SKILLED NURSING FACILITY (SNF) QUALITY REPORTING PROGRAM PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON JULY 31 AND AUGUST 1, 2018

Current as of September 2018

Acronym List

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
DRR	Drug Regimen Review
EHR	Electronic Health Record
FY	Fiscal Year
MDS	Minimum Data Set
NPE	Nursing Home End of Medicare Stay
NQF	National Quality Forum
PAC	Post-Acute Care
PPS	Prospective Payment System
QRP	Quality Reporting Program
RAI	Resident Assessment Instrument
SNF	Skilled Nursing Facility

#	Question Category	Question	Answer
1	General	What documentation will be required to support the codes reported on the MDS reflecting the resident's usual self-care and mobility abilities?	Data entered in Section GG should be consistent with the clinical assessment documentation in the resident's medical record. Documentation such as therapy and nursing notes can be used to support assessment coding of self-care and mobility data elements.
2	General	What is the tentative release date for the RAI Manual that will be effective October 1, 2018?	The MDS 3.0 RAI Manual v1.16 effective October 1, 2018 has been posted in the Related Links section on the Nursing Home Quality Initiative web page and is available at: https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf.
3	General	When will the Fiscal Year (FY) 2019 SNF PPS Final Rule be released?	The FY 2019 SNF PPS Final Rule was posted for public inspection on July 31, 2018, and was posted in the Federal Register on August 8, 2018, at https://www.gpo.gov/fdsys/pkg/FR-2018-08-08/pdf/2018-16570.pdf.
4	General	Will questions and answers from the SNF QRP Training be posted after the conference?	Post-training materials (for the SNF Provider Training from July 31 to August 1, 2018) will be made available in the downloads section of the CMS SNF QRP Training web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html. Please monitor the SNF QRP Spotlights and Announcements web page for ongoing up-to-date announcements and information regarding the SNF QRP: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Spotlights-and-Announcements.html.
5	General	Where does the data come from for expected spending for the SNF QRP quality measure Medicare Spending Per Beneficiary – Post-Acute Care SNF?	Expected spending is calculated from a risk adjustment model predicting expenditures based on demographics and health status identified using Medicare claims and administrative data. For detailed information, please refer to the Measure Specifications: MSPB-PAC Resource Use Measures Skilled Nursing Facility, Inpatient Rehabilitation Facility, and Long-Term Care Hospital Resource Use Measures: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/2016_07_20_mspb_pac_ltch_irf_snf_measure_specs.pdf. Section 3.2.2 outlines the risk adjustment approach for predicting expected episode spending.

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6	General	Will the outcomes in the SNF QRP measures eventually affect the Annual Payment Update, not just the process or compliance with completion?	The SNF QRP is not an outcome-based, performance-based program. The SNF QRP is a quality reporting program that requires the submission of data, including data used in quality measures that are to be publicly reported. Failure to submit such data could result in a reduction of a provider's Annual Payment Update of 2 percentage points.
7	Section GG	Do we need to complete all of the goals, or can we report one goal?	At least one goal must be coded to meet the requirements of the function process measure, 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), which was adopted into the SNF QRP. Any one of the self-care or mobility goals may be coded to meet this requirement. SNFs may code more than one goal in Section GG to reflect multiple self-care and mobility goals.
8	Section GG	Who should be involved in coding the Section GG self-care and mobility data elements? Therapist?	Procedures for data collection are to follow facility policies, and resident assessments are to be done in compliance with facility, State, and Federal requirements. In addition, 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 Section GG. The RAI manual includes the following guidance: Assess the resident's self-care performance based on direct observation, as well as the resident's self-report and reports from clinicians, care staff, or family documented in the resident's medical record during the 3-day assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the resident during the 3-day assessment period.
9	Section GG	Section GG self-care and mobility activities need to be assessed the first 3 days. Does it mean we have to conduct the assessment for 3 days? Or can we complete it on day 1? Before therapy intervention?	The admission assessment should reflect the resident's baseline status at the time of admission prior to any benefit from therapy interventions. For some activities (e.g., eating, oral hygiene, toileting hygiene), the resident's abilities may be assessed on day 1 or day 2, because these activities occur more than once a day. Certain mobility activities, such as GG0170K, Walk 150 feet, or GG0170O, 12 steps, may only occur once during the 3-day assessment period. If this is the case, code the items based on the single occurrence of an activity. If the resident's admission functional status for an activity is assessed more than once during the admission assessment period, and the resident's 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.

