SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

Z0100: Medicare Part A Billing

Z0100. Medicare Part A Billing	
	A. Medicare Part A HIPPS code: ☐☐☐☐☐☐☐
	B. Version code: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Used to capture the *Patient Driven Payment Model (PDPM) case mix version code* followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

DEFINITION

MEDICARE-COVERED STAY
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

Coding Instructions for Z0100A, Medicare Part A HIPPS Code

- Typically, the software data entry product will calculate this value.
- The HIPPS code is a Skilled Nursing Facility (SNF) Part A *five-position* billing code*; the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator*. For information on HIPPS, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
- If the value for Z0100A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the *PDPM case mix version* code and a table that defines the assessment type indicator).
- Note that the *version code* included in this HIPPS code takes into account all MDS items used in the *PDPM* logic and is the "normal" group since the classification considers the rehabilitation therapy received.
- This HIPPS code is usually used for Medicare SNF Part A billing by the provider.
- Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.

DEFINITION

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

Z0100: Medicare Part A Billing (cont.)

Coding Instructions for Z0100B, Version Code

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

Z0200: State Medicaid Billing (if required by the state)

Z0200. State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐ B. Version code: ☐☐☐☐☐☐☐☐☐☐
Enter Code ☐	C. Is this a Short Stay assessment? 0. No 1. Yes

Item Rationale

- Used to capture the payment code in states that employ the MDS for Medicaid case-mix reimbursement.

Coding Instructions for Z0200A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0200B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0200A.

Coding Instructions for Z0200C, Is this a Short Stay assessment?

- ***Code 0, no:*** *if this is not a Short Stay assessment.*
- ***Code 1, yes:*** *if this is a Medicare Short Stay assessment.*

Coding Tip

- *The standard RUG-IV grouper automatically determines whether or not this is a Short Stay assessment. MDS software typically makes this determination automatically.*

Z0250: Alternate State Medicaid Billing (if required by state)

Z0250. Alternate State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐ B. Version code: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Used to capture an alternate payment group in states that employ the MDS for Medicaid case-mix reimbursement. States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model or to allow blended payment between two models during a transition period.

Coding Instructions for Z0250A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0250B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0250A.

Z0300: Insurance Billing

Z0300. Insurance Billing	
	A. Billing code: ☐☐☐☐☐☐☐☐☐☐ B. Billing version: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs).

Coding Instructions for Z0300A, *B*illing Code

- If the other payer has selected a standard *payment* model, this item may be populated automatically by the software data entry product. Otherwise, enter the billing code in the space provided. This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs.

Z0300: Insurance Billing (cont.)

Coding Instructions for Z0300B, Billing Version

- If the other payer has selected a standard *payment* model, this item may be populated automatically by the software data entry product. Otherwise, enter an appropriate billing version in the spaces provided. This is the billing version appropriate to the billing code in Item Z0300A.

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting

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

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

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.

Z0400: Signatures of Persons Completing the Assessment (cont.)

- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
  - the development of an individualized care plan;
  - the Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - quality monitoring activities, such as the quality measure reports
  - the data-driven survey and certification process
  - the quality measures used for public reporting
  - research and policy development.

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Coding Tips and Special Populations

- Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a sub-set of items within a section should identify which item(s) he/she completed within that section.
- Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
- Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.

Z0400: Signatures of Persons Completing the Assessment (cont.)

- If an individual who completed a portion of the MDS is not available to sign it (e.g., in situations in which a staff member is no longer employed by the facility and left MDS sections completed but not signed for), there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date this verification occurred.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion	
A. Signature:	B. Date RN Assessment Coordinator signed assessment as complete: ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

Item Rationale

- Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.
2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Coding Instructions

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date *must* be *equal to the latest date at Z0400 or* later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.
- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Coding Tips

- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion (cont.)

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