit and will be remaining in the facility, a Part A PPS Discharge would be required, and A0310H would be coded 1 when filling out Section A. For instruction 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.

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11	Why would we issue an ABN if the resident is not staying in the SNF?	For information related to ABNs, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf, as well as Chapter 30, Financial Liability Protections, Section 70 of the Medicare Claims Processing Manual linked here: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html.
12	According to the current draft of submission specs, the unplanned/planned discharge coding and A0310h coding are not force coded. Are we hearing the submission specs final will be changing this?	There have been an errata posted to the MDS 3.0 Technical Information Web page that speaks to this logical specification for data submission. There is a new edit –3877 being added to the data specifications that reads as follows: If (A0310F = 10 or 11) AND ((A2400C = A2000) OR (A2000 – A2400C = 1)), then A0310H must be equal to 1. The errata are available here in the Downloads section: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html. Examples will be updated in the RAI manual to reflect that A0310H = 1 in the described case.

#	Question	Answer
Quality Measure – Function & MDS 3.0 – Section GG		
13	My software vendor has programmed Section GG to appear on the MDS based off an ARD of October 1, 2016, or later. This appears to be incorrect, as I believe Section GG is only required for Medicare stays that begin October 1, 2016, or later (A2400B). Can you confirm which logic is correct so that I can ask my software vendor to correct the application? Thank you.	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 PPS 5-Day 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 there may be special cases where a resident was admitted in September and had the ARD on or after October 1, 2016, for their PPS 5-Day assessment and/or discharge assessment: (1) a resident admitted in September with the start date of their Medicare Part A stay (A2400B) occurring before October 1, 2016, and ARD for their PPS 5-Day assessment on or after October 1, 2016, (2) a resident admitted in September and discharged on or after October 1, 2016, with the start date of their Medicare Part A stay (A2400B) occurring before October 1, 2016, but the ARD for their discharge assessment on or after October 1, 2016. For these special cases, the V1.14.1 item set, which includes the Section GG items, will be required. In these circumstances, the SNFs can receive credit in the calculation of their Annual Payment Update threshold compliance determination when dashing Section GG in its entirety on the assessment(s).

#	Question	Answer
13	Why are the "usual" performance self-care and mobility items extracted from physical therapy (PT) and occupational therapy (OT) events versus collected through interdisciplinary discussions? Typically patients perform better for rehab.	Clinicians should code the resident's admission functional status based on a functional assessment that occurs soon after the resident's admission. Currently, the Minimum Data Set (MDS) assessment should be completed using an interdisciplinary process and should already be including the input of therapists throughout the resident's stay. The resultant admission function scores from that assessment are to reflect the resident's admission baseline status. Therefore, as we suggest in the RAI Manual, if possible this assessment should occur prior to the person benefitting from treatment interventions. This is because therapy interventions can affect the resident's functional status, and what we want to see on admission is the score that most reflects the resident's status prior to any benefit from therapy.
15	How does CMS define safety?	We interpret this question to be related to Section GG. The term safety refers to the risk for the resident in performing an activity. This would be determined by the clinician when determining whether a resident is at risk for injury or harm in completing an activity with or without a helper. The clinician may determine that an activity should not be completed if there is a high risk for injury or harm to the resident with or without assistance in completing an activity. In scenarios such as these, the clinician should use code 88, Not attempted due to medical condition or safety concerns.
16	This is a follow-up regarding my question on planned discharges to the hospital and expecting them to come back to continue Part A stay for rehab: will this affect quality measures (QMs)? How would you set the goals for the initial Part A stay?	The readmission to Medicare Part A covered stay following a discharge will start a new Medicare Part A SNF stay. All requirements regarding completing the items required for the SNF QRP measures apply for that new stay, including the 3-day assessment period for the Section GG items assessing the resident's performance and establishment of discharge goals. At admission, when coding for the resident's discharge goal(s), use the six-level rating scale to indicate the resident's expected status at the end of that SNF stay. Instructions about coding discharge goals are provided in the MDS 3.0 RAI Manual V1.14 under Discharge Goal(s): Coding Tips. For Section GG 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	Answer
17	Slide 13 states "documented in the resident's medical record during the 3-day assessment period." Does this mean that only information noted in the medical record can be utilized for coding? For example, the assessor interviews the resident, staff, etc., on Day 3 but does not enter a note in the medical record until the next day; that information cannot be used for coding?	The assessment of residents' self-care and mobility status can be based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 3-day assessment period. Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. 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.