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10	Section GG	What is the look back period for prior functioning (GG0100) and prior device use (GG0110)?	GG0100 Prior functioning is the resident's level of functioning immediately prior to the illness, exacerbation, or injury that led to the most recent acute care stay.
11	Section GG	Can we download a copy of the decision tree for GG that is in a single page?	Yes, a copy of the decision tree in a single page is in development and will be available soon.
12	Section GG	If admission performance for GG0170I1. Walk 10 feet is coded 07, 09, 10, or 88, we can skip to GG0170M1, 1 step (curb). Similarly, if admission performance for GG0170M1, 1 step (curb) is coded 07, 09, 10, or 88, we can skip to GG0170P1, Picking up object. How does this affect Discharge Goals for these items?	If the resident does not walk 10 feet at the time of admission, as indicated by a code of 07, 09, 10 or 88 for admission performance (GG0170I1 = 07, 09, 10, 88), there is a skip pattern to GG0170M1, I step (curb). The skip pattern applies to the admission performance items (GG0170x1), not the goals (GG01170x2). A resident who does not walk at the time of admission may have a goal to walk by discharge. If the resident does not go up and down one step at the time of admission, as indicated by a code of 07, 09, 10 or 88 for admission performance (GG0170I1 = 07, 09, 10, 88), there is a skip pattern to GG0170P1, Picking up object. The skip pattern applies to the admission performance items (GG0170x1), not the goals (GG01170x2). A patient who does not go up and down step(s) at the time of admission may have a goal to go up and down step(s) by discharge.
13	Section I	Can you provide more information about the primary medical category item (I0020)?	This item identifies the primary medical condition category that resulted in the resident's admission to the facility and that influences the resident's functional outcomes. To code this item, review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
14	Section I	I am surprised that sepsis is not listed as primary diagnosis as it is ranks high across the country as reason for admission and readmission.	If the resident is admitted to your SNF for care related to recovering from sepsis, code 13, Medically Complex Conditions.

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15	Section I	Suggest items at I0020 have check boxes beside each item versus having to enter numbers. This will better align with other Section I items. Suggest having the ability to choose more than one item in I0020. Many SNF residents admit with more than one condition that are at the same level of complexity.	Thank you for this suggestion. The purpose of the primary medical condition category (item I0020) is to identify a single condition category that describes the reason the resident was admitted to the facility. Therefore, only one category code is selected for this item.
16	Section I	Where would acute myocardial infarction be coded in I0020?	If a patient is admitted for SNF care following an acute myocardial infarction, code item I0020 as 12, Debility, cardiorespiratory conditions.
17	Section M	How will removing M0800 items effect the SNF QRP measure, (NQF #0678) Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (short-stay)?	The current SNF QRP measure, (NQF #0678) Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (short-stay), is calculated using M0300 items. The specifications for this measure can be found in the linked document: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QM-Users-Manual-V10-FINAL-5-22-17.pdf. Since the measure does not use M0800 items, removal of these items will not impact the SNF QRP measure. Please note the current pressure ulcer measure will be removed from the SNF QRP measure set and replaced with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, beginning with the FY 2020 SNF QRP. The specifications for the new measure can be found in the linked document: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Final-Specifications-for-SNF-QRP-Quality-Measures-and-Standardized-Resident-Assessment-Data-Elements-Effective-October-1-2018.pdf.

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18	Section M	How would you code present on admission in the following example: • A resident is admitted with a stage 3 pressure ulcer/injury that subsequently becomes covered with slough or eschar. • The slough or eschar is subsequently debrided prior to discharge and the pressure ulcer/injury is once again determined to be a stage 3. The pressure ulcer/injury remains a stage 3 at discharge.	When a stageable pressure ulcer/injury covers over with slough and/or eschar such that it becomes unstageable, but within the stay again becomes stageable, to determine whether the ulcer/injury was present on admission, the clinician would first need to determine whether the ulcer increased in numerical stage or remained the same stage it was first assessed on admission. Per the example, if the pressure ulcer was a stage 3 on admission, covered with slough and/or eschar during the stay, then was debrided and was staged at a stage 3 on discharge, this ulcer would be captured on the PPS Part A Discharge Nursing Home End of Medicare Stay (NPE) as stage 3, present on admission. However, if after debridement, the ulcer is staged as a stage 4, it would be coded on the NPE as such and considered not present on admission because it increased in numerical stage over the course of the PPS stay. Remember that the new quality measure compares the coding on the 5-day PPS/Admission assessment with the Discharge/NPE at the end of the PPS stay. If the assessment was coded as above (i.e., as a stage 3 on admission and as stage 4 (not present on admission) on discharge), this ulcer would be included in the numerator of the quality measure.
19	Section M	How long after a wound heals should it still be referred to as a healed staged wound? For example, if a documented healed Stage 4 pressure ulcer reopens at the same anatomical site, would it still be considered a stage 4 pressure ulcer, regardless of the condition of the wound observed upon reopening?	The answer to this question is a matter of clinical practice and judgement. Please refer to best-practice guidelines for pressure ulcer management and discuss with nurse practitioner/physician at your facility.