18	If a resident received oral gratification in addition to tube feeding, is the oral gratification provided counted for eating activity?	If a resident is able to eat and drink, SNFs should assess the patient for item GG0130A. Eating. The score should be coded according to the amount of assistance/supervision that is provided by a helper for the oral gratification. 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.
19	If a resident was coded with 09 for any of the self-care or mobility items for admission performance, and the resident is not anticipated to improve, can the discharge goal be dashed?	Yes, the use of a dash is acceptable when the clinician does not anticipate a discharge goal for the resident. 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 PPS 5-Day assessment. A 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.
20	With regard to eating and needing set-up/clean-up assistance, would removing trays count? Since set-up counts and there is no contact with the resident, would it be the same for removing/cleaning up trays?	GG013A. Eating refers to the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented of the table/tray. The item definition states the activity begins after the meal is presented on the table/tray. Set-up and clean-up would not include the presentation or removal of the tray. Examples of set-up/clean-up are available in the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.

#	Question	Answer
21	I believe the speaker said that if one helper is assisting with gait/mobility safety and one helper is following with a wheelchair, that would be an automatic score of 1? Thank you for clarifying.	Yes, we wish to emphasize that coding of 01, Dependent should be used when the resident activity requires the assistance of two helpers. The rationale for use of code 01, Dependent when two helpers are used, is because without two helpers the activity could not be completed or would be unsafe for the resident to perform the activity without two helpers. The rating scale measures a person's functional abilities based on the need for assistance. For example, if a resident requires the assistance of two helpers to ambulate short distances at the time of discharge, there would be a significant burden for the family to ensure that they have two people to help the person each time he/she walks to the bathroom, kitchen, or bedroom. For additional item examples of coding when assistance of two helpers is required for a resident to complete an activity, 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.
22	If a mechanical lift for transfers is used with one staff member, would this be coded as a 02 since a healer is required for more than half of the task?	Protocol for use of a mechanical lift is for two helpers to be present. The need for two helpers would result in coding 01, Dependent, for use of a mechanical lift for coding an activity.
23	What if the resident is unable to lie on their back at all? Would you code this 88 or 09?	Items GG0170A. Roll left and right, GG0170B. Sit to lying, GG0170C. Lying to sitting on the side of bed require lying on back during these activities. If the resident cannot complete these activities due to a medical condition or safety issues then these activities should be coded 88, Not attempted due to medical condition or safety concern. For additional item examples of coding, 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.
24	A resident is discharged from Medicare Part A with days remaining and stays in the facility, then is picked back up within the 30 days without a hospital stay, and a new 5 days is initiated. Is Section GG still required?	Yes, it is correct that a new PPS 5-Day assessment will start a new Medicare Part A SNF stay, so all requirements regarding completing the items for the SNF QRP measures apply for the new stay.

#	Question	Answer
25	1. If a therapist is assessing someone's eating ability and the patient has a new G-tube and is depending upon the nursing staff to feed him through the tube, why would the correct response not be 01? The example gave a response of 88 as correct. 2. If a nurse is assessing ambulation and the patient can walk 75 feet but not 150 feet because the patient fatigues and says that's all they can do, why would the correct response not be 01; the patient is dependent with ambulating 150 feet?	1. If the resident is not able to eat by mouth, item GG0130A. Eating should be coded as 88, Not attempted due to medical condition or safety concerns. 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. 2. 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 medical condition would warrant not attempting the activity, please code 88. 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.
26	When you are referring to "care planning" the goal in GG, are you talking about the "therapy plan of care" or "nursing care plan"?	Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the PPS 5-Day 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 interdisciplinary care plan based on the assessment information gathered throughout the RAI manual process, with necessary monitoring and follow-up. 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.
27	Consider the following situation: After the first 3 days of the stay, the RAI staff gather data documented on the chart from the admitting nurse and interview the resident. They also review the PT evaluation completed on Day 2. Nursing and resident assess the resident at a 3 – Partial assist level but Therapy assesses at a 2 – Maximal assistance level for sit-to-stand item GG0170D. How would you instruct the RAI staff in coding this item based on the information given?	It is up to the facility to reconcile any discrepancies in assessments by clinical staff and determine who the most appropriate staff are to participate in the resident assessment process, how the assessment process is completed, and how the assessment information is documented and coded, while remaining in compliance with the requirements of State and Federal regulations and the instructions contained within the RAI Manual. For Section GG, the staff would determine what the resident's usual status is for each activity and code the appropriate level based on their clinical judgment and in collaboration with appropriate staff. The admission code should reflect the resident's admission baseline status.

#	Question	Answer
28	If a patient is not going to realistically ever ambulate 150 feet, let alone 50 feet, do we need to set a discharge goal for these items? If we use code 88 for the admission and discharge performance (e.g., they were unable to complete as it would significantly impair the safety of the patient), can we set the goal as a "–"?	Discharge 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's motivation to improve. If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be entered using the six-point scale if the resident is expected to be able to perform the activity by discharge. 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 PPS 5-Day assessment. A 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: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
29	1. Is mouthwash considered a suitable item to clean teeth? 2. For toileting hygiene, I am confused about the having a bowel movement in bed scenario given, based on the definition which is "using the toilet, commode, bedpan, or urinal." Please provide specific clarification. Many residents are incontinent and are changed in bed. Is this included?	1. Item GG0130B. Oral hygiene assesses the ability to use suitable items to clean teeth (Dentures [if applicable]: the ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them). Resident-centered care and facility policy and procedures can inform the suitability of oral hygiene products that are medically necessary or reflect the resident's preference. 2. Toileting hygiene includes the tasks of managing clothing and perineal cleansing when voiding or having a bowel movement. If the resident is totally dependent on a helper(s) to complete the activity then code 01, Dependent. Toileting hygiene (managing clothing and perineal cleansing) can take place in bed as well as before and after use of the toilet, commode, bedpan, or urinal. For additional item examples of coding, 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.
30	Who determines the discharge goal, patient or clinician?	Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the PPS 5-Day assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. 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	Answer
31	1. If a resident has an indwelling urinary catheter and resident toileting activities were only for bowel movement, could we still code toileting hygiene for the episodes of bowel movement? 2. What if the res. had a rectal tube in place along with the indwelling catheter? Would that be a code of 88?	1. If the resident has an indwelling urinary catheter and has bowel movements, coding of GG0130C. Toilet hygiene should reflect the resident's function associated with instances of moving his or her bowels. 2. 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 concern.
32	Please clarify the 3-day assessment period for Section GG when the OBRA Discharge assessment and Part A PPS Discharge assessment are combined.	The assessment period for Section GG Discharge times is the last 3 days of the SNF PPS stay ending on A2400C, which includes the day of Medicare Part A PPS discharge and the 2 days prior to the day of discharge. 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." For a combined OBRA/Part A PPS Discharge, if the date in A2400C (End Date of the Most Recent Medicare Stay) is the same date as the day of discharge that is, when (A2000=A2400C), the 3-day assessment period in Section GG on discharge, would be the day of discharge and 2 days prior. When the date in A2400C is 1 day prior to the day of discharge, the 3-day assessment period in Section GG on discharge, would be the date in A2400C and 2 days prior. This means that the day of physical discharge would not be counted in the 3-day assessment of these items.