#	Question Category	Question	Answer
20	Section N	Many residents in skilled nursing facilities (SNFs) are admitted late on a Friday night. When does the drug regimen review (DRR) on admission need to be completed? Can it be completed Monday morning and still be considered timely?	No. SNFs would follow best practices by conducting the DRR upon admission (start of SNF Prospective Payment System (PPS) stay) or as close to the actual time of admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. The DRR is intended to incorporate the identification of any potential or actual clinically significant medication issue(s), timely communication with a physician, and completion of physician prescribed or recommended actions in response to identified potential or actual clinically significant medication issues by the clinician in a timeframe that reduces the risk for medication errors and resident harm throughout the stay.
21	Section N	Are we required to obtain a list of the resident's medications taken prior to the proximal hospital stay to ensure that there were no omissions?	No, you are not required to obtain a list of medications from the transferring facility. The list of medications is only one source for completing the DRR. The clinician would make a determination on the sources of documentation used in conducting the DRR. Other data sources/resources may include, but are not limited to, the following: • Medical record (within the electronic health record (EHR)/electronic medical record and/or paper medical records as transferred from the acute care hospital). • Medication list (e.g., medication administration record, home medication list). • Clinical communication notes (including pharmacy, nursing, physician/physician-designee, and other applicable clinical notes). • Acute care hospital discharge summary and discharge instructions. • Discussions (including with the acute care hospital; other staff members and clinicians responsible for completing the DRR; resident; and resident family/significant other).
22	Section N	If a resident ends a Medicare Part A stay, remains in the SNF, and resumes Medicare Part A benefits for further covered care within 30 days of ending his/her prior Medicare stay (without a new hospitalization), is a new DRR required with the new PPS 5-day assessment?	Yes. A new DRR is conducted and items N2001 and N2003 are to be completed on each PPS 5-day assessment (A0310B = 01) for all residents in a Medicare Part A stay.

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23	Section N	Since the DRR data elements are coded upon discharge, how often should a medication review be conducted? Is documentation required that supports there is a clinically significant medication issue upon review?	The DRR item N2005, Medication Intervention, includes the entire resident stay, including the time of admission through time of discharge. While the items only measure DRRs conducted at admission (N2001 and N2003), the provider uses clinical judgement to determine when a resident's medication regimen is reviewed, including medication review throughout the resident's stay. The timing of formal (and informal) DRR activities would be completed based on resident need, complying with State and Federal regulations, as well as facility policies and procedures. N2005, Medication Intervention, which is completed at discharge, identifies if every clinically significant medication issue identified at the time of or at any time since the admission was communicated to the physician (or physician-designee), and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification. For example, a DRR may be conducted when a resident is transferred to another provider. 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 resident documentation practices and completing the assessments in compliance with State and Federal requirements. Data in the Minimum Data Set (MDS) should be consistent with information in the resident's medical record.
24	Section N	I thought in Appendix PP of the State Operations Manual that a DRR was to be conducted by a pharmacist. Is this true?	Yes. The DRR as described in the State Operations Manual is conducted by a pharmacist at least monthly and applies to all SNF and nursing home residents. The SNF Quality Reporting Program (QRP) quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC SNF QRP, is intended to identify issues with safety on admission and throughout the resident's stay, requires two-way communication with the physician, and applies only to SNF residents in a Medicare Part A stay.