#	Question	Answer
33	Can you please clarify that while the Section GG scenario provided today is applicable to the inpatient rehabilitation facility where everyone receives PT and OT, it would not be appropriate to solely rely on the PT and OT evaluations in the Skilled Nursing Facility? There are a lot of providers who presume that "this is a therapy section" and require their therapists to fill this section out. I don't believe that is the intent of CMS, but it will require reinforcement from CMS that therapy information is just a "part" of the assessment. Unfortunately, this scenario that providers are taking home and using to "train the trainer" reinforces their position that it should be "therapy." Thank you.	As has always held true for the completion of the MDS, CMS does not prescribe who can and should participate in completing clinical assessments. The facility is required to determine who the most appropriate staff are that should participate in the assessment process, how the assessment process is completed, and how the assessment information is documented and coded, while remaining in compliance with the requirements of facility, State, and Federal regulations and the instructions contained within the RAI Manual, which can be found here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
34	Will there be any quality measures or survey consequences if Section G is not coded in a similar fashion regarding support and performance (using each section's appropriate scales)?	Section GG and Section G items are different in rating scales, item definitions, and type of data collected. The two sections will not be compared in quality measure calculation or by the surveyor. For more coding instructions, 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.
35	What if they can roll independently to one side but not the other to sit up from lying?	If the resident has a medical order that prevents rolling to both sides, then GG0170A. Rolling left to right is coded 88, Not attempted due to medical condition.
36	Resident does not toilet wears briefs: this would be coded 09?	GG0130C. Toileting hygiene assesses the resident's ability to perform perineal hygiene and adjust clothes before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then SNFs should assess the resident's need for assistance to manage lower body clothing and perineal hygiene.

#	Question	Answer
37	A patient can only ambulate 5 feet and then has to stop due to pain. Would you answer Does the resident walk? as No or Yes? If you answer Yes, but then would have to code GG0170J and GG0170K as 88, does that matter?	If a resident walks 5 feet and is unable to walk further, item GG0170H1 should be coded as Yes, because the patient does walk. GG0170J and GG0170K should be coded 88 Not attempted due to medical condition or safety concerns. In coding Section GG items, 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 medical condition would warrant not attempting the activity, please code 88.
38	If walking 50 feet only occurred twice during the 3-day lookback and the first time the resident required partial/moderate assistance and the second time the resident required substantial/maximal assistance, how would this be coded on the MDS for usual performance on admission and/or discharge?	A resident's functional status should be based on an assessment and 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 over the 3-day assessment period, 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.
39	Regarding walking: making two turns, it was indicated that those two turns can be in the same direction. If these are made at the same time (essentially turning 180 degrees), does the client need to stop after the first 90-degree turn and then resume to perform the second 90-degree turn? Or can they be done consecutively in a fluid fashion?	Item GG0170J. Walk 50 feet with two turns assesses the resident's ability to walk at least 50 feet and make two turns, once standing. The clinician should use clinical judgment to assess the resident's ability to complete the two 90-degree turns. For additional item examples of coding, 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	Answer
40	If resident used motorized chair at home but one is not available at the facility, should the facility attempt assessment in manual chair or assess if clinically appropriate to even attempt wheelchair assessment	The intention of the wheelchair items is to assess the resident's use of a wheelchair for self-mobilization. The clinician should use clinical judgment to determine if the resident's use of a wheelchair is appropriate for self-mobilization due to the resident's condition or safety. If a resident uses a wheelchair only when transported between locations within the facility, then answer the wheelchair gateway question as 0. No. The wheelchair gateway questions GG0170Q1 and GG0170Q3 should be coded as 0. No. Answering the question with "0. No" will allow you to skip all remaining wheelchair questions. SNFs should code wheelchair mobility based on an assessment of the resident's ability to mobilize in the wheelchair. If during the rehabilitation stay the resident's care plan includes improving the resident's self-mobilization skills (for example use of a manual wheelchair) then SNFs should assess the resident's need for assistance when using a manual wheelchair and code GG0170RR1/RR3 and GG0170SS1/SS3, accordingly.
41	For purposes of Section GG, toileting hygiene, it was stressed "three steps, pants up, pants down, hygiene." I have many questions. What if the client does not wear pants? Or underwear? What about fasteners, belt, zipper, etc.? There are so many facets of clothing management: how are these incorporated or considered, or are they not?	For the purposes of coding Section GG, if the resident does not wear pants, the coding should be based on whatever clothing management is necessary prior to and after voiding or having a bowel movement. Fasteners are coded as part of clothing management in Section GG.
42	If a resident walks down the hall, makes a turn (90 degree to left and a second 90 degree to the left immediately after the first—total 180 degrees), then returns back to the original place, is this counted as two turns or one turn?	The turns included in the items GG0170J (walking 50 feet with 2 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 (for example, cane or wheelchair). In the example, the resident has actually made four turns. 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	Answer
43	On the case study, if the goal would be not to need a wheelchair at discharge, would we code 6 or 9 for the wheelchair goals?	Currently, the data specifications only allow numeric codes on the six-point scale (06, Independent through 01, Dependent) to be entered. "Activity was not attempted" codes (07, 09, or 88) cannot be used to code discharge goal(s), because these codes are not recognized valid codes for these items. 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 PPS 5-Day assessment. A 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.
44	If the resident Part A LCD was on Day 8, the 5-day ARD was on Day 8 of the PPS stay, and the resident remains in the facility in a certified bed, when the 5-Day and Part A PPS Discharge assessments are combined, would we see both the admission performance and discharge performance in Section GG?	When the facility "combines" any MDS assessments, the assessment with the more stringent requirements is the one that is completed. This will be determined by how items A0310A, B, C, D, E, F, G, and/or H are coded. Most facilities have MDS software that provides the correct assessment and the data elements to be completed based on the coding of these Section A items, and if Section GG Admission and Discharge items are supposed to be completed, they would display in the facility's computer system as "active" items to complete. If the facility is attempting to complete the assessment on paper, it would first have to determine which item set is required (referring to the Nursing Home Item Set Code (ISC) Reference Table in the RAI Manual, Chapter 2, p. 2-86, or if a Swing bed, a similar table on p. 2-87, https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf) and then follow the skip patterns and instructions on the item set and in the RAI Manual to complete the assessment. The Section GG Discharge items are always required to be completed at the end of the Part A stay (i.e., when the resident is discharged from Part A services), unless there is a physical discharge involved, and that discharge is unplanned, the Part A Stay was less than 3 days, or the resident is being discharged to an acute hospital.
45	Code 05 says "but not during the activity." How would you code no set-up BUT during the activity it is discovered the patient needs help opening a tube, denture container, etc.?	When assessing the amount of help a resident needs during the admission assessment, the clinician should use clinical judgment to determine if the type of help needed is set-up assistance; that is, if the help is required before or after the activity to provide the help needed to complete the activity. In this example, you would code GG0130B. Oral hygiene as 05. Set-up or clean-up assistance because the help needed can be completed prior to or following the activity. The resident's status was assessed and the clinician determined that if a helper provided set-up or clean up assistance before or following the activity, the resident can complete the activity of oral hygiene.

#	Question	Answer
46	Just to clarify when scoring Y or N, this asks if the client walks in any capacity (regardless of distance)? So hypothetically a patient could walk three steps in the parallel bars and this would be scored "Yes." Scoring is irrespective of device, assistance, distance, or quality of walking?	This item asks the assessor to determine if the resident walks with or without the use of an assistive device. Parallel bars are not an acceptable assistive device to use when assessing walking. While walking distance is not necessarily prescriptive, a walking assessment should only be attempted if the resident is safe walking and if their medical condition allows for an assessment of the activity. If the resident is unsafe walking or cannot do so due to his/her current medical condition, the item should be coded as 88, Not attempted due to medical condition or safety concerns would be coded.