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25	Section N	Can a pharmacist conduct the DRR remotely via the resident's EHR?	Yes. Facilities should refer to best clinical practices, facility, State, and Federal policies and procedures to determine which SNF staff members may complete the DRR items at your facility. 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 resident documentation practices and completing the assessments in compliance with State and Federal requirements. Data in the MDS should be consistent with information in the resident's medical record.
26	Section N	Does the DRR also include the review of ointments and other wound treatments a resident is receiving?	Yes. The DRR includes all medications—prescribed and over-the-counter, including nutritional supplements, vitamins, and homeopathic and herbal products—administered by any route. The DRR also includes total parenteral nutrition and oxygen.
27	Section N	Are the DRR data elements on all MDS assessments?	The DRR items N2001 and N2003 are coded when A0310B =01 (PPS 5-day assessment). Item N2005 will be coded when A0310H = 1 (Part A PPS Discharge).

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28	Section N	Would use of a medication without indication for use be classified as a potential or actual clinically significant medication issue? An example would be the use of an antipsychotic medication without a diagnosis.	Yes, this might be an example, as would use of any medication without evidence of an adequate indication for use. The clinician would use his/her clinical judgement in determining if this is a clinically significant medication issue. A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. Clinically significant medication issues may include, but are not limited to, (1) medication prescribed despite documented medication allergy or prior adverse reaction; (2) excessive or inadequate dose; (3) adverse reactions to medication; (4) ineffective drug therapy; (5) drug interactions (serious drug–drug, drug–food and drug–disease interactions); (6) duplicate therapy (e.g., generic name and brand name equivalent drugs are co-prescribed); (7) wrong resident, drug, dose, route, and time errors; (8) medication dose, frequency, route, or duration not consistent with the resident's condition, manufacturer's instructions, or applicable standards of practice; (9) use of a medication without evidence of adequate indication for use; (10) presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed); (11) omissions (medications missing from a prescribed regimen); and (12) nonadherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the DRR items.
29	Section N	Who can complete the DRR? Are State-licensed registered nurses authorized to complete it, or must it be an advance practice nurse, physician assistant, physician, or pharmacist?	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 determining who may complete the DRR in compliance with State and Federal requirements. Providers should refer to State and Federal policies and guidelines to determine who may complete a DRR.
30	Section N	Is the DRR to be conducted with all new admissions or just those with a PPS stay?	For the SNF QRP, the DRR applies to residents in a Medicare Part A-covered stay.

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31	Section N	To meet the requirements of coding the data elements for the DRR, is the provider expected to add each medication order, such as a vitamin supplement, with the dose, route, and frequency on the resident's care?	Federal Regulations at §483.21 Comprehensive Person-Centered Care Planning outline the requirements for completing Baseline and Comprehensive Care plans. The associated guidance with these regulations describe the intent, development, implementation, and evaluation of resident care planning. Since each resident's care plan must be person-centered and individualized to each resident's needs, it is best for you to review the regulations and interpretive guidance regarding the regulations in §483.21, which is located in Appendix PP in the State Operations Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. If after reviewing the regulations and guidance you have additional questions, please submit your questions to nhsurveydevelopment@cms.hhs.gov.

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32	Section N	Does “nonadherence” (purposeful or accidental) referred to in Section N include a resident’s refusal to take the prescribed medication?	Possibly. The clinician should use clinical judgement to determine if the resident’s refusal to take the prescribed medication would be considered a potential or actual clinically significant medication issue that would require two-way communication with the physician. A clinically significant medication issue is a potential or actual issue that, in the clinician’s professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. Clinically significant medication issues may include, but are not limited to, (1) medication prescribed despite documented medication allergy or prior adverse reaction; (2) excessive or inadequate dose; (3) adverse reactions to medication; (4) ineffective drug therapy; (5) drug interactions (serious drug–drug, drug–food and drug–disease interactions); (6) duplicate therapy (e.g., generic name and brand name equivalent drugs are co-prescribed); (7) wrong resident, drug, dose, route, and time errors; (8) medication dose, frequency, route, or duration not consistent with the resident’s condition, manufacturer’s instructions, or applicable standards of practice; (9) use of a medication without evidence of adequate indication for use; (10) presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed); (11) omissions (medications missing from a prescribed regimen); and (12) nonadherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the DRR items.
33	Section N	What information should be documented to indicate that the DRR was completed? Who should document that the DRR was completed?	CMS does not impose specific documentation procedures on nursing homes in completing the Resident Assessment Instrument (RAI). CMS does not provide guidance on who can complete the DRR nor on documentation practice. 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 resident documentation practices and who may complete the assessments in compliance with State and Federal requirements. Data in the MDS should be consistent with information reported in the resident’s medical record.