47	If surgery is involved and the patient can't bear weight, a "scooter" is used for one leg. Is that an assistive device or a manual scooter? How would/could this change the coding?	Assuming that this is a scooter that has a pad for the affected leg with handlebars that allows the resident to propel with the unaffected leg, the use of a "knee scooter" would be considered a walking device since the resident is upright and using the unaffected leg to balance and propel. 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 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.
48	Did I hear you say this includes getting on and off a bed pan?	For item GG0170F. Toilet transfer, the transfer includes only transfers on and off a toilet or commode. It is item GG0130C. Toilet hygiene that takes into account managing clothing and perineal hygiene after voiding or having a bowel movement.
49	Section GG: This section is only on discharge residents from PPS; does this replace Section G on the discharge assessment?	Section GG is collected at the start of a Medicare Part A stay on the PPS 5-Day assessment and is also collected at the end of the Medicare Part A stay on the Part A PPS Discharge assessment. It is important to note that data collection for Section GG does not substitute for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for both Section GG and Section G. 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	Answer
50	If a Medicare stay is less than 3 days, would admission performance and discharge goals still be required in GG without the full 3-day assessment window (e.g., a resident is admitted on October 1 and discharged on October 2)?	For residents who have an incomplete stay, discharge data for Section GG are not required to be reported. Residents with incomplete stays are identified based on the following criteria: • Unplanned discharge indicated by A0310G (Type of Discharge) = 2 (Unplanned discharge). • Discharge to an acute hospital, psychiatric hospital, or long-term care hospital as indicated by A2100 (Discharge Status) = [03, 04, 09] • The resident's death as indicated by A2100 (Discharge Status) = 08 (Deceased) or A0310F (Entry/discharge reporting) = 12 (Death in facility) that has a discharge date (A2000) that is on the same day or the day after the End Date of Most Recent Medicare Stay (A2400C) • SNF PPS Part A stay is less than 3 days as indicated by A2400C (End date of most recent Medicare stay) minus A2400B (Start date of most recent Medicare stay) < 3 days. Discharge functional status data are not required to be reported for these residents. However, for the cross-setting 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, complete admission functional assessment data on the PPS 5-Day assessment and a minimum of one self-care or mobility goal must be coded per resident stay on the PPS 5-Day assessment.
51	If the goals on Admission MDS Section GG have to use Days 1–3 but you want to use Day 8 as the ARD for the Admission MDS to obtain a Rehab Resource Utilization Group (RUG) rate, are you able to still enter all information - usually MDS questions and GG with the ARD of Day 8?	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 period for Section GG is different from the actual completion date required for the entire PPS 5-Day assessment, which must be completed within 14 days after the ARD (A2300 + 14 days) or if combined with the OBRA Admission assessment, must be completed by the end of Day 14 of admission (admission date + 13 calendar days). 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	Answer
52	Just to clarify: The Part A PPS Discharge assessment does not ask if discharge was planned or unplanned, so slide 29 bullet 2 would be incorrect unless you are combining a OBRA Discharge assessment that is coded unplanned with a Part A Discharge assessment, correct? Section GG would be "grayed out"?	Per current requirements, the OBRA Discharge assessment is used any time a resident is physically discharged from the facility, regardless of whether the discharge was a planned or unplanned discharge. When a resident's Medicare Part A stay ends but the resident remains in the facility, the Part A PPS Discharge assessment would be completed. If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or 1 day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. The actual item set that will be completed in this instance will be the OBRA Discharge, since the resident is physically leaving the facility. In providing for this combination, a special specification was employed to force-code A0310H as 1, which allows Section GG to populate the OBRA Discharge where applicable. In the situation of an unplanned discharge (A0310G = 2), Section GG will be grayed out.
53	While I realize CMS is not dictating who completes the assessment or collects data, is it acceptable that items in Section GG are completed solely based on the findings obtained by the therapist(s) during the therapy evaluation(s)?	We anticipate that a multidisciplinary team of clinicians is involved in assessing the resident. Clinicians from more than one discipline may assess the resident's performance based on direct observation, the resident's self-report, and reports from the clinician, care staff, or family as documented in the medical record during the 3-day assessment period. Section GG is not expected to be completed by therapists only. CMS does not provide guidance on who can or cannot complete assessment items. Please refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Each facility delivers resident care according to its unique characteristics and standards (e.g., resident population). Thus, each facility self-determines its policies and procedures for completing the assessments in compliance with State and Federal requirements. That said, the goal for the assessment is to accurately reflect the resident's status; therefore, staff completing the MDS should have knowledge of the resident's status in these areas. For most items, the assessment should not be based upon a single assessment by the therapist, but rather in collaboration with other clinicians and "helpers" over the 3-day assessment period.
54	Is a Geri Chair or Broda Chair considered a wheelchair?	Neither geriatric recliners nor Broda chairs, which are primarily used for those with special seating and positioning needs, are considered wheelchairs. The type of chair that should be considered when coding the wheelchair items include a typical wheelchair, either self-propelled (manual) or motorized (scooter or electric wheelchair).

#	Question	Answer
55	How do you code these two items when a resident uses a mechanical lift (Sarah and Hoyer) since they can't sit on the side of the bed? Do we code it 88?	Any activity that includes sitting at the side of the bed would be coded as 88, Not completed due to medical condition or safety concerns if the resident cannot start or end the task with sitting at the side of the bed, even with assistance of one or two helpers. If the resident can sit at the side of the bed with one or more helpers and there are no medical or safety conditions that prevent the activity, then SNFs should code activities that begin or end sitting at the side of the bed as 01, Dependent.
56	Are we penalized for not achieving the discharge goal set on the 5-day MDS on the end-of-stay MDS? Can we dash-fill the other goals without counting in the 80-percent threshold if we are only setting a discharge goal in one area?	1. 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 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 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 2. 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 PPS 5-Day assessment. A SNF's Annual Payment Update will not be affected if at least one self-care or mobility goal is submitted. At this time, the minimum requirement for one goal is necessary to calculate the quality measure for function. A dash may be entered for any other self-care or mobility that is not reported. Providers are also free to include as many goals as they deem appropriate.
Quality Measure – Falls & MDS 3.0 – Section J		
57	Why is J1800 part of the falls measure since only J1900C affects the outcome? Does the "dash" penalty apply to J1800?	Item J1800 introduces the assessor to this section. The item is completed as part of a skip pattern in order to make the next item active. You cannot answer item J1900 without first answering J1800. If the resident has had a fall, the assessor will code J1800 as 1, Yes, and the assessor will then move to collect information for J1900 items. If the resident has not had any falls, the assessor would code J1800 as 0, No, and J1900 items would be skipped. Since item J1800 is an item required to be completed to calculate the falls measure, if a dash is entered, it could be used as part of the APU determination.

#	Question	Answer
Quality Measure – Pressure Ulcer & MDS 3.0 – Section M		
58	If a resident developed a Stage 2 pressure ulcer while in the SNF, goes to the hospital, and returns with unstageable pressure ulcer due to eschar, is this pressure ulcer considered as "present on admission"?	When a resident has a pressure ulcer that developed in the facility, is hospitalized, and returns with the pressure ulcer at the same numerical stage, the pressure ulcer would not be coded as present on admission, because it was present and developed in the facility prior to the hospitalization. In the scenario provided, the Stage 2 ulcer developed in the facility, but when the resident returned, the ulcer was not the same numerical stage as it was; in fact, it is now unstageable. Therefore, the pressure ulcer would be coded as present on admission, as it was not present at the same numerical stage it was prior to the hospitalization. For more coding instructions, please refer to Chapter 3 Section M of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.
59	When will CMS adopt/adapt the April 14, 2016, National Pressure Ulcer Advisory Panel (NPUAP)-revised terminology and staging definitions?	CMS understands clinicians may vary in the use of terminology in reference to pressure ulcers and that the term "pressure injury" is synonymous with the terms pressure ulcer, decubitus ulcer, bed sore, and pressure sore. The 2016 NPUAP guidelines for replacing the term "pressure ulcer" with "pressure injury" and staging definitions are under review by CMS clinical and subject matter experts. Any decisions related to the review of these guidelines will be shared at a later date.
60	For Section M, where should the mucosal pressure ulcers that occur on the penis, vagina, or nasal area be coded since they cannot be staged they are still considered a pressure ulcer.	The MDS does not collect data on mucosal pressure ulcers other than those that appear in the oral cavity, which would be coded in L0200C. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made (p. M-5 of RAI Manual V1.14 https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf).
61	Slide 3 indicates the numerator for the pressure ulcer QM that the numerator is derived from M0300 B1, C1, or D1 in today's presentation. In the previous presentation and in the QM manual, the numerator is defined or derived from M0800 A, B, and C. M0300 plays a role in determining the "usability" or "validity" of M0800 but is not part of the numerator, correct?	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. Please note: Regarding Section M items M0300 and M0800 for the SNF QRP Pressure Ulcer measure, nothing has changed in how the assessor is to complete these items. The difference is simply in how the measures are calculated for the different quality programs. For the Nursing Home Quality Initiative (NHQI), the Short-Stay version of the Pressure Ulcer measure is calculated using M0800. For the SNF QRP, the Pressure Ulcer measure is calculated using M0300.

#	Question	Answer
62	When people have horrendous lower extremity edema and have fluid-filled blisters or cracks in skin form and leak, what do you call this skin condition on MDS?	Determining the etiology of any skin alteration is key to determining whether or not there are data elements on the MDS in Section M where they may be captured. For instance, if there are ulcers due to peripheral venous disease or peripheral arterial disease, they can be coded in item M1030. If the etiology is not that of pressure or arterial or venous disease, there are several other skin conditions that should be coded. We encourage the provider to read Section M of the MDS 3.0 RAI Manual V1.14 https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf () very carefully to determine whether or not the particular skin condition is captured on the MDS.
Other SNF QRP and MDS Related Topics		
63	Where can I find the RAI Manual?	The MDS 3.0 RAI Manual v1.14 and any future manual updates can be found on the CMS Web site linked here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html.
64	"The CNA provides": Can the Certified Nursing Assistant assess for documentation purposes? What can licensed professionals do versus certified in regards to resident documentation?	Please refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.
65	Now we have to look beyond the ARD, but if someone is hospitalized and does not return to us, we are not given that medical information. Are we to contact the hospital for this? I fear this is a HIPAA conflict, as it is not necessary for their care.	Asking for and obtaining this information does not violate any HIPAA laws, as this personal health information is covered under the business associate rules of HIPAA and is required for the proper management and administration of the health care operations required by the facility by law. Business associate functions include claims processing or administration, utilization review, quality assurance, data analysis processing or administration, billing, benefit management, practice management, and repricing. Business associate services may be legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation oriented or financial. If the hospital is refusing to share this information with the facility, we suggest contacting your local State agency for assistance.
66	During this presentation, the presenter said that three claim-based measures had been proposed. What are these measures?	In the FY 2017 SNF PPS final rule, three additional measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP, including Discharge to Community – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), and Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure. For more information about the specifications for these three measures, please refer to the two linked documents: Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule and Measure Specifications: Medicare Spending Per Beneficiary.

#	Question	Answer
67	Where would one find the process and/or forms for requesting exception/extension?	The CMS Web site for information on Exceptions and Extensions is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-QR-Reconsideration-and-ExceptionExtension.html.
68	I find it confusing to use the phrase "end of stay" synonymously with "discharge assessment." Is this common?	The phrase, "end of stay" is not being used synonymously with "discharge assessment." A Part A PPS Discharge assessment is required when the resident's Medicare Part A stay ends but the resident remains in the facility.
69	Currently there is nothing on the MDS addressing cognitive function; when will we see the addition of this?	Section C of the MDS 3.0 is used to assess residents' cognitive status. For more information, please refer to Chapter 3 Section C of the MDS 3.0 RAI Manual V1.14 linked here: https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf.