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

PARTICIPANT QUESTIONS FROM
MAY AND AUGUST 2019 SNF QRP PROVIDER TRAININGS
ON MAY 9 AND 10, 2019,
AND AUGUST 15 AND 16, 2019

Current as of December 30, 2019

Acronym List

Acronym	Definition
ABN	Advance Beneficiary Notice of Noncoverage
AIDS	Acquired Immunodeficiency Syndrome
APU	Annual Payment Update
ARD	Assessment Reference Date
ASAP	Assessment Submission and Processing
BIMS	Brief Interview for Mental Status
CAH	Critical Access Hospital
CASPER	Certification And Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
FY	Fiscal Year
HICN	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICD-10-CM	ICD, Tenth Revision, Clinical Modification
IPA	Interim Payment Assessment
iQIES	Internet Quality Improvement and Evaluation System
jRAVEN	Resident Assessment Validation and Entry System
LOA	Leave of Absence
MA	Medicare Advantage
MBI	Medicare Beneficiary Identifier
MDS	Minimum Data Set
NHC	Nursing Home Compare
NHQI	Nursing Home Quality Initiative
NOMNC	Notice of Medicare Non-Coverage
NQF	National Quality Forum
NTA	Non-Therapy Ancillary
OBRA	Omnibus Budget Reconciliation Act

Acronym	Definition
OSA	Optional State Assessment
OT	Occupational Therapy
PAC	Post-Acute Care
PCS	Procedure Coding System
PDPM	Patient Driven Payment Model
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PPS	Prospective Payment System
PT	Physical Therapy
QIES	Quality Improvement Evaluation System
QIN-QIO	Quality Innovation Network/Quality Improvement Organization
QM	Quality Measure
QRP	Quality Reporting Program
QTSO	QIES Technical Support Office
RAI	Resident Assessment Instrument
RN	Registered Nurse
RUG	Resource Utilization Group
SCSA	Significant Change in Status Assessment
SLP	Speech Language Pathology
SNF	Skilled Nursing Facility
SPADE	Standardized Patient Assessment Data Element

#	Topic	Question	Response
1	Measure Overview of Current SNF QRP Measures	Are State averages for Quality Reporting Program (QRP) Quality Measures (QM) posted somewhere?	State averages are currently not readily available. One can estimate State averages using the provider-level table posted for the Skilled Nursing Facility (SNF) QRP on Nursing Home Compare (NHC) https://data.medicare.gov/data/nursing-home-compare.
2	Measure Overview of Current SNF QRP Measures	Where is the calculation for the expected discharge scores?	Expected Self-Care and Mobility scores are calculated for the QMs: • Discharge Self-Care Score for Skilled Nursing Facility Residents (National Quality Forum (NQF) #2635) (Centers for Medicare & Medicaid Services (CMS) ID: S024.01). • Discharge Mobility Score for Skilled Nursing Facility Residents (NQF #2636) (CMS ID: S025.01). • Change in Self-Care Score for Skilled Nursing Facility Residents (NQF #2633) (CMS ID: S022.01). • Change in Mobility Score for Skilled Nursing Facility Residents (NQF #2634) (CMS ID: S023.01). The expected scores are calculated by CMS or a CMS contractor using the intercept and coefficient values from a risk-adjustment model, which includes resident stay-level factors such as age, admission function scores, primary medical condition, and comorbidities. For the specifications used to calculate these measures, please refer to Tables 7-6 through 7-9 in the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf. For details on the steps taken to calculate the functional outcome measures, including applying the intercept and coefficients, please refer to Section 6.5: Measure Calculations Used in Discharge Function Measures and Appendix Table A-5 in the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.

#	Topic	Question	Response
3	Measure Overview of Current SNF QRP Measures	For the new QRP measures, is the 2-percent penalty still based coding 100 percent of the quality items on at least 80 percent of records, or will it be based on performance percentage?	SNFs are required to submit QM and standardized resident assessment data elements to CMS. For a given data submission period, the Minimum Data Set (MDS) assessments submitted by a SNF must meet the annual payment update (APU) minimum submission threshold of no less than 80 percent of MDS assessments having 100 percent completion of the required SNF QRP data elements. These are the data elements needed to calculate the SNF QRP QMs and are defined as standardized data elements. Successful assessment completion is submission of actual resident data, as opposed to non-informative response options (e.g., "dash" (–)). Please note that while the coding of a dash is an optional response value for the data elements listed in this table, its use does not count toward meeting the APU minimum submission threshold. Failure to meet the minimum threshold may result in a 2-percentage point reduction in the SNF's APU. We provide the following information available in the Post-Acute Care (PAC) SNF Quick Reference Guide Fiscal Year (FY) 2020 Version 1.0, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PAC-SNF-Quick-Reference-Guide-FY2020-v1-0.pdf, regarding how APU thresholds are calculated. For additional information on the data elements needed to calculate the SNF QRP QMs, defined as standardized data elements for the SNF QRP QMs, please refer to the SNF QRP Table for Reporting Assessment-Based Measures for the FY2020 SNF QRP APU, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Table-for-Reporting-Assessment-Based-Measures-for-the-FY-2020-SNF-QRP-APU.pdf.
4	Measure Overview of Current SNF QRP Measures	Please clarify, what are the assessments to be captured in the assessment-based QMs? Is it limited to Prospective Payment System (PPS) assessments?	For most assessment-based QMs, the assessments used in the calculation of the measure include the Nursing Home PPS 5-Day Item Set, the Nursing Home Part A PPS Discharge Item Set, or both. However, the SNF QRP QM "Application of Percent of Residents Experiencing Falls with Major Injury (Long Stay)" uses the PPS 5-Day, PPS Discharge, and all intervening PPS and Omnibus Budget Reconciliation Act of 1987 (OBRA) assessments, including the OBRA Discharge assessments. Please refer to the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf, for details about each QM.

#	Topic	Question	Response
5	Measure Overview of Current SNF QRP Measures	Will Mobility and Self-Care QRP data be reported on NHC? If so, what is the timeline?	The following functional outcome measures were adopted and finalized for use in the SNF QRP: • Change in Self-Care Score for Skilled Nursing Facility Residents (NQF #2633) (CMS ID: S022.01). • Change in Mobility Score for Skilled Nursing Facility Residents (NQF #2634) (CMS ID: S023.01). • Discharge Self-Care Score for Skilled Nursing Facility Residents (NQF #2635) (CMS ID: S024.01). • Discharge Mobility Score for Skilled Nursing Facility Residents (NQF #2636) (CMS ID: S025.01). Public reporting of these measures on NHC is anticipated for October 2020. For more details on measures adopted and finalized for the SNF QRP, please refer to the SNF Quality Reporting Program Measures and Technical Information page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html. To review the measure logical specifications for these measures, please refer to the latest version of the SNF QRP Measure Calculations and Reporting User's Manual, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf. The measure logical specifications can be found in Chapter 7.
6	Measure Overview of Current SNF QRP Measures	Will the calculation for SNF QRP QMs reported on NHC for Pressure Ulcer/Injury include Medicare Part A SNF Type 1 Stays only, just like the SNF QRP Measure?	As stated on page 52 of the SNF QRP Measure Calculations and Reporting User's Manual (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf), the SNF QRP Measure "Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (CMS ID: S038.01)" includes Type 1 Stays only. A Type 1 SNF Stay is a SNF stay with a PPS 5-Day Assessment (A0310B = [01]) and PPS Discharge Assessment (A0310H = [1]) and no Death in Facility Tracking Record (A0310F = [12]) within the SNF Stay. Data collection for this measure began on October 1, 2018, and is expected to be reported on NHC in the fall of 2020.

#	Topic	Question	Response
7	Measure Overview of Current SNF QRP Measures	Why is N2005 counting the issues identified upon admission again if that is already captured in N2001 and N2003? Why not have N2005 only count after admission through discharge?	According to page N-21 of the MDS Resident Assessment Instrument (RAI) Manual v1.17.1 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html), N2005 records medication intervention since the admission. For the SNF QRP QM "Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP," the intent of N2005 is to address all potential or actual clinically significant medication issues throughout the stay. This includes data collected upon admission (N2001 and N2003) and at any time thought the resident's stay (N2005).
8	Measure Overview of Current SNF QRP Measures	Are there any exclusions for drug regimen review? How are dashes calculated for this QRP?	Please refer to Table 7-4 Drug Regimen Review Conducted With Follow-Up for Identified Issues – PAC SNF QRP (CMS ID: S007.02) on page 51 of the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf). There are no denominator exclusions listed for the measure "Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP"; if a dash is entered for any of the three data elements (N2001, N2003 and N2005), the stay will not be included in the numerator count for the measure.
9	Measure Overview of Current SNF QRP Measures	How are the risk scores calculated for the 30-day re-admission?	For the potentially preventable 30-day post-discharge readmission measure for the SNF QRP, please refer to Sections 2.2.7 and 2.2.8 on pages 27 to 31 of the measure specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf) for a detailed discussion on the statistical risk model, the risk adjustment covariates, and the measure calculation algorithm. Chapter 2 of the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf) provides a link to the measure specification document mentioned above.

#	Topic	Question	Response
10	Measure Overview of Current SNF QRP Measures	Do swing beds report these QMs? We are not on NHC either, correct?	Swing beds in non-critical access hospitals (CAH) are subject to the SNF QRP requirements and are required to submit PPS assessments to CMS through Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP). For more information about requirements for swing bed providers in non-CAH, please refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html. For information and training materials related to the SNF QRP, please refer to the SNF QRP website, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Overview. Non-CAH swing bed unit performance on the SNF QRP measures is reported on NHC. To view non-CAH swing bed unit performance on the SNF QRP measures, providers can go to https://www.medicare.gov/nursinghomecompare/swingbeddata.html. Currently, the second bulleted link under Spotlight on NHC (https://www.medicare.gov/NursingHomeCompare/search.html), "View swing bed performance on Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) measures," opens a new window that will redirect providers to this page when selected. Instead of searching for a facility and viewing results on the facility's profile page (or comparing info for up to three facilities), swing bed data is embedded in one file for all facilities on the website.
11	Measure Overview of Current SNF QRP Measures	To clarify, it is not necessary to have both a Self-Care and a Mobility goal, or do we have to have just one?	For the SNF QRP, a minimum of one Self-Care or Mobility discharge goal must be coded. However, facilities may choose to complete more than one Self-Care or Mobility discharge goal. Code the resident's discharge goal(s) using the 6-point scale or one of the "activity not attempted" codes (07, 09, 10, and 88). Use of a dash is permissible for any remaining Self-Care or Mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.

#	Topic	Question	Response
12	Measure Overview of Current SNF QRP Measures	If your information is incomplete on NHC, what is the most likely reason?	There are four reasons why a facility's measure score for a SNF QRP measure may show "Not Available" when displayed on NHC: • The number of cases/resident stays is too small to report. If the number of SNF stays in the measure denominator was less than 20, the facility score for this measure will display as "Not Available" on NHC. In this case, the number "13" will also display as hover text, explaining that the number of cases/resident stays is too small to report. • Data not available for this reporting period. If data are not available for this reporting period, the facility score for this measure will display as "Not Available" on NHC. In this case, the number "14" will also display as hover text, explaining that data are not available for this reporting period. • Data suppressed by CMS for one or more quarters. If data were suppressed by CMS for one or more quarters, the facility score for this measure will display as "Not Available" on NHC. In this case, the number "16" will also display as hover text, explaining that data were suppressed by CMS for one or more quarters. • Data not submitted for this reporting period. If data were not submitted for this reporting period, the facility score for this measure will display as "Not Available" on NHC. In this case, the number "17" will also display as hover text, explaining that data were not submitted for this reporting period. Please note, State averages for the SNF QRP measures are not currently displayed on NHC. In place of the State average, "Not Available" is displayed. There is no additional hover text for this result. Please refer to Table 8 of the Data Dictionary for SNF QRP Measures on NHC for footnote description details. The data dictionary can be downloaded together with the NHC database https://data.medicare.gov/data/nursing-home-compare.

#	Topic	Question	Response
13	Measure Overview of Current SNF QRP Measures	For the SNF QRP claims-based measures, is there no review and correct period for the preventable 30-day readmissions?	There is no review and correct period for claims-based measures. However, data on these claims-based measures can be reviewed in the Facility-level QM report as well as the Provider Preview report. SNFs will have 30 days to preview their QM results beginning on the date the Provider Preview reports are available. A SNF may request a CMS review of the data contained within their Provider Preview report, should they believe it to be inaccurate (denominator or quality metric). For more information, please see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Public-Reporting.html.
14	Measure Overview of Current SNF QRP Measures	If there is a standalone quarterly or annual assessment done on a Part A stay, are these also included in the QRP calculation?	Please refer to the SNF QRP Measure Calculations and Reporting User's Manual at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf for measure specifications for each measure. The numerator and denominator fields specify the types of assessments used in the calculation for each assessment based QRP measure. Further definitions of types of assessments (e.g., look-back scan assessment) can be found in Chapter 1 of the same document.
15	Measure Overview of Current SNF QRP Measures	Is a discharge against medical advice considered as an incomplete stay?	Yes, if a SNF Part A stay ends with the resident leaving against medical advice, this is considered an incomplete stay.

#	Topic	Question	Response
16	Measure Overview of Current SNF QRP Measures	Can you provide some clarification around N002.03? 1) Does the target assessment selection and stay criteria follow the QRP or QM rules? 2) There are two sets of covariates in the risk adjustment appendix for pressure ulcers as well as for the national average. What determines when to use Update ID 1 or Update ID 2?	In order to reduce provider burden and duplication of measures as well as to align measures across the Nursing Home Quality Initiative (NHQI) and the SNF QRP, the NHQI version of the QM "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)" is being replaced with the SNF QRP version of measure CMS ID: S002.01 and therefore will follow the assessment selection and stay criteria for the QRP version of the measure. The SNF QRP specifications for the QM "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)" can be found in the latest version of the SNF QRP Measure Calculations and Reporting User's Manual linked here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf. For your second question on covariates, please refer to the Schedule for Risk-Adjustment tab in the Risk-Adjustment Appendix File (available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Risk-Adjustment-Appendix-File-for-SNF-Measure-Calculations-and-Reporting-Users-Manual-V20.xlsx) to determine the measure calculation application dates that are associated with each of the Update IDs. If the discharge date fell between October 1, 2017, and September 30, 2018, use Risk Adjustment Update ID 2. For discharge dates between October 1, 2016, and September 30, 2017, use Risk Adjustment Update ID 1.

#	Topic	Question	Response
17	Measure Overview of Current SNF QRP Measures	Will the Standardized Patient Assessment Data Elements (SPADEs) that are not included in a formal QRP measure affect the APU requirements (i.e., 100 percent/80 percent)?	SPADEs adopted in the SNF QRP that are included in the compliance requirements for the SNF QRP and that may affect a SNF's APU are proposed and adopted through the Federal rulemaking process. For more information regarding SPADEs, we refer you to Section 1888(e)(6)(B)(i)(III) of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title18/1888.htm), which requires that, for FY2019 and each subsequent year, SNFs must report SPADEs required under section 1899B(b)(1) of the Act. Section 1899B(b)(1)(B) of the act defines standardized patient assessment data as data required for at least the QMs described in the act for the following categories: (1) functional status; (2) cognitive function; (3) special services, treatments, and interventions; (4) medical conditions and comorbidities; (5) impairments; and (6) other categories deemed necessary and appropriate by the Secretary (https://www.congress.gov/bill/113th-congress/house-bill/4994/text). In addition, in the FY2018 SNF PPS Final Rule (82 FR 36568 through 36570 (found at https://www.federalregister.gov/documents/2017/08/04/2017-16256/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities), we finalized the definition of standardized resident assessment data that SNFs must report to comply with section 1888(e)(6) of the Act as well as the requirements for the reporting of these data. We intend to use these data for a number of purposes, including facilitating their exchange and longitudinal use among healthcare providers to enable high-quality care and outcomes through care coordination, as well as for QM calculation and identifying comorbidities that might increase the medical complexity of a particular admission. For a given data submission period, the MDS assessments submitted by a SNF must meet the APU minimum submission threshold of no less than 80 percent of the MDS assessments having 100-percent completion of the required SNF QRP data elements.
18	Measure Overview of Current SNF QRP Measures	Stay Definition for QRP measures: If a resident is discharged from a Part A stay but returned for a continued stay related to an interrupted stay, would these be two stays for QRP purposes?	No, for the purposes of the SNF QRP, this would be considered a single stay. The provider would code A0310G1. Is this an interrupted stay = Yes. If A0310G1 = [1], then if A0310H is active, it must equal [0]. For more information on the Patient Driven Payment Model (PDPM) and the Interrupted Stay Policy, please refer to the PDPM page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

#	Topic	Question	Response
19	Measure Overview of Current SNF QRP Measures	Will QRP measures continue to look back into prior PPS assessment types for FY2020?	For Medicare Part A SNF stays with an admission prior to October 1, 2019, the resident stay calculation will use the definitions and follow the measure specifications outlined in the SNF QRP Measure Calculations and Reporting User's Manual Version 2.0 through September 30, 2019: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Calculations-and-Reporting-Users-Manual-V20.pdf. Medicare Part A SNF stays beginning on or after October 1, 2019, will use the definitions and follow the measure specifications outlined in the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.
20	Measure Overview of Current SNF QRP Measures	Are the risk factors obtained from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) codes in Section I such that if you do not claim a particular ICD-10 (say for compressed brain) then the risk adjustment does not happen?	The risk factors used for risk adjustment items may be found in Table A-4 Primary Medical Condition Category (I0020A) and Active Diagnosis in the Last 7 days (I8000A through I8000J) – ICD-10-Clinical Modification (CM) Codes of the Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual Version 3.0, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf. ICD-10-CM codes include the ICD-10 codes used for exclusions, such as the example provided, compression of the brain. In Table A-5 Risk-Adjustment Covariates for the Change in Self-Care Score, Change in Mobility Score, Discharge Self-Care Score, and Discharge Mobility Score Measures, both the ICD-10 Codes and other MDS 3.0 variables that are used for risk adjustment are included. All data that are available for risk adjustment are used, such that missing data for one risk adjustment variable does not mean that expected scores are not calculated or risk adjustment does not occur.

#	Topic	Question	Response
21	Measure Overview of Current SNF QRP Measures	With the four new QMs related to function, how is each measure compared? What are the desired results? Will there be percentages?	There are four new SNF QRP quality measures that are functional outcome measures: Change in Self Care, Change in Mobility, Discharge Self Care, and Discharge Mobility. Data submitted for these four QMs will begin to appear in QM reports in fall 2019. The Change in Self-Care and Change in Mobility QMs report the SNF's risk-adjusted mean change in Self-Care and Mobility scores between admission and discharge for Medicare Part A SNF stays and the National Observed Change in Self-Care and National Observed Change in Mobility. The national data may be used as a comparison reference. The Discharge Self-Care and Discharge Mobility QMs report the percentage of Medicare Part A SNF Stays whose observed Self-Care/Mobility score meets or exceeds the expected discharge Self-Care/Mobility score. It will be reported as a percent. The National Average for these quality measures will also reported as a percent. The national data may be used as a comparison reference. For information about the measure calculation algorithm (steps to calculate the measure), including the numerator and denominator, please refer to Chapter 6 of the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.
22	Measure Overview of Current SNF QRP Measures	Can you get negative scores for the Self-Care and Mobility discharge score QMs?	It is possible for the resident level Change in Self-Care Score and Change in Mobility Score to be negative, if the observed discharge performance is lower than the observed admission performance for that the resident. Please refer to Section 6.6 on page 40 of the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf. It is also possible that facility-level Change in Self-Care Score QM and Change in Mobility Score QM could be negative. Discharge Self-Care Score, and Discharge Mobility Score Measures are reported as a percent, and the QM scores will not be negative.

#	Topic	Question	Response
23	Measure Overview of Current SNF QRP Measures	For pressure ulcers, is it the providers' documentation that classifies the ulcer as a pressure ulcer for the QM?	The pressure ulcer quality measure is an assessment-based measure. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths; monitors their condition on an ongoing basis; and records treatment and response to treatment is a matter of good clinical practice and an expectation of trained and licensed healthcare professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. The intent of the items in Section M, Skin Conditions, is to document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. For the purposes of coding pressure ulcers/injuries in items M0210 and M0300, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. The Steps for Assessment include medical record review and examining the skin. 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any skin ulcers/injuries are present.
24	Measure Overview of Current SNF QRP Measures	If a resident is discharged return not anticipated but comes back two days later, is this a new stay?	Yes. If a resident is discharged return not anticipated and returns to the facility within 3 days and receives care under a Medicare Part A benefit, a new PPS 5-Day assessment would be required and this would be considered the beginning of a new Part A stay for the SNF QRP and PDPM. Please see the page 2-51 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.

#	Topic	Question	Response
25	Measure Overview of Current SNF QRP Measures	What exactly are the criteria for completing the Interim Payment Assessment (IPA)? Are there any conditions?	Please refer to the IPA guidance in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
26	Measure Overview of Current SNF QRP Measures	If the QRP now includes Death in Facility, is it required to do a Section GG discharge when there has been a death in facility?	Death in Facility is used to designate the end of the Part A stay for the measure and is one of the criteria used to designate an incomplete stay. Although admission performance and one goal are required for the PPS 5-Day assessment, there will be no opportunity to complete a Part A PPS Discharge assessment in the event of resident death; a tracking record is completed instead, which does not contain Section GG. Refer to the Death in Facility definition on page 2-10 of the RAI Manual.
27	Measure Overview of Current SNF QRP Measures	How are the risk factors weighted when calculating "expected" QRP scores? Are they all equal or do some factors weigh more?	Each risk factor used in risk adjustment has its own unique estimate (value), based upon the relationship between each factor and the functional score of interest in a regression model. The calculation algorithm for these measures (i.e., detailed steps to calculate the measures), including the risk adjusters, is provided in Chapter 6 Calculations for Assessment-Based (MDS) Measures That Are Risk-Adjusted and Appendix Table A-5 in the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.
28	Measure Overview of Current SNF QRP Measures	What if the resident who has admission, 5-Day assessment, and discharge that are all a total of 7, and the difference is 0 between admission, 5-Day, and discharge?	We believe you are referring to the Change in Self-Care and Change in Mobility Score measures. This resident would have an observed change score of "0."
29	Measure Overview of Current SNF QRP Measures	Are the risk adjustment criteria for the various QRP measures publicly available?	Yes, you will find all of the risk adjustment factors in the SNF QRP Measure Calculations and Reporting User's Manual Version 3.0: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf.

#	Topic	Question	Response
30	Measure Overview of Current SNF QRP Measures	Is there a way to see how the covariates are impacting the measures for a specific facility?	We assume this question is not asking for the national beta estimate but the impact of risk adjustment for each provider. With the provider covariate information, one can follow the method specifications in Chapter 6 of the SNF Measure Calculations and Reporting User's Manual Version 3.0 available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf to calculate the impact of risk adjustment on the provider.
31	Measure Overview of Current SNF QRP Measures	When is information pulled for the QRP measures? What time period does it pull from?	Review and Correct Report: To allow a quarter to be displayed on the Certification And Survey Provider Enhanced Reports (CASPER) Review and Correct Report as soon as that quarter is completed, the QMs are calculated and updated in the early morning hours of the first day of the following quarter. The reports are then updated/refreshed on weekly the early morning hours every Monday until the data submission deadline for that quarter. QM Reports (i.e., the SNF facility-level and SNF resident-level QM reports) are refreshed monthly. Provider Threshold Reports: Each time the provider runs the Provider Threshold Report, the report is produced with updated data. The Provider Threshold Report does not have scheduled updates or refreshes like other CASPER Reports (e.g., the QM Reports are refreshed monthly), but instead will include updated data each time the provider runs a new Provider Threshold Report.
32	Measure Overview of Current SNF QRP Measures	When will RAI Manual updates be published?	The MDS 3.0 RAI Manual v1.17_October 2019 is available at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. In general, the most updated version of the RAI manual are published at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
33	Measure Overview of Current SNF QRP Measures	How do we determine when an IPA is warranted?	The IPA is completed at the discretion of the provider and would be completed in order to reflect changes in the resident's clinical status or care needs. Please refer to IPA guidance in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.

#	Topic	Question	Response
34	Measure Overview of Current SNF QRP Measures	What date will the new rule become effective?	The FY2020 SNF PPS Final Rule is effective as of October 1, 2019. However, there may be components within the SNF PPS Rule that become effective in future dates. You may view the FY 2020 SNF PPS Final Rule on the Federal Register website at https://www.govinfo.gov/content/pkg/FR-2019-08-07/pdf/2019-16485.pdf.
35	Measure Overview of Current SNF QRP Measures	Will we transmit and bill for Managed Care the same as Medicare Part A?	No, QIES ASAP can only receive Medicare Part A, OBRA assessments and tracking forms, and the Optional State Assessment (OSA). PPS assessments that are completed for private insurance and Medicare Advantage Plans cannot be submitted to the QIES ASAP system. Refer to the Chapter 3 Introduction of the RAI Manual for more information: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.

#	Topic	Question	Response
36	SNF Public Reporting	Drug Regimen Review Question: I reviewed all the x's in my QM report and noticed that they were all answered as "0" from Admission. Not Triggered (NT), which is equivalent to the number of stays that triggered the QM, was coded as "9." Why will it trigger if it was not applicable; is this an unacceptable answer?	We believe you are referring to the SNF QRP Review and Correct Report for the DRR SNF QRP QM**.** For a resident stay to be included in the numerator**,** the total number of Medicare Part A SNF Stays (Type 1 SNF Stays only) in the denominator must meet each of the following criteria: 1. The facility conducted a drug regimen review on admission, which resulted in one of the three following scenarios: o No potential or actual clinically significant medication issues were found during the review (N2001 = [0]); OR o Potential or actual clinically significant medication issues were found during the review (N2001 = [1]) and then a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day (N2003 = [1]); OR o The resident was not taking any medications (N2001 = [9]). 2. Appropriate follow-up occurred each time a potential or actual clinically significant medication issue was identified during the stay (N2005 = [1]); or no potential or actual clinically significant medications issues were identified since the admission or resident was not taking any medications (N2005 = [9]). The resident stay will not be included in the numerator if the stay does not meet these criteria and the Review and Correct Report will include an "NT," meaning the individual resident stay was not included in the numerator. The stay will be included in the denominator count. For example: If N2001 is coded 1, Yes, issues found during review, and N2003 is coded 0, No, indicating the provider did not contact a physician (or physician-designee) by midnight of the next calendar and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues, and N2005 is coded 0, No, All identified potential or actual clinically significant medication issues were not completed by midnight of the next calendar day, then the stay would not be included in the numerator. Additionally, if a dash is entered for any of the three data elements on either the PPS 5-day assessment or Part A PPS discharge, the resident stay will not be included in the numerator count and the Review and Correct Report will indicate "NT." Reviewing resident records with NT is encouraged to identify if any of the three data elements were coded with a dash as entering a dash may affect your facility's APU.

#	Topic	Question	Response
37	SNF Public Reporting	What is the most efficient way to change the ownership information (such as board members or administrators) on NHC? It is difficult to get through and get the information changed.	If the information about your nursing home is incorrect or has changed, please contact your State Survey Agency to have it updated. State Survey Agency contact information is available at https://www.medicare.gov/NursingHomeCompare/Resources/infoforresidents.html#fileacomplaint.
38	SNF Public Reporting	From the SNF QRP QMs, can facilities see if they will have APU penalty?	A SNF's rates/scores on the SNF QRP QMs indicate performance in several quality domains and does not indicate compliance with the SNF QRP 80-percent threshold for the APU. APU compliance for a given data submission period refers to the requirement that no less than 80 percent of the MDS assessments submitted have 100 percent of the required SNF QRP data elements completed. SNF QRP tables for reporting assessment-based measures for the SNF QRP APU are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.
39	Changes to the RAI Manual and MDS 3.0	If a resident had an interrupted stay on day 3 and we have not scheduled and completed the 5-Day Prospective Payment System (PPS) assessment yet, can we complete the 5-Day PPS after the interrupted stay?	Since the Assessment Reference Date (ARD) window for scheduling the assessment includes days 1 through 8, the facility would still be in compliance with assessment scheduling rules. Therefore, the provider in this instance can complete the 5-Day PPS after the interrupted stay if it so chooses.
40	Changes to the RAI Manual and MDS 3.0	What is done with the data collected under the QRP? Are there consequences for a "bad" score? I understand that there is a penalty for incomplete data. My question is if there are consequences, for example, for a high percentage of falls with major injury?	The data collected under the SNF QRP is used to calculate QMs. The QM scores for each SNF are publicly posted on NHC. The consequences for a "bad" score are far reaching: Stakeholders use this data to compare the quality of care provided at each SNF; patients and families use this data to guide care choices and evaluate care outcomes; and State surveyors integrate the QM scores into the certification and survey process which feeds into facility survey results. Please refer to the CMS program web page for more details about the purpose and scope of the SNF QRP program: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Overview.html.

#	Topic	Question	Response
41	Changes to the RAI Manual and MDS 3.0	I thought terminology for the 5-Day assessment changed to initial Medicare assessment. It is being referenced to a 5-day assessment. Please clarify.	The reference in the final rule to the "initial Medicare assessment" describes the initial Medicare assessment, which is currently the 5-Day PPS Assessment. In the future. Please see Chapter 2, Section 2.9 - MDS PPS Assessments for SNFs in the RAI Manual for more information: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
42	Changes to the RAI Manual and MDS 3.0	Please explain again the implications of the dash entries. It was stated that if we enter dashes for MDS data elements relevant to the SNF QRP that we may not meet the reporting threshold for the APU, and as such be subject to a 2-percent penalty.	The SNF QRP requires SNFs to submit QM and SPADEs to CMS. For a given data submission period, the MDS assessments submitted by a SNF must meet the APU minimum submission threshold of no less than 80 percent of the MDS assessments having 100 percent completion of the required SNF QRP data elements. These are the data elements needed to calculate the SNF QRP QMs and are defined as standardized data elements. Successful assessment completion is submission of actual resident data, as opposed to non-informative response options (e.g., "dash" [–]). Please note that while the coding of a dash is an optional response value for certain data elements, their use does not count toward meeting the APU minimum submission threshold. Failure to meet the minimum threshold may result in a 2 percent reduction in the SNF's APU. As CMS has said in the past, and continues to today, the use of dashes should be a rare occurrence.
43	Changes to the RAI Manual and MDS 3.0	Can we copy any interview done in 5-Day assessment into the discharge assessment if they are 15 days apart?	No. Although a policy to re-use interview responses was allowed previously, there has been no such policy created under PDPM.
44	Changes to the RAI Manual and MDS 3.0	If a resident's payer changes from Medicare Advantage (MA) plan to Medicare Part A while hospitalized and returns within 3 days, therefore meeting the interrupted stay policy definition, which assessment type, if any, should be completed?	The interrupted stay policy applies to changes in payer source, however this situation does not meet the interrupted stay policy because the resident was not on Medicare Part A when the resident was discharged. In the example, when the resident returns to the facility for the Part A stay, a 5-Day assessment would need to be completed since it is the first Medicare assessment required for a Medicare Part A stay. Refer to page Chapter 2 of the RAI Manual for more information on transition from Medicare Advantage to Medicare Part A. See Chapter 3, Section A for more information related to interrupted stay: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
45	Changes to the RAI Manual and MDS 3.0	Will CMS provide any guidance to States regarding the OSA?	States are responsible for determining how they implement the OSA. Each State's Medicaid case-mix is different, so implementation may be different for each State.

#	Topic	Question	Response
46	Changes to the RAI Manual and MDS 3.0	Is a Part A PPS Discharge required if a resident goes home after a Medicare Part A stay?	Yes, the Part A PPS Discharge is required at the end of the Medicare Part A stay (whether or not the resident remains in the facility or is physically discharged), and may be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS is physically discharged from the facility, and has a Discharge Date (A2000) that occurs on the day of or one day after the End Date of Most Recent Medicare Stay (A2400C). Please refer to Chapter 2 of the RAI Manual, Tracking Records and Discharge Assessments Reporting: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
47	Changes to the RAI Manual and MDS 3.0	On a readmission return anticipated to the facility, if the facility determines an IPA is needed and the resident also meets requirements for OBRA significant change in status, can the facility combine MDS or does the facility complete two separate assessments: 1) IPA and 2) Significant Change In Status (SCSA)?	The IPA is a standalone assessment used for payment purposes under the PDPM and cannot be combined with any other assessment. Please refer to the IPA guidance on page 2-46 of the of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. Therefore, if the facility decides to do a Significant Change in Status Assessment and an IPA they can do so, but they must be completed separately.
48	Changes to the RAI Manual and MDS 3.0	Because of the PPS 5-Day assessment, which assessments are no longer necessary?	The interim PPS assessments were removed from the completion requirements under PDPM—these assessments are the 14-, 30-, 60-, and 90-Day PPS assessments, the Other Medicare Required Assessments (Start of Therapy, End of Therapy, Start and End of Therapy) and Swing Bed Clinical Change assessments. But this is not “because of the 5-Day PPS assessment.” These item sets were removed because they are no longer required under PDPM. For assessments required under PDPM, please see Section 2.9 MDS PPS Assessments for SNFs on pages 2-45 through 2-46 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
49	Changes to the RAI Manual and MDS 3.0	Do we need to use the Resident Assessment Validation and Entry System (jRAVEN) for the PDPM?	You may use jRAVEN, which is free software provided by CMS, or MDS software purchased from a vendor.

#	Topic	Question	Response
50	Changes to the RAI Manual and MDS 3.0	Related to MDS item I0020B, until now in the SNF, ICD-10 coding guidelines require that we do not code acute codes, rather that we use the 7th digit to code subsequent encounters or aftereffects. Have these guidelines changed and will CMS issue clarification on this issue?	The guidelines have not changed in relation to SNFs using acute diagnosis codes; please refer to the Coding Instructions for I0020 on page I-2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. However, as with other payment systems that map the acute diagnosis codes for use in post-acute settings, CMS felt it appropriate to map these acute diagnosis codes within the ICD-10 mapping used under the PDPM. The mappings can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/pdpm.html.
51	Changes to the RAI Manual and MDS 3.0	What are the required assessments in swing bed facilities?	Swing bed providers must complete these assessments: Swing Bed PPS assessment and Swing Bed Discharge in addition to the Entry Tracking and Death in Facility record. Please refer to Chapter 2, Section 2.3 Responsibilities of Nursing Homes for Completing Assessments, subsection for Swing bed facility residents in the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
52	Changes to the RAI Manual and MDS 3.0	Is there any problem with completing the Brief Interview for Mental Status (BIMS) on day 1 to 3 consistently?	The BIMS is required to be completed during the 7-day look-back period (preferably the day before or day of the ARD). Within that timeframe, providers can choose which day works best for the resident/facility schedule. Please refer to Section C – Brief Interview for Mental Status in the RAI Manual for more information: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
53	Changes to the RAI Manual and MDS 3.0	Who is the best discipline to do BIMS?	CMS does not prescribe which staff should complete assessments. It is up to the provider to determine this and to ensure that whoever is completing assessments is allowed to do so per State licensure laws and professional scope of practice.
54	Changes to the RAI Manual and MDS 3.0	PHQ-9©, per the RAI Manual, does not yield a diagnosis of depression. Why do PDPM training materials call it a “depression” split?	We are assuming that this question is related to #3 in the PDPM Calculation Worksheets under some of the PDPM Classification Groups. The intent for the third-level depression split for several of the PDPM Classification Groups is to evaluate for signs and symptoms of depression. The terms depressed/depression are labels under PDPM but relate to signs and symptoms of depression as identified by the PHQ-9© and do not refer to a clinical diagnosis of depression.
55	Changes to the RAI Manual and MDS 3.0	Can an OSA assessment be combined with an OBRA assessment?	No, the OSA cannot be combined with any other assessment. Please refer to the Item Set guidance on page 2-13 of the of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.

#	Topic	Question	Response
56	Changes to the RAI Manual and MDS 3.0	Do we have to do an IPA if one therapy discipline discharges the resident?	The IPA is an optional assessment, completion of which is at the discretion of the provider. Please refer to the IPA guidance on page 2-46 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
57	Changes to the RAI Manual and MDS 3.0	Can the IPA or OSA assessment be combined with an OBRA assessment?	Neither the IPA nor the OSA can be combined with any other assessment. Please refer to the Item Set guidance on page 2-12, 2-13, and 2-46 of the of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
58	Changes to the RAI Manual and MDS 3.0	It was stated that the IPA and OSA are standalone and cannot be combined. Does that include combining with an OBRA assessment?	The OSA and IPA cannot be combined with any assessments. That is, they cannot be combined with each other, and neither can be combined with any OBRA or PPS assessment. Please refer to the Item Set guidance on page 2-12, 2-13, and 2-46 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
59	Changes to the RAI Manual and MDS 3.0	Can you complete more than one IPA during a stay?	The IPA is an optional assessment, completion of which is at the discretion of the provider. Please refer to the Interim Payment Assessment guidance on page 2-46 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
60	Changes to the RAI Manual and MDS 3.0	Does the resident have to return with the same diagnosis to qualify for interrupted stay?	No, the same diagnosis it is not required to meet the criteria of an interrupted stay. An interrupted stay is one in which a patient discharged from Part A SNF care and readmitted to the same SNF within a 3-day window. However, the change in diagnosis during the readmission can only be captured through an IPA.
61	Changes to the RAI Manual and MDS 3.0	The 5-Day is the first PPS MDS after a Discharge Return Not Anticipated. What if the resident returns within the interruption window (e.g., the day after discharge)? Should we hold OBRA discharge completion until the interruption window concludes?	In the example provided, if the resident was discharged from the facility and returned to the facility the day after the discharge to resume Part A services, this is an interrupted stay. If the Discharge assessment was a Discharge Return Not Anticipated, the provider would be required to complete a new OBRA Admission on return because according to OBRA rules, when there is a Discharge Return Not Anticipated and the resident returns to the facility within 30 days, it is considered a new OBRA Admission. Therefore, on return to the facility, an Entry Tracking record and a new OBRA Admission would be required. Because there was an interrupted stay, no new 5-Day would be required. It is up to the discretion of the provider as to whether or not they wish to hold completion of the discharge assessment until the interruption window is over. Per assessment completion rules, providers have 14-days from the date of discharge (A2000 + 14 calendar days) in which to complete a discharge assessment.

#	Topic	Question	Response
62	Changes to the RAI Manual and MDS 3.0	If resident is out longer than 3 days (so no interruption of stay), will 3-day qualifying hospital stay days remain original stay dates or new recent stay dates?	As stated in Section 20.2.3 of Chapter 8 of the Medicare Benefit Policy Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf), "If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met." Therefore, as long as the resident returns within 30 days from having been discharged, then the original hospital stay should be used.
63	Changes to the RAI Manual and MDS 3.0	Does an IPA imply that an SCSA would also be needed?	No, there is no expectation that completion of an IPA necessitates completion of an SCSA, although changes in condition and status of the resident that meet criteria for an SCSA would indicate that an SCSA should be completed. Please refer to the section on SCSA in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
64	Changes to the RAI Manual and MDS 3.0	If a Part A resident is Discharged Return Not Anticipated and returns to the same SNF before midnight of the third day, Interrupted stay/Continued stay, then when the resident returns would the provider need to complete an OBRA admission assessment on return?	Yes, an OBRA Admission is required on return from a Discharge Return Not Anticipated. An entry tracking record is also required on return. Please see OBRA Discharge Assessments information in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
65	Changes to the RAI Manual and MDS 3.0	What about cases of Medicare B residents that have an interrupted stay and come back to the SNF as eligible for Medicare Part A? Does the standard interrupted stay mechanism apply?	The interrupted stay policy does not apply to Medicare Part B. An interrupted stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.
66	Changes to the RAI Manual and MDS 3.0	Does the default payment also have a variable payment adjustment?	Yes. Please see the PDPM FAQs for information on default Health Insurance Prospective Payment System (HIPPS) codes and the variable per diem schedule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip.

#	Topic	Question	Response
67	Changes to the RAI Manual and MDS 3.0	Is payment tied to submission timeframes? If a PPS assessment is submitted to QIES later than 14 days after completion, are the days to be submitted as default payment?	Default payment applies in cases when the ARD is set outside the appropriate window. It is not related to submission timeframes. Please refer to Late PPS assessment in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
68	Changes to the RAI Manual and MDS 3.0	For K0710, will the "During Entire 7 Days" column still code back into the preadmission stay?	Yes, Column 3 "During Entire 7 Days" for K0710 includes time not as a resident and can span back to previous stays. Refer to pages K-13 through K-17 of the RAI Manual for Item K0710 coding instructions.
69	Changes to the RAI Manual and MDS 3.0	When do I get the Nursing Grouping to use on the fourth digit of the HIPPS? Is there material to refer to?	The nursing classification is calculated as part of the overall resident classification. Information on how this is calculated can be found in Chapter 6 of the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
70	Changes to the RAI Manual and MDS 3.0	1. Can multiple IPAs be completed for a stay in case the resident has changes? 2. What is the default HIPPS billing code? 3. If a facility inadvertently does an IPA that decreases payment, can that IPA be inactivated, and bill adjusted if discovered after the claim is billed?	1. The IPA is an optional assessment, completion of which is at the discretion of the provider. 2. The default HIPPS billing code is ZZZZZ. 3. Again, the IPA is an optional assessment, completion of which is at the discretion of the provider. Please note that as with any assessment, the assessment should be an accurate representation of the resident, regardless of the impact on payment.
71	Changes to the RAI Manual and MDS 3.0	In what chapter of the RAI Manual are the PDPM worksheets located?	The PDPM Classification Worksheets are available in Chapter 6 of the RAI Manual https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
72	Changes to the RAI Manual and MDS 3.0	Are the final v1.17.1 Item Sets truly final?	Yes.
73	SNF QRP Reports Enhancements & Case Study	If the resident is placed back on skilled care within 30 days after being discharged from Part A that is not an interrupted stay. Will the variable payment schedule restart?	Yes, because this would be considered a new Part A stay. Please see Interrupted Stay in Chapter 6 of the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.

#	Topic	Question	Response
74	SNF QRP Reports Enhancements & Case Study	CMS allows two individual users per facility to obtain access, but isn't there a form that can be completed to add more than just two individual users?	Providers can call the Help Desk and request a form to complete and have more than two individual users.
75	SNF QRP Reports Enhancements & Case Study	What was the web address again for the QIES Technical Support Office (QTSO)?	https://qtso.cms.gov/
76	SNF QRP Reports Enhancements & Case Study	Is there somewhere that has a listing of all error numbers to know which to run for the assessments with error number report?	Section 5 of the MDS 3.0 Provider User's Guide provides error number information and is available on the QTSO website via the following https://qtso.cms.gov/reference-and-manuals/mds-30-provider-users-guide.
77	SNF QRP Reports Enhancements & Case Study	You said you can request up to five error numbers on the report (slide 20); however, based on the slide 14 view of the report, it looks like you can only select one.	To select more than one error, press and hold the Ctrl and/or Shift keys on the keyboard as you click to select/highlight multiple measures.
78	SNF QRP Reports Enhancements & Case Study	Are data for QRP QMs always 2 years old or only the data used for compliance/APU calculations?	Data used in the QM reports comes from assessments with target dates from the selected time period. For the CASPER QM reports, Begin Date (mm/dd/yyyy) and End Date (mm/dd/yyyy) dates are pre-filled for the most recent completed 6-month period prior to the month the data were last calculated. You may enter alternate dates in mm/dd/yyyy format. For the SNF QRP QM reports, the default value is the End Date of the most recently calculated quarter. You may select a different quarter End Date from the list. Begin Date is a read-only field that displays the first day of the 12-month period ending with the specified End Date.
79	SNF QRP Reports Enhancements & Case Study	Are there any plans to provide facility characteristic comparison reports to national providers?	The MDS 3.0 Facility Characteristics Report (detailed in Section 11 of the CASPER Reporting User's Guide for MDS Providers at https://qtso.cms.gov/system/files/qtso/cspr_sec11_mds_prvdr_0.pdf) includes State and national statistics to allow providers to compare their populations to State and national averages.

#	Topic	Question	Response
80	SNF QRP Reports Enhancements & Case Study	Are residents under a respite stay excluded from the functional assessment improvement QM?	No, being in a respite stay is not an exclusion. However, keep in mind that the measure only includes residents in a Medicare Part A stay. Please see Table 7-3 on pages 47 through 50 of https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf for more detail.
81	SNF QRP Reports Enhancements & Case Study	If a facility submits a correction to data submitted via the MDS after the data have been publicly reported, how long until the data are corrected?	For the SNF QRP, once data are publicly reported, the data submission deadlines have passed and facilities can no longer correct the data. Prior to the release of SNF QRP data on NHC, SNFs are given the opportunity to review their QM results during a 30-day preview period using a SNF Provider Preview Report, which will be issued quarterly by CMS. See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Public-Reporting.html for more details.
82	SNF QRP Reports Enhancements & Case Study	I thought that risk adjustment items (with exception of the skin integrity measure, due to those data elements also being SPADEs) are not utilized in the APU calculation?	Please refer to the SNF QRP Overview of Data Elements Used for Reporting Assessment-Based Quality Measures Affecting FY 2021 APU Determination, available at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Table-for-Reporting-Assessment-Based-Measures-for-the-FY-2021-SNF-QRP-APU.pdf. This document identifies those elements that are included for compliance determination.
83	SNF QRP Reports Enhancements & Case Study	It is very frustrating to realize that the relatively new Provider Threshold Report does not aid in determining our reporting compliance, which I thought was the point of this one. Please can we get a report that helps us ensure reporting compliance related to APU?	The SNF Provider Threshold Report details the status of the measures required for the APU by fiscal year of the APU. Providers should use this report in conjunction with their other SNF QRP and CASPER reports to identify opportunities to correct resident assessments with missing data. CMS continues to analyze ways to enhance the SNF Provider Threshold Report. It is important to note that data elements designated as SPADEs used to risk-adjust the QMs used in the SNF QRP (e.g., a dash = APU penalty) are not included in the Provider Threshold Report. As such, providers need to proactively monitor compliance with submitting all required data elements through their quality assurance and performance improvement programs.
84	SNF QRP Reports Enhancements & Case Study	For the MDS system login, should we assign it to the Director of Nursing?	Following guidance of the RAI manual, each provider should determine which staff are most appropriate to access the CMS systems.

#	Topic	Question	Response
85	SNF QRP Reports Enhancements & Case Study	How can a Quality Innovation Network/Quality Improvement Organization (QIN-QIO) gain access to facility level Confidential Feedback Reports?	The reports are confidential and only made available to the provider. The only way the QIN-QIO could receive this information is if the provider shares it directly with the QIN-QIO.
86	SNF QRP Reports Enhancements & Case Study	When will CMS be moving to iQIES? Will this platform allow for more than two users per facility?	CMS expects to transition to iQIES for Nursing Home (NH)/SNF after CY 2020. Yes, iQIES will allow more than two users per facility.
87	SNF QRP Reports Enhancements & Case Study	Is CASPER reporting still not a best practice to pull the data after the 5th of the month to have the prior month's full data?	The reports are routinely updated, with the timing varying based on the report. Some can be pulled weekly with new information provided.
88	SNF QRP Reports Enhancements & Case Study	Did I understand correctly that the SNF QRP Provider Threshold Report cannot be used to measure APU compliance? If this is correct, what report is used to monitor and ensure each facility is exceeding the SNF QRP 80 percent no dash requirement to avoid a 2-percent APU penalty?	Yes, that is correct. Providers should use all the available SNF QRP reports to monitor their ongoing compliance with SNF QRP requirements. SNF QRP tables for reporting assessment-based measures for the SNF QRP APU are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html.
89	SNF QRP Resources	Is there a list of the different help desks and the corresponding email addresses?	Please refer to the slides in the SNF QRP Resources presentation (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html) for this information. All of the email addresses and contact information for the different help desks are within this presentation.
90	SNF QRP Resources	Is there an email address electronic health records vendors can contact to work on integrating CASPER reports into our system?	We suggest that you contact the QTSO Help Desk by calling (800) 339-9313 or by email to help@qtso.com. You may wish to refer to the "I'm a Vendor" link on the QTSO web page, available at https://qtso.cms.gov/vendors/minimum-data-set-mds-vendors.

#	Topic	Question	Response
91	Sections A, I, J, and O	Do all non-therapy ancillary (NTA) diagnoses and speech-language pathology (SLP) comorbidity diagnoses have to be listed in I8000A–J or are the checkbox diagnoses in Section I adequate?	Per the instructions in the RAI Manual, you are to only enter a diagnosis in I8000 A through J if there are diagnoses that the resident has that are not listed in I0100 through I7900. If a condition has an associated checkbox, then checking this box is sufficient to receive credit for this comorbidity for the purposes of the PDPM.
92	Sections A, I, J, and O	Since the worksheet refers to I8000 and not to Section I seizures, what is the guideline for coding intractable seizure? Some MDS and mid-level practitioners note only “seizures” in their notes even if it was an intractable seizure due to recent changes in clinical practice for high therapy dosing of seizure medications. Stanford’s guidelines state it is an intractable seizure if a resident is on two anti-epileptic medications.	Item I8000 can be coded with the appropriate ICD-10 Code for intractable seizure if it is an active diagnosis for the last 7 days. If there is ever any discrepancy related to a resident’s diagnosis, it should be discussed with the physician and an appropriate diagnosis recorded in the resident’s medical record and on the MDS as applicable.
93	Sections A, I, J, and O	A resident is admitted to the hospital for pneumonia where he had intravenous antibiotics. He is admitted to the SNF for rehabilitation due to weakness and debility caused by the pneumonia which was treated in the hospital. Would we use pneumonia as the primary diagnosis for the SNF skilled stay?	Per Section I: Active Diagnoses in the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf), the ICD Code in I0020B should indicate the resident’s primary medical condition category that best describes the primary reason for the Medicare Part A stay. The assessor should use his/her clinical judgment or consult with the admitting physician to determine the appropriate diagnosis code to enter into I0020B.
94	Sections A, I, J, and O	Is there a list of which States request OSA assessments?	No, there is not a list of which States will require the OSA. Please contact your local State agency to inquire whether or not your State will require the OSA for State payment purposes.

#	Topic	Question	Response
95	Sections A, I, J, and O	Please clarify if the Managed Care plans can request the OSA to be completed.	Please contact your Managed Care plan to determine what information they will require for payment. As is currently in place, a facility may choose to complete a particular CMS item set for purposes other than OBRA, SNF PPS, or State payment purposes (e.g., for Medicare managed care, private insurance, etc.), but they **may not** submit these assessments to QIES ASAP, as neither CMS nor the State has authority to receive the data collected on these assessments.
96	Sections A, I, J, and O	How do we bill an interrupted stay? Is it the same as a leave of absence (LOA)? Or skip day?	Interrupted stays will be indicated on the claim in the same way as a LOA. Refer to 13.11 on page 36 of the PDPM FAQs document (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip).
97	Sections A, I, J, and O	In regard to the OBRA discharge does the interrupted stay affect the 14-day window for the ARD?	No, the interrupted stay policy does not affect or change completion requirements of OBRA assessments.
98	Sections A, I, J, and O	For interrupted stays, would the physician certification from the initial admission date be acceptable and is the every 30-day count considered calendar days or coverage days (not including days out of facility)?	There is no change to the physician certification or recertification requirements as a result of the interrupted stay policy.
99	Sections A, I, J, and O	It's my understanding that effective 1/1/2020, Medicare patients/residents must use their Medicare Beneficiary Identifier (MBI) or their claim will be rejected (there are a few exceptions). Will the MDS specs be modified to no longer allow the Health Insurance Claim Number (HICN) or will that number be allowed for a longer time period?	Currently the MBI must be used for Medicare billing purposes, eligibility, and claims. The MDS itself does not have a data element labeled "HICN," nor will it have one labeled "MBI." Regarding status of the MBI, CMS is still in the transitional period that goes through December 31, 2019, where the HICN or MBI can be used to exchange billing data with CMS. Effective January 1, 2020, providers must submit claims (with a few exceptions) using the MBI. MDS 3.0 Data Submission Specifications v3.00.1 have been updated to accommodate this transition and will be active when the change occurs on January 1, 2020. There was no change to the actual item label or instructions in the RAI Manual because the label for A0600B is "Medicare Number," which is a generic term and can be used to describe the HICN or the MBI. Therefore, the MBI will be required to be entered in A0600B as of January 1, 2020.

#	Topic	Question	Response
100	Sections A, I, J, and O	Why does the primary clinical category continue to be collected if we are putting in a specific ICD-10 code instead of having it map automatically to a clinical category?	Items I0020 and I0020B are collected for two different but related purposes related to quality measurement and payment.
101	Sections A, I, J, and O	To clarify, the admitting and primary diagnosis do not necessarily need to be the same and depends on what the interdisciplinary team decides is the main reason why they are being skilled?	There is a difference between the various reasons why someone may be skilled under Medicare and what the primary medical condition category is that describes the primary reason for the Medicare Part A stay and the ICD Code for that condition. The interdisciplinary team does not decide what the primary diagnosis is, the physician does, but the team may have input on what particular skilled services may be required based on the resident's diagnosis, condition, and abilities.
102	Sections A, I, J, and O	Why would we need to complete the OSA if it is not State-required?	The OSA is only required to be completed for State payment purposes, so if your State does not require the OSA be completed for State payment purposes, you do not have to complete the OSA.
103	Sections A, I, J, and O	In A0310E, please explain the note, "the first submitted assessment may not be an OBRA Admission assessment."	This is just a clarification stating that the first assessment may not be an OBRA Admission. For example, if in a newly certified facility an admission assessment was completed prior to the certification date, the facility would continue the OBRA schedule with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, OBRA Discharge, etc., the facility may receive a sequencing warning message but should still submit the required assessment.
104	Sections A, I, J, and O	If the resident is out of the facility overnight at the emergency room but not admitted, would this be considered an interrupted stay? As of now it is not considered a discharge if not admitted and returns within 24 hours.	The interrupted stay policy only applies to residents in a SNF Part A stay. An interrupted stay occurs when a resident in a SNF under Part A is discharged from Part A (either physically discharged or remains in the facility) and resumes Part A within the 3-day interruption window. A LOA, which is an OBRA policy, occurs when a resident has a temporary home visit of at least one night, therapeutic leave of at least one night, or hospital observation stay less than 24 hours and the hospital does not admit the resident.
105	Sections A, I, J, and O	Does the Interrupted stay rule include when payer source changes from Medicare Part A, to a Medicare replacement policy and then back to Medicare Part A while in the building?	Yes, the Interrupted Stay policy applies to changes in payer source as described.

#	Topic	Question	Response
106	Sections A, I, J, and O	With discharge assessments for part A residents, these cannot be completed until after the third midnight after October 1 to ensure that it would not be an interrupted stay, correct?	When to complete the discharge assessment for Part A residents is up to the discretion of the provider; however, it seems it would be advisable for facilities to hold completion of a Discharge assessment for a resident under a Part A stay until after the interruption window expires.
107	Sections A, I, J, and O	Can providers use the OSA for MA Plans requesting Resource Utilization Groups (RUG)?	Providers should contact their MA plan provider to determine what they require. However, if your software is programmed to allow you to complete the OSA and generate a RUG III/IV code, you could provide that to the MA plan, though you cannot submit that OSA to QIES ASAP because it will end up in the MDS 3.0 Daily Assessment Extract file. This file contains a copy of all MDS 3.0 records that were accepted into the QIES ASAP database since the last time the file was generated on the previous day. The above file is pushed to the State server for use by the State Medicaid agency, and other purposes as requested by the State.
108	Sections A, I, J, and O	If a resident had a surgery but it does not directly relate to the SNF stay, would you code No?	In order to code J2100 as Yes, the surgery has to qualify as major surgery (that is, the resident was inpatient in an acute care hospital for at least 1 day within the last 30 days prior to admission to the SNF, and the surgery carried some degree of risk to the resident's life or the potential for severe disability) that requires active care during the SNF stay. If the surgery performed does not fit this definition, then it cannot be coded in J2100.
109	Sections A, I, J, and O	Please clarify when completing the IPA after an interrupted stay for J2100. If surgery was prior to 5-Day admission, but not during the hospital stay of interrupted stay would you still code yes? Language on MDS only says prior inpatient hospital stay but slide 93 indicates prior to Part A admission.	J2100 is coded based on the most recent Medicare Part A stay. If there was a major surgery that was coded in J2100 on the 5-Day assessment, and an interrupted stay occurred, that major surgery would also be captured on the IPA as long as it occurred within the 30 days prior to the start of the Medicare Part A stay as documented on the 5-Day (A2400B). If the major surgery occurred more than 30 days prior to this date, it cannot be coded on the IPA. If a resident was discharged to the hospital, but there was no interrupted stay, and a new Part A Stay occurs, a new 5-Day would be required, and you would look back into the hospital stay that immediately preceded this new SNF Part A stay and determine whether or not there was a major surgery within the last 30 days prior to the start of this new Medicare Part A stay (as documented in A2400B).

#	Topic	Question	Response
110	Sections A, I, J, and O	Is a Part A PPS Discharge assessment done after 3 days if the resident does not return?	We interpret this question to be related to the Interrupted Stay policy. If a resident is discharged from Part A, remains in the facility, and does not resume Part A within the 3-day interruption window, it is not an interrupted stay. Therefore, a Part A PPS Discharge is required. Should the resident resume a Part A stay in the same facility, a 5-day assessment would be required (as long as resumption of Part A occurs within the 30-day window allowed by Medicare). If a resident is discharged from Part A, leaves the facility, and does not resume Part A within the 3-day interruption window, it is not an interrupted stay and the Part A PPS Discharge and OBRA Discharge are both required and may be combined (see Part A PPS Discharge assessment in Chapter 2 of the RAI Manual). If the resident returns to the same SNF to resume Part A, it would be considered a new entry—that means that an Entry Tracking record, OBRA Admission and 5-Day assessment would be required.
111	Sections A, I, J, and O	Other PDPM speakers have emphasized that primary diagnosis on the MDS could be different from the reason why the resident was admitted to the hospital. But from what I understand from the presentation today, primary diagnosis is the reason why the resident was hospitalized and not the reason for Medicare Part A SNF care.	The primary medical condition category, item I0020, documents the etiologic diagnosis that best describes the primary reason for the Medicare Part A stay (i.e., the primary reason for admission to the SNF for the Part A stay). The ICD code for that condition is what is entered into I0020B.
112	Sections A, I, J, and O	How can I determine what level of risk is enough to be considered a risk to life? The example shows that a bronchoscopy or central line placement is not major surgery. Anytime anesthesia is administered there is a risk. What is the threshold for that risk?	The assessor should use clinical judgment to determine, for each resident, what the risk to the resident's life or potential for severe disability would be depending on the patient's/resident's particular situation. If the provider is unsure how to answer this for a particular patient/resident, then the clinician should consult with the physician.

#	Topic	Question	Response
113	Sections A, I, J, and O	We have a resident who had a hip fracture with open reduction internal fixation, was admitted to the facility and stayed 7 days before being readmitted to the hospital for a stroke. I would not be able to count the open reduction internal fixation surgery when the resident is readmitted to my SNF, correct?	In this instance, the SNF Part A stay would be considered a new SNF Part A stay. As long as the surgery qualifies as major surgery (that is, the resident was inpatient in an acute care hospital for at least one day within the last 30 days prior to admission to the SNF, and the surgery carried some degree of risk to the resident's life or the potential for severe disability), and occurred within 30 days of the start date of new Medicare Part A stay (as documented in A2400B), you would be able to code it in J2100. If the surgery was more than 30 days prior to the start date of the new Medicare Part A stay (as documented in A2400B), you would not be able to code it in J2100.
114	Sections A, I, J, and O	Is the interrupted stay a policy or an optional practice?	The interrupted stay is a SNF PPS Part A policy. The IPA is what is optional under SNF Part A PPS.
115	Sections A, I, J, and O	A J2100 resident has major surgery, goes home for a few days, develops an infection, and goes back to hospital. The resident during this hospital stay does not have another major surgery. Therefore, the major surgery was within 30 days of the first admission but was not "during the inpatient hospital stay that immediately preceded the resident's Part A admission" (i.e., the second admission). How do you code J2100 for the second admission?	If a resident is admitted to the facility, is qualified for skilled care under Part A, and the surgery qualifies as major surgery which occurred within 30 days of the date of the start of the Medicare Part A stay (as documented in A2400B), J2100 would be coded as 1. Yes. If the major surgery did not occur within 30 days of the date of the start of the Medicare Part A stay (as documented in A2400B), J2100 would be coded as 0. No. This is regardless of whether or not there was a subsequent hospital stay in-between the first Medicare Part A Stay where there was a major surgery, and the second Medicare Part A Stay, where there was no major surgery performed. The deciding factor is if the major surgery occurred 30 days prior to the start date of the Medicare Part A Stay as documented in A2400B.
116	Sections A, I, J, and O	Regarding the fall and fracture example that mentions needing modification due to the error coding of fall and fracture: Another X-ray was done after the ARD had passed, so can we do a modification of OBRA assessment or do another OBRA MDS assessment?	Even though the X-ray was completed after the ARD, the injury itself occurred during the assessment window of the submitted quarterly assessment, therefore a modification is appropriate. There would be no need to complete another OBRA assessment in this situation unless there was a significant change in status.

#	Topic	Question	Response
117	Sections A, I, J, and O	What is the difference between the LOA and Interrupted stay? When a resident leaves the facility to the hospital but was under observation only and returned back to the SNF after 24 hours, will this be an LOA (skip day) or an interrupted stay?	In the example provided, if a resident leaves the facility and returns after 24 hours it would not be considered an LOA. A LOA occurs when a resident has a temporary home visit of at least 1 night, therapeutic leave of at least 1 night, or hospital observation stay of ***less than*** 24 hours and the hospital does not admit the resident. If the resident was in the facility under a Part A stay and left the facility but returned to the same SNF to resume Part A after 24 hours but within the 3-day interruption window, this would be considered an interrupted stay. Since in the example provided, the resident returned more than 24 hours later, the midnight rule would also apply. Therefore, the day preceding the midnight on which the resident was absent from the SNF is not a covered Part A day. For example, if the resident goes to the emergency room at 10:00 pm Wednesday, Day 22 of his Part A stay, and returns at 11:00 pm the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes Day 22 of his Part A stay. More information can be found in the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf). Refer to page 2-13 for the LOA definition, page 2-11 for interrupted stays, and page 2-50 for the midnight rule.
118	Sections A, I, J, and O	On what assessment would you code A0310G1? Is this a SNF Part A interrupted stay? The entry?	A0310G1 is active on the Comprehensive (Entry), Quarterly, PPS Assessments (NH and Swing Bed), and OBRA Discharge.
119	Sections A, I, J, and O	A surveyor at a facility states that Section GG items should have been signed off on Z0400 on either Day 1, 2 or 3. MDS Coordinator signed off on Day 5 after collaborating and reviewing documentation from the first 3 days. Unlike interviews, GG Items require supporting documentation. Please clarify.	According to the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf) coding instructions for item Z0400: 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. There would be no reason for the MDS Coordinator to sign at Z0400 unless it was the MDS Coordinator who completed the Section GG items.

#	Topic	Question	Response
120	Sections A, I, J, and O	Last week a rep of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) team noted they have not yet spoken to CMS to target items for PEPPER going forward from October 1, 2019, and PDPM. RUGs are nearly half of the current target areas. Is this conversation happening soon?	CMS has discussed changes in the PEPPER report with the teams responsible for PEPPER development.
121	Sections A, I, J, and O	Can skilled therapy and restorative programming be congruent with each other? Under the new regulation will restorative be reimbursed during a Part A stay that had active skilled therapy being performed?	A registered nurse (RN) or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies and O0425, Part A Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in SLP and Audiology Services item O0400A or O0425A, Occupational Therapy (OT) item O0400B or O0425B, and Physical Therapy (PT) item O0400C or O0425C.
122	Sections A, I, J, and O	If a resident is discharged to acute care and is not admitted but placed in observation status and returns within the 3 days, is this considered an interrupted stay?	An interrupted stay occurs when a resident under a Part A stay is discharged from Part A (either remains in the facility or is physically discharged) and resumes Part A or returns to resume Part A (if physically discharged) in the same SNF within the 3-day interruption window. Observation status has no bearing on the interrupted stay policy. More information on interrupted stay policy can be found on pages 2-11 and A-36 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).

#	Topic	Question	Response
123	Sections A, I, J, and O	If the resident discharges to another SNF but returns within the 3 days, would this fall under the interrupted stay policy, or would the facility have to start with a new 5-Day?	Yes, this situation falls under the interrupted stay policy. More information on interrupted stay policy can be found on pages 2-11 and A-36, the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
124	Sections A, I, J, and O	Is there an expectation that Items I0020 and I0020B correlate?	Yes. In I0020, enter the code that represents the primary medical condition that resulted in the resident's admission to the SNF Part A stay and enter the ICD Code for that condition in I0020B. Additional active diagnoses are captured in Section I0100 through I8000, Active Diagnoses in the Last 7 Days. Coding instructions for Section I can be found on pages I-1 through I-15 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
125	Sections A, I, J, and O	Where should we code cancer?	We interpret this question to be related to the coding of I0020. Indicate the Resident's Primary Medical Condition Category. Cancer would be coded in Code 13, Medically Complex Conditions. Additionally, Item I0100 is an Active Diagnoses in the Last 7 Days checkbox for cancer. Coding instructions for Section I can be found on pages I-1 through I-15 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
126	Sections A, I, J, and O	In scenario 4, the resident is not admitted to the SNF for the stroke, but for the sequela of the stroke (hemiplegia, dysphasia, etc.). Stroke is not why they are receiving skilled care.	Item I0020 is not asking why the resident is receiving skilled care in the facility. It is asking for the diagnosis that best represents the primary medical condition that resulted in the resident's admission to the SNF. Therefore, in this example, Code 01, Stroke, is the correct response.
127	Sections A, I, J, and O	Is there anything in PDPM to assure Respiratory Therapists, Physical Therapists, and Occupational Therapists are providing the skilled services and are not just being done by nursing?	Yes. Section O0400 (Therapies) in the RAI Manual documents medically necessary skilled therapy performed by qualified therapists. For more information, refer to Section O0400: Therapies in the RAI Manual starting on page O-15 (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf). In particular, pages O-18 to O-19 provide detailed guidelines of counting therapy minutes.

#	Topic	Question	Response
128	Sections A, I, J, and O	A resident is skilled only for rehabilitation. On Wednesday and Thursday, the resident refuses despite team encouragement. Under PDPM, to continue the Part A stay as an interrupted stay, I assume the resident must participate in at least 15 minutes of therapy on Friday?	No changes occur with regard to coverage criteria as a result of the interrupted stay policy. The resident must still have a continued need for skilled services in order for coverage to continue.
129	Sections A, I, J, and O	So, if a resident has knee surgery outpatient, we cannot count it?	Surgery conducted in an outpatient setting cannot be counted as a major surgery for items J2000, J2100, and J2300–J5000 because major surgery requires a 1-day inpatient hospital stay. Refer to pages J-35 through J-40 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
130	Sections A, I, J, and O	How will Section J account for procedures that have a root operation of repair, which is the Procedure Coding System (PCS) root operation for not elsewhere classifiable type procedures where there is no way in the PCS classification to create the code for the procedure?	The section J items do not use ICD-10 PCS codes.
131	Sections A, I, J, and O	Does inpatient include being admitted to observation stay for coding major surgeries?	No. Patients admitted under observation status are considered outpatients, even though they may stay in the hospital (in the emergency room or in another area of the hospital) for several days and receive treatment in a hospital bed. You are considered an inpatient only when formally admitted to the hospital with a doctor's order. You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, x-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you spend the night at the hospital. A major surgery would not likely occur while a patient is in an observation stay. However, if there was an outpatient surgery and the physician ordered to keep you overnight, you would still be considered an outpatient and Part B would cover physician and hospital services (e.g., surgery, lab tests, fluids). (Source: https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf).

#	Topic	Question	Response
132	Sections A, I, J, and O	If the resident had a fracture repaired by a joint replacement, is it appropriate to code the joint replacement in Section J even though we do not code it as a joint replacement in Section I?	If a resident had a fracture repaired by a joint replacement, the provider would code the joint replacement in both Section J and Section I, as the surgical procedures documented in Section J must have a direct relationship to the SNF diagnosis coded in item I0020B. The primary medical condition coded in Item I0020 is also coded in Section I0100 through I8000, Active Diagnoses in the Last 7 Days. For example, hip fracture repaired by joint replacement would be coded as 10, Fractures and Other Multiple Trauma, in I0020; the appropriate ICD Code would be entered in I0020B; and a checkmark would be placed in item J2310, Hip Replacement.
133	Sections A, I, J, and O	In item I0020, is the primary reason for admission meant to refer to the resident's acute care etiologic diagnosis leading to the SNF stay (I63 category codes – current stroke) or their diagnosis treated in the SNF (I69 category codes – sequela of stroke)?	Item I0020 is asking for the diagnosis that best represents the primary medical condition that resulted in the resident's admission to the SNF, therefore, in this example, Code 01, Stroke, is the correct response and the appropriate ICD-10 Code for the type of stroke would be added in I0020B. Please note that the diagnosis representing the medical condition resulting in SNF admission can differ from the patient's acute care diagnosis.
134	Sections A, I, J, and O	Historically, only documentation in the look-back period can be coded on the MDS. When a fall occurs but no injury is documented until 3 days after, what is the justification? Would this apply to a wound classified as one type on admission but reclassified by a wound care specialist after?	The justification is that the fall occurred during the assessment period. The injury was there, it was just not known at the time the assessment was completed. Once the information was available, the prior assessment was modified to reflect that the injury occurred during that assessment period. No, this does not apply to a wound classified as one type on admission but reclassified by a wound care specialist after. The definition of "on admission" is as close to the time of admission as possible. So, if a skin/wound assessment was done on admission, it is that information that is coded on the MDS. Subsequent skin/wound assessments would be captured on subsequent assessments.

#	Topic	Question	Response
135	Sections A, I, J, and O	Can you explain the statement "even if no documentation exists" further in reference to items J2300–J5000?	For items J2300 to J5000, in order to determine whether a surgery should be coded as requiring active care during the SNF stay, there either has to be specific documentation in the medical record that indicates that the SNF stay is for treatment related to the surgical intervention. In the case that specific documentation does not exist, page J-43 of the RAI Manual instructs that the surgical intervention may be considered as requiring active care during the SNF stay when the complexity of services prescribed can only be performed safely/effectively by or under the general supervision of skilled nursing and/or rehabilitation. Examples provided include surgical wound care, daily skilled rehabilitative therapies, administration of medication and skilled monitoring. Of course, these types of interventions would be documented in the medical record as well.
136	Sections A, I, J, and O	If the resident had a hip replacement at an ambulatory surgical center, but following surgery experienced complications and ended up hospitalized, it is the hospitalization that qualifies the resident for SNF admission but the surgery cannot be coded related to location, correct?	That is correct. J2100 identifies whether the resident had major surgery during the inpatient stay that immediately preceded the admission for the resident's Part A stay, and that meet these criteria: The resident was inpatient in an acute care hospital for at least 1 day in the 30 days prior to the admission to the SNF and start of the Part A stay (as documented in A2400B) and the surgery carried some degree of risk to the resident's life or the potential for severe disability. The surgical procedures in J2300–J5000 are only completed when J2100 = 1, Yes; and the surgical procedures requiring active SNF care were documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under State licensure laws) in the last 30 days and occurred during the inpatient stay that immediately preceded the resident's Part A admission. If the surgery was performed in an ambulatory surgical center, with the resident as an outpatient, rather than while the resident was an inpatient in an acute care hospital, it cannot be captured in J2100 or in J2300–J5000. Refer to pages J-37 through J-40 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
137	Sections A, I, J, and O	What documentation is required for therapy sessions? Is "time in" and "time out" required on daily notes, or just total amount of time?	There is no specific requirement to log the time in and out of therapy sessions, although facilities may have other requirements based on their written policies/procedures.

#	Topic	Question	Response
138	Sections A, I, J, and O	Section J prior surgery "immediately preceded the resident's Part A admission." If a resident has had multiple acute care admissions (no surgery occurred) after an initial acute stay for surgery (in the last 30 days) and continues requiring active care related to surgery is this coded Yes or No?	In this scenario, if the resident had multiple acute care admissions, and there was no interrupted stay, it would only be the most recent admission to the SNF for the start of the Part A stay (as documented in A2400B) that would be used to determine whether or not the major surgery that had originally occurred during the initial acute care stay can be coded in J2100. If the major surgery that occurred in the initial acute care hospital stay of at least 1 day, was within 30 days prior to the SNF admission for the current Medicare Part A stay (as documented in A2400B), then it can be coded in J2100; if it occurred more than 30 days from the start date of the most recent Medicare Part A stay (as documented in A2400B), then it cannot be coded in J2100.
139	Sections A, I, J, and O	How does the interrupted stay impact Medicare certification and Notice of Medicare Non-Coverage (NOMNC)?	The certification/recertification, Advance Beneficiary Notice of Noncoverage (ABN), NOMNC, etc., processes have not changed under PDPM. Refer to page 37 of the PDPM FAQ document for more information about interrupted stays, NOMNC, and ABN (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip).
140	Sections A, I, J, and O	Are therapy evaluation minutes counted?	No. As with RUG-IV, the therapy evaluation minutes are not counted. Time spent on documentation or the initial assessment is not included in the minute count. However, subsequent reevaluations, conducted as part of the treatment process, should be counted. Refer to page O-18 of the RAI Manual for more detail (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
141	Sections A, I, J, and O	Why wouldn't the craniotomy example be a Traumatic Brain Injury?	For the practice scenario example, a different diagnosis was used. The diagnosis and ICD-10 codes listed in the examples are indicative of potential ICD-10 codes that could be used for the particular example.
142	Sections A, I, J, and O	Is the new RAI going to have a definition for "Immediately Preceding Current SNF Stay" for the Major Surgery Section?	The RAI Manual provides the definition for "immediately preceding current SNF stay" that was provided in both the Changes in the RAI Manual and Item Set and Sections A, I, J, and O presentations. This language provides the guidance that "Immediately preceding" means the 30 days prior to the admission to the SNF, meaning the start of the Part A Stay. The start date of the Part A stay is documented in A2400B, so surgeries that occur in the 30 days prior to the date in A2400B would be coded as long as the surgery conforms to the definition of "major surgery" as defined in the RAI Manual. Please refer to the Item Rationale and Coding Tips sections of item J2100 in the MDS RAI Manual v1.17.1, located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

#	Topic	Question	Response
143	Sections A, I, J, and O	I see therapy minutes are also on the 5-Day MDS. Is that correct?	Yes. Item O0400 remains on the 5-Day. Refer to page O-14 of the RAI Manual for more detail (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
144	Sections A, I, J, and O	Please clarify if intravenous fluids coded in section K will allow look-back into the hospital if within 7-day look-back to qualify for Special Care High after October 1, 2019, for PDPM nursing case mix groups.	No. The PDPM nursing case mix groups use the response entered in the "While a Resident" column, which captures whether or not the specific nutritional approaches were performed while the resident was a resident of the facility and within the last 7 days, so it does not reach back into the prior stay. Refer to the coding instructions for item K0510A on page K-10 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
145	Sections A, I, J, and O	Is it still necessary to add the co-treatment minutes in the individual minutes total since there is not calculation for a RUG-IV code?	Co-treatment minutes are counted with individual minutes because each type of therapist is providing individual treatment to one resident, but at the same time. Therefore, the minutes provided in the co-treatment session for each discipline are added together and then added to the individual therapy minutes for that particular discipline. Refer to the definition of co-treatment minutes on page O-21 and to an example of individual and co-treatment therapy minutes calculation on page O-28 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
146	Sections A, I, J, and O	It was mentioned that therapy can be given outside the facility too—can you please elaborate on that?	This statement is consistent with language describing the provision of skilled services under Medicare. For example, this situation might occur if a resident needed aquatic therapy and the SNF did not have a pool, so the patient was taken to a facility with a pool.
147	Sections A, I, J, and O	Since Section O0425 will be added to the Discharge Assessment to track rehabilitation intervention, can you comment on when Section O0400 will be removed from the 5-Day MDS?	Section O0400 will remain on the 5-Day MDS for the time being. Refer to page O-14 of the RAI Manual for more detail (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
148	Sections A, I, J, and O	Why was the acceptable percentage of group and concurrent therapy set at 25 percent when current levels are 1–2 percent? Is CMS encouraging group and concurrent therapy?	This information can be found in the FY19 SNF PPS Final Rule under section E. Revisions to Therapy Provision Policies Under the SNF PPS, located at https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.

#	Topic	Question	Response
149	Sections A, I, J, and O	Previously we were not allowed to bill for therapy on the date of discharge from the facility; has this changed?	No, the day of discharge from the facility is still a non-covered day. Generally, the day of discharge, death, or a day on which a patient begins a LOA is not counted as a utilization day and cannot be billed. Please refer to section 40.3.5 of the Claims Processing Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf.
150	Sections A, I, J, and O	Are we counting less than 15 minutes as a therapy treatment in co- treatments?	For co-treatment you count the total minutes without adjustment. Refer to co-treatment minutes coding guidance on page O-17 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
151	Sections A, I, J, and O	Should the ICD-10 code in I0020B also be documented in I8000A-J to be captured for nursing, NTA, or SLP comorbidities (if applicable)?	Yes, if applicable.
152	Sections A, I, J, and O	Section I: If we have a list of previous diagnoses from a prior stay and diagnoses are in our computer system, should those remain and just not code them on MDS?	Diagnoses should only be coded in Section I of the MDS if they are active diagnoses per the definition in the RAI Manual. Refer to Section I: Active Diagnoses in the Last 7 Days coding guidance on page I -7 of the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
153	Sections A, I, J, and O	Would an IPA be required if speech therapy was to end prior to PT and OT ending?	The IPA is an optional assessment, completion of which is at the discretion of the provider.
154	Sections A, I, J, and O	In relation to distinct calendar days, according to the scenario example, there would be no skilled service provided. It was only 4 days of therapy. Skilled services should be 5–7 days. Am I seeing this wrong? Please clarify.	Per Chapter 8 of the Medicare Benefit Policy Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf), skilled nursing services **or** skilled rehabilitation services (**or a combination** of these services) must be needed and provided on a "daily basis"—i.e., on essentially a 7-days-a-week basis. A resident whose stay is based **solely** on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least 5 days a week. In this instance, if therapy services are provided less than 5 days a week, the "daily" requirement would not be met. It is not mentioned in the example, but the stay was not necessarily solely for skilled rehabilitation services; additional skilled services could have been provided under nursing. Furthermore, Item O0430. Distinct Calendar Days only counts calendar days of rehabilitation therapy (i.e., OT, PT, or SLP) and does not include skilled nursing services.

#	Topic	Question	Response
155	Section GG	If a resident is re-hospitalized before 3 days of admission and comes back to a SNF before 3 nights, what is the look-back for GG, and are the 3 days counted as skipped days?	We assume that the question is related to the provider having started but not yet completed the 5-Day assessment. Regarding the functional assessment, the days that the facility has functional data available either before or after the interrupted stay that adds up to 3 days of data would be used to code Section GG. For example, if a resident was admitted on Day 1 but left partly through Day 2, was gone from the facility on Day 3, and returned partly through Day 4, you would use any functional assessment data from Day 1, half of Day 2, half of Day 4, and Day 5 to code Section GG. In terms of "skipped" days, the midnight rule would be in effect, and providers should follow this policy as described in Section 2.12 Factors Impacting SNF PPS Assessment Scheduling on page 2-50 in the Resident Assessment Instrument (RAI) Manual, located at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
156	Section GG	In Section GG, Picking up object—can that item be assessed for a resident sitting in a wheelchair or do they have to be in a standing position?	GG0170P. Picking up object assesses a resident's ability to bend/stoop from a standing position to pick up a small object such as a spoon from the floor and must be assessed while the resident is in a standing position. If the resident is not able to stand, the activity did not occur, and the appropriate activity not attempted code would be used. Please refer to Section GG0170 on page GG-33 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
157	Section GG	Is there a clear definition of "the usual score"?	We interpret this question to be about the definition of "usual performance" in Section GG. Please refer to the definition provided in Section GG of the RAI Manual, located at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf: "A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance."

#	Topic	Question	Response
158	Section GG	Can therapy students and aides participate in Section GG charting/documentation/ assessment?	For the purposes of completing Section GG, resident Self-Care and Mobility performance is based on direct observation, incorporating resident self-reports and reports from qualified 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 qualified clinicians is involved in assessing the resident during the 3-day assessment period. Qualified clinicians are healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations. Please see Steps for Assessment in Section GG0130 on page GG-10 of the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
159	Section GG	IPA is not used for QMs?	That is correct. The IPA is used for payment only.
160	Section GG	Does the language of completing GG before the resident benefits from therapy interventions mean that GG should be completed before therapy begins?	If treatment has started, for example, on the day of admission, an admission functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
161	Section GG	Besides a car simulator or a real car, is there any other way to do car transfer training?	According to page GG-51 of the MDS RAI Manual v.1.17.1 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html), for item GG0170G. Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half- or full-size cars would need to have similar physical features of a real car for the purpose of simulating a car transfer—that is, a car seat within a car cabin.
162	Section GG	Did I hear that agency nursing or contracted nurses/therapy could not be counted as the helper when coding?	For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). It does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

#	Topic	Question	Response
163	Section GG	Will the videos on Section GG be available for providers to use for further training purposes?	The presentation with videos embedded in the PowerPoint are available in the Downloads section of the SNF QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html. Additionally, videos are available as standalone video tutorials on the CMS YouTube Channel and have also been embedded in a web-based training that can be accessed from the SNF QRP Training webpage.
164	Section GG	All GG examples in the RAI are conducted by the nurse. Is there any reason a therapist could not complete this assessment with interview and other information from nursing care staff with resident and family interview?	The examples in the RAI Manual are not meant to be all-inclusive of every type of circumstance or staff member(s) involved. They are meant to assist the provider in determining the correct response code for the scenario provided. CMS does expect that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the 3-day assessment period using direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family. This information should also be documented in the resident's medical record during the 3-day assessment period.
165	Section GG	Does Section GG information gathered by certified nursing assistants and nurses stop once therapy is started or does it continue throughout all 3 days, even if therapy has started in first 3 days?	Assessments in Section GG for Self-Care or Mobility performance is based on direct observation as well as the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the 3-day assessment period. CMS expects that an interdisciplinary team of qualified clinicians is involved in this assessment throughout the 3-day assessment period. Ideally, function should be assessed before it is affected by therapy, but if some of the functions are addressed by therapy, they can be assessed after therapy has started. Treatment should not be withheld in order to conduct the functional assessment.
166	Section GG	What supporting documentation will be required for Section GG?	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. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

#	Topic	Question	Response
167	Section GG	The process QM application admission and discharge functional assessment and care plan (NQF#3621) uses incomplete stays in the numerator. Would GG need to be coded on all PPS stays including incomplete stays in order to capture those residents for that measure?	Table 7-3 on page 47 of the SNF QM User's Manual Version 3.0 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf) states the following: For incomplete Medicare Part A SNF Stays (incomplete = [1]) in the denominator, collection of discharge functional status might not be feasible. Therefore, two criteria are required for inclusion in the numerator: (i) complete admission functional assessment data on the PPS 5-Day assessment, and (ii) a discharge goal for at least one self-care or mobility item on the PPS 5-Day assessment.
168	Section GG	Where does a cane get coded in GG0110?	Prior device use is included on the MDS because it is a risk adjustor for the functional outcome measures. When the functional outcome measures were developed, testing was conducted regarding whether prior use of a cane or crutches affected either Self-Care or Mobility outcomes. It was found that these devices did not affect functional outcomes. For that reason, CMS did not include these items on the list of devices.
169	Section GG	Can a lift chair recliner be used when assessing sit to stand for GG0170D?	The intent of GG0170D. Sit-to-stand is to determine the resident's ability to come to a standing position from sitting in a chair or on the side of the bed. Clinicians should use clinical judgement to determine if it is appropriate to assess the resident with or without assistive devices. If a resident requires an assistive device (e.g., lift chair) to transfer from sit to stand, then assess the resident's need for assistance to complete the activity.
170	Section GG	What if a resident only sleeps in a recliner or if the recliner lays back flat? Can it be considered a bed?	Please refer to page G-9 of the MDS RAI Manual, located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. The Coding Tips and Special Populations section reads: "Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility."

#	Topic	Question	Response
171	Section GG	There is no option for "unknown" for prior device use (GG0110) if family is unavailable and resident has dementia and is unable to answer. How should we code in this situation? There are occasionally times we honestly don't know what devices, if any, a resident used prior to their hospital stay.	If the resident's usual ability prior to the current illness, exacerbation, or injury is unknown, code GG0100 as 8.
172	Section GG	Our facility does not have a staircase with 12 steps. Can we use our 4-step staircase to assess 12 steps?	The intent of GG0170O, 12 Steps is to observe the resident's ability to go up and down 12 steps safely. If the facility does not have access to 12 stairs to assess the resident's ability for item GG0170O 12 Steps, a simulation of the activity may be used. The combination of climbing and descending 4 stairs consecutively, in this case, is an acceptable alternative to meet the requirements to complete this activity.
173	Section GG	When selecting coding response 05. Setup or clean-up assistance, what constitutes clean-up assistance?	When coding an item 05. Setup or clean-up assistance, a helper sets up or cleans up and the resident completes activity. Using this code indicates that a helper assists only prior to (i.e. setup) or following the activity (i.e., clean-up)), but not during the activity. For further detail and examples, please refer to section GG of the MDS RAI Manual https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html)
174	Section GG	Will the Section GG decision tree video be available for download?	The Section GG video has been posted to the CMS YouTube Page and is available at https://www.youtube.com/watch?v=RKckbxLKWCA. Materials from the August 2019 SNF QRP Provider Trainings are posted in the Downloads section of the SNF QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html.
175	Section GG	If a resident walks 50 feet three times in the same session, should this be counted as 150 feet since breaks are allowed?	For any of the walking items, a resident may take a **brief** standing rest break to catch their breath while walking. However, if the resident needs to sit during the attempt to walk 10, 50 or 150 feet, we would consider that the resident was unable to complete the activity of walking 10, 50 or 150 feet.

#	Topic	Question	Response
176	Section GG	Can you get a decision tree for GG0130 and GG0170 for us that has text on it and is usable?	We interpret your question to be about the Decision Tree for Section GG Self-Care and Mobility data elements. A decision tree is available at the link below to help guide clinicians through the questions they should answer when determining how to code Section GG activities. You will find the Decision Tree in Chapter 3, Section GG of the RAI Manual effective October 1, 2019, as well as the direct link to the Decision Tree available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf.
177	Section GG	If the facility policy is to always use gait belts when going from sit to stand, is it always coded a 03?	No; when coding Sit to Stand, code based on the type and amount of assistance provided. For example, if no more than steadying/touching assistance is provided from one helper, then code Sit to stand 04, Supervision/touching assistance. If more assistance is required Sit to stand could be coded 03, 02, or 01.
178	Section GG	In Florida, only an RN can assess. Does this mean that only an RN can complete the observations required for GG section?	We believe that the questioner is referring to "nursing" assessment. Physical, Occupational and Speech-Language Pathologists can all perform resident assessments within their scope of practice and can participate in the observations of the resident and document their findings related to Section GG. (References: PT: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0486/Sections/0486.021.html, OT: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0468/Sections/0468.203.html, Speech-Language Pathology: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0468/Sections/0468.1125.html.)
179	Section GG	What is an example of the use of a dash?	There are circumstances in which SNFs may not be able to complete every item on the MDS. In these circumstances, refer to the instructions provided in the RAI Manual for these sections and code the item set accordingly. For example, if you are unable to assess the resident and therefore unable to enter a response on the MDS, code the data element with the default response of a dash (–). CMS expects dash use to be a rare occurrence.

#	Topic	Question	Response
180	Section GG	Would eating ice chips be considered as eating for Section GG when all other intake is through a feeding tube?	The intent of GG0130A. Eating is to assess the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Clinicians should use clinical judgement to determine if observing the resident eating ice chips allows the clinician to adequately assess the resident's ability to complete the activity of eating. If the clinician determines that the observation of eating ice chips is adequate, code based on the type and amount of assistance required by the helper. If the clinician is unable to determine the resident's ability to eat, code the appropriate activity not attempted codes.
181	Section GG	How would you code a resident who does not void in a toilet, commode, bedpan or urinal but voids in adult incontinence briefs where the caregiver completes all care for toileting hygiene?	Toileting hygiene includes the following three tasks: managing clothing (undergarments and incontinence briefs) before voiding or a bowel movement, performing perineal cleansing, and managing clothing after voiding or a bowel movement. Toileting hygiene can be assessed if a resident voids in incontinence briefs. Code based on the type and amount of assistance needed to managing clothing (e.g., pulling down pants, taking off incontinence briefs), performing perineal cleansing, and managing clothing (putting on new incontinence briefs, pulling up pants).
182	Section GG	For bed mobility, how is this coded if a resident sleeps on alternate furniture, such as a couch or a recliner?	Please refer to page G-9 of the MDS RAI Manual, located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. The Coding Tips and Special Populations section reads: "Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility."
183	Section GG	Does CMS intend to require all Section GG Discharge Goals to be coded in the future? If so, what is that anticipated implementation date?	At least one Self-Care or Mobility goal must be coded for 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. SNFs are encouraged to code more than one goal in Section GG to reflect multiple Self-Care and Mobility goals based on the resident's care plan in order to best address the needs of the resident. Data collection for this measure began October 1, 2016.

#	Topic	Question	Response
184	Section GG	If the resident you are assessing is in a vegetative state, what goals would you choose since they don't respond and there is no participation?	Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment Self-Care and Mobility status, discussions with the resident and family, professional judgment, the professional's standard of practice, expected treatments, anticipated length of stay, the resident's discharge plan, etc. Goals should be established as part of the resident's care plan. If a resident was not performing any of the activities prior to their current exacerbation, illness or injury, remember that activity not attempted codes may be used to code Discharge Goals.
185	Section GG	During the training on Section GG, there was a slide that stated there are two activities that are not assessed in GG0170E. Can you please clarify what this means?	The statement referred to, "The activities of Sit to lying and Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E," simply means that items GG0170B. Sit to lying, GG0170C. Lying to sitting on side of bed, and GG0170E. Chair/bed-to-chair transfer are three separate functional activities, therefore the resident's performance in Sit to lying and performance in Lying to sitting on side of bed are not considered when coding GG0170E. Item GG0170E. Chair/bed-to-chair transfer begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.
186	Section GG	Many orthopedic physicians want therapy started immediately. How will this affect the 3-day assessment?	If treatment has started, for example, on the day of admission, an admission functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
187	Section GG	Upon readmittance after a week's stay in the hospital, the resident comes back under Medicare Part A. Do we complete Section GG?	We interpret this question to be related to the Interrupted Stay policy. If a resident is discharged from the SNF and does not return to the same SNF within the 3-day interruption window, it is not an interrupted stay. Therefore, a 5-day assessment that includes Section GG is required.
188	Section GG	How does a patient/resident do a curb in a wheelchair? I see this as a safety concern.	Clinicians should use clinical judgement to determine if it is appropriate to assess the resident completing GG0170M. 1 step curb using a wheelchair. Please note that 88. Not attempted due to medical condition or safety concerns is an option when coding section GG items.
189	Section GG	Section GG0170P asks about the resident's ability to bend or stoop from standing to pick up an object. The scenario used a reacher, but they didn't bend or stoop from standing. This confuses me.	GG0170P. Picking up object assesses the resident's ability to bend/stoop from a standing position to pick up a small object such as a spoon from the floor. If a resident does not need any assistance to use a reacher to pick up an object from the floor and the resident was independent in retrieving the object, code GG0170P. Picking up object as 06, Independent. Activities may be completed with or without assistive device(s).

#	Topic	Question	Response
190	Section GG	If the resident is not able to do a car transfer in the first 3 days but they will be able to do one upon discharge, what do you code for the admission assessment?	In the situation where the resident is unable to perform a car transfer in the first 3 days, code admission performance using the appropriate "activity not attempted" code (07, 09, 10, or 88). You may use any of the Section GG codes 01 through 06 to code a discharge goal if you expect that the resident will be able to perform a car transfer upon discharge.
191	Section GG	A resident is working to improve their ambulation. One staff uses contact guard assist while the resident uses her front-wheeled walker. A second staff person is following behind with a wheelchair in case the resident should need to sit/rest but did not provide any assist, as the wheelchair was not actually needed. How is this scenario coded?	In the scenario provided a second person was required to assist. Therefore, Code 01, Dependent because the assistance of two or more helpers is required for the resident to complete the activity. Providers may find the GG Self-Care and Mobility Activities Decision Tree helpful which is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf.
192	Section GG	The IPA doesn't include an opportunity for establishing or editing Section GG goals for discharge. These "goals" potentially have cause and effect on the facility's QMs and discharge outcomes of the resident. Can CMS explain what the reason is behind the IPA not including these items?	The IPA is solely related to the PDPM and has no bearing on the SNF QRP Functional Outcome Measures.
193	Section GG	How does the certification and recertification process reflect the changes related to PDPM?	The certification/recertification processes have not changed under the PDPM.
194	Section GG	Do we need a GG Discharge Goal to be coded if the resident expired when doing a 5-Day assessment?	If the resident dies during the 5-Day assessment period, a minimum of one self-care or discharge goal is required. Clinicians should use clinical judgement and code the goal based on the resident's planned stay at the time of admission.
195	Section GG	For Section GG does CMS expect to see a signature attesting to accuracy on Day 3, after Day 3, or when the MDS is completed? Or would any of those be acceptable?	Per the RAI Manual, all staff who completed any part of the MDS must enter their signatures, titles, sections or portions of sections they completed and the date they were completed. So, in this example, the person who completed the item(s) in Section GG is the person who should sign at Z0400 with the date(s) that the item(s) were completed.

#	Topic	Question	Response
196	PDPM	For Minimum Data Set (MDS) items I0020B and J2100–J5000, could these change from what was recorded on the initial assessment with the completion of an IPA?	Yes, the IPA may be completed to capture changes in the resident's status and condition. Please refer to Unscheduled PPS Assessments on page 2-43 of the RAI manual, located at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
197	PDPM	If the resident's BIMS interview was not done on or prior to the ARD, will the staff assessment be allowed in order to complete the 5-Day assessment for a HIPPS code?	Because a PDPM cognitive level is used in the SLP payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident **when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS**. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status. For a description of when the staff assessment can be completed in lieu of the resident interview, please refer to the Coding Tips for C0100 in the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
198	PDPM	If a staff assessment is allowed, will there be allowance for completion after the ARD in the event of unplanned discharges, especially late in day discharges?	Per the coding tip for C0100 in the RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf): "Because a PDPM cognitive level is utilized in the SLP payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status." The staff assessment may be completed after the ARD when there is an unplanned discharge but should be completed as timely as possible to ensure the accuracy of the information about the resident.
199	PDPM	Where do we find the payment estimators for PDPM so that we can compare our RUGs payment to the projected PDPM payments?	The final version of the PDPM Grouper DLL has been posted along with the source code on the MDS 3.0 Technical Information webpage at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

#	Topic	Question	Response
200	PDPM	Why is congestive heart failure not placed in the diagnosis list	We interpret this question to be related to the Primary Medical Condition Categories in item I0020. Congestive heart failure would be coded under Code 12, Debility, Cardiorespiratory Conditions, per the Coding Instructions for I0020 in Section I of the RAI Manual, located at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. Additionally, the diagnosis can be recorded under I0600 for Active Diagnoses in the Last 7 Days.
201	PDPM	Will the claim format need to be changed for Medicare or will the PDPM feed into the current claims?	PDPM makes no changes in the SNF claim form itself, but it makes changes to certain policies related to the SNF claim (e.g., interrupted stay, which will be indicated on the claim in the same way as a LOA). Please see the PDPM FAQs (revised August 27, 2019) for more information: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip.
202	PDPM	Does the MDS diagnostic information need to correlate to the claim form?	CMS expects that these diagnoses should match. There is no claims edit that will enforce such a requirement. Please refer to the PDPM FAQs (revised August 27, 2019) for more information: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip.
203	PDPM	How will private insurance and MA plans be affected by PDPM?	For details on how private insurance and MA plans are impacted by PDPM, questions should be directed to the private insurance and MA plan sponsors.
204	PDPM	Please discuss the difference between nursing vs. therapy doing the functional assessment and how this can potentially affect payment under PDPM.	The functional assessment factors into payment in the same way, regardless of which type of qualified clinician assesses the resident. Qualified clinicians are defined as healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations. Please see Section GG, GG0130, Steps for Assessment in the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
205	PDPM	How will CMS interpret modifications of Admission/5-Day once PDPM goes into effect, especially if the case mix is higher with the modified assessment?	As with any assessment, the assessment should be an accurate representation of the resident, regardless of the impact on payment. There may be implications if such modifications are noticed to be frequent on the part of providers.

#	Topic	Question	Response
206	PDPM	Will the Medicare Claims Processing Manual Chapter 6 be updated to reflect all the changes that take effect on October 1, 2019? I believe that we (especially our billers) need specific guidance on how to accurately complete the Medicare claims with the implementation of PDPM.	Yes, Chapter 6 of the Medicare Claims Processing Manual was revised (October 4, 2019) to reflect changes due to PDPM, and can be accessed at the following link: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf.
207	PDPM	Do I get a point/points on the NTA tab of the Excel diagnosis mapping spreadsheet if the diagnosis of my resident is not found in the NTA diagnosis mapping tab?	No, the ICD-10 code must be found in the mapping in order for the comorbidity to be included in the resident's NTA comorbidity score.
208	PDPM	If neither the BIMS nor the Cognitive Performance Scale is completed/assessed, and the resident is not classified under PDPM with no HIPPS code for the assessment, what will display in Z0100? What are payment implications?	If neither is completed, then the resident will be considered cognitively intact for the purposes of calculating the SLP component of the PDPM HIPPS code. Please refer to the PDPM FAQs, located at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip.
209	PDPM	Will a significant change still impact payment during a PPS stay?	There is no longer a Significant Change in Status assessment, but a significant change in the resident's status can be captured by completing an IPA, at the discretion of the provider, which would change the PPS payment for the rest of the Part A stay. Please refer to Unscheduled PPS Assessments on page 2-43 of the RAI manual, located at https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
210	PDPM	As the PDPM classification walkthrough is updated, can changes be highlighted or bolded to easily determine the updated content?	Yes, CMS provides change tables and "red-lined" versions to identify the edits and updates that have occurred.

#	Topic	Question	Response
211	PDPM	Many PDPM training companies are stating that facility must have policy outlining when to complete the IPA and facility will be monitored for following that policy, but that isn't what it sounds like during the presentation.	Providers can choose to create written policies around when an IPA would be completed, but this assessment is optional and entirely at the discretion of the provider. CMS is not requiring providers to create such policies. Please refer to the Interim Payment Assessment guidance on page 2-46 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
212	PDPM	How does the Interrupted Stay affect the Medicare Certification? Would the current certification continue if within 3 days or would a new certification be required?	The certification and recertification policies have not changed under the PDPM. For more information on interrupted stay policy and Medicare physician certification, please refer to the PDPM FAQs document: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip.
213	PDPM	Under the new PDPM system, if an ARD is not set during Days 1–8 of the Medicare A stay and the resident returns to the hospital, can the ARD be set and the MDS completed? How would the MDS is opened and the ARD set? Would it be provider liable or a default rate?	PDPM makes no changes in the requirement to have the ARD set prior to the end of the ARD window. Per Chapter 6 of the MDS RAI Manual, if the provider fails to set the ARD on the assessment before the end of the resident's Medicare stay, then this would be considered a missed assessment and provider liability would occur. Please see Missed PPS Assessment in Chapter 2 of the RAI manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
214	PDPM	Section K items removed can still be collected on a State-by-State basis correct? This is a case-mix calculation in certain States.	Items removed from Federal assessments that are used for legacy payment purposes can be collected through the OSA.
215	PDPM	Will OBRA assessment still produce RUGs III and IV? If so, how long will CMS support RUGs?	CMS expects that OBRA assessments will continue to support RUG-III/IV calculations until October 2020, at which point the OSA will be necessary for calculating payment codes for these legacy systems. Please see the PDPM FAQ (last revised August 27, 2019) for more information: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html#faq.
216	PDPM	Will Certified Occupational Therapy Assistants and Physical Therapy Assistants still be allowed to be used?	Yes.

#	Topic	Question	Response
217	PDPM	A resident in a Medicare Part A stay was in the facility prior to October 1 and was discharged to the hospital (admitted) on September 30. The resident returned on October 1 (not out for 3 days). On return, an OBRA Discharge & Re-entry is due. Is PPS discharge also due since the resident left on the 30th, or would that depend on the actual time of admission to the hospital (i.e., admitted at 11 p.m. on September 30 vs. 1 a.m. on October 1)? Is an IPA due or optional in this situation?	FY2019 SNF Final rule states: "… about a patient that begins a stay under RUG-IV but ends under PDPM, given that there will be no transition period between RUG-IV and PDPM, providers would bill under RUG-IV for all days up to and including September 30, 2019 and then bill under PDPM for all days beginning October 1, 2019. Further, RUG-IV assessment scheduling and other RUG-IV payment-related policies would be in effect until September 30, 2019. Beginning on October 1, 2019, all PDPM related assessment scheduling and other PDPM payment-related policies would take effect." If the resident is discharged and admitted to the hospital on September 30, then the resident would be under RUG-IV, but when the resident returns on October 1, he/she would be admitted under PDPM. This resident would require a PPS 5-Day assessment and payment would begin as of the admission date (October 1).
218	PDPM	PDPM: Please explain the Diagnosis Excel Mapping. On the NTA tab, do we get a NTA point if the resident diagnosis is not listed on the NTA tab?	No; the ICD-10 code must be found on the mapping in order for the comorbidity to be included in the resident's NTA comorbidity score.
219	PDPM	Is Section G going away?	As of October 1, 2020, Section G will no longer be collected on the MDS item sets.
220	PDPM	In the Section O practice coding scenario, were we to assume PT and OT were delivered 5 days per week? If so, would suggest providing that info in the scenario info.	No. The O0425 Practice Scenario provided the date range and number of sessions for the different modes of therapy for each therapy type that was needed to complete the exercise. For example, under SLP, 6 sessions were received over a 9-day period (October 6–14) for 45 minutes each session. These sessions each qualified for 1 day of therapy and could have been completed on any number of different days during that 9-day period. For OT, the date ranges were October 7–19. Starting on October 8, individual daily sessions of 30 minutes each were provided for ADL activities—this would have occurred every day over the 12 days that OT was provided. OT group therapy occurred in 10 sessions for 20 minutes each session. These could have occurred on any number of different days during the 10 different sessions over the 12 days that OT was provided, and so on.

#	Topic	Question	Response
221	PDPM	Several Medicare Administrative Contractors are doing Targeted Probe and Educate prepayment reviews on Ultra-High Rehab/Very-High Rehab RUGs. There are supposed to be up to 3 rounds. What will happen to those once there are no more Ultra-High Rehab/Very-High Rehabs?	The Medical Review strategy being used by the Medicare Administrative Contractors is still under development.
222	PDPM	How will providers receive the add-on in the NTA co-morbidity score component if we can't code human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) on the MDS?	As under RUG-IV, this HIV/AIDS adjustment will be accomplished in the Pricer if the ICD-10 code B20 is present on the submitted SNF claim. Refer to 83 FR. 39221 of the FY2019 SNF PPS Final Rule (https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf).
223	PDPM	What is the rationale for the nursing adjustment factor for residents with AIDS?	The rationale for this adjustment is provided in the FY2019 SNF PPS Final Rule. Refer to 83 FR. 39218 at https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf.
224	PDPM	Why did CMS use cost reports for 1995 to create payment groups? Was cost adjusted for cost in 2019?	Per the Social Security Act, CMS is required to use cost reports from 1995 as the base for the SNF PPS. The base rates are updated for inflation to the first effective period of the PPS. Refer to the FY2019 SNF PPS Final Rule under section B. Revisions to SNF PPS Federal Base Payment Rate Components (https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf).
225	PDPM	Does CMS believe that many facilities have software to calculate the ICD-10 code? I am not sure that is true, as it is costly and does not always follow all the coding guidelines for ICD-10.	The ICD-10 code is not calculated by software, but rather identified by the clinician after evaluating the resident.
226	PDPM	Under PDPM, how will CMS prevent facilities from selecting diagnosis codes based on higher payment vs. the reason they are requiring placement in the facility?	We expect facilities to use diagnosis codes that will match the resident's condition as indicated with robust documentation. If medical reviewers find that this is not the case, they will take necessary action. CMS will closely monitor coding practices and may take administrative action if specific adverse behaviors are identified. Refer to the FY2019 SNF PPS Final Rule at 83 FR 39186 (https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf).

#	Topic	Question	Response
227	PDPM	Please give some guidance for long term residents that have a current admitting diagnosis of Alzheimer's dementia that have a skilled stay and return back to the facility on Medicare Part A. Would the I0020 diagnosis be the original admitting diagnosis or would it be the current primary diagnosis that caused the hospitalization?	The diagnosis in I0020 should identify the resident's primary medical condition from the inpatient hospital stay that immediately preceded the resident's Part A admission that resulted in the resident's Part A admission to the SNF. This is the primary reason for the Medicare Part A skilled nursing facility stay, not the hospitalization. It does not need to be the original admitting diagnosis.
228	PDPM	I am assuming a physician or a physician extender to specify a reference to opportunistic infection and/or immunosuppressive. How do you capture this to get the NTA points since there is no corresponding ICD10 code to reflect this issue	Only those NTA-related conditions and services outlined in Table 16 of the RAI Manual as being related to the NTA component would provide the relevant number of points for the resident's NTA comorbidity score. Any items that do not use an ICD-10 code may be checked off on the MDS. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.
229	PDPM	Several years ago, when changes were made to payment system that did not turn out to be budget-neutral, rates were adjusted in the middle of the fiscal year. What is the plan to evaluate the impact of PDPM and how soon could we expect there to be revisions?	Payment rate adjustments are only made in the beginning of a fiscal year. CMS will evaluate PDPM once implemented and make adjustments as necessary to ensure budget neutrality.
230	PDPM	Am I correct to assume that the SCSA will not affect payment during the Part A stay?	Yes, that is correct.
231	PDPM	The assessment window for Section GG for optional IPAs is the ARD and 2 days prior, right?	Yes, that is correct.

#	Topic	Question	Response
232	PDPM	If you don't do an IPA when a resident improves, will Medicare auditors (Medicare Administrative Contractors, Recovery Audit Program) retroactively determine the end of skilled care services, reasonable and necessary, and eventually carve out days? How do we teach skilled care needs on a daily basis and when to cut Medicare? What about the risks related to length of stay?	PDPM makes no changes in SNF coverage criteria. Completion of an IPA is at the sole discretion of the provider and would be reflective of a change in the resident's condition and needs.
233	PDPM	Since section O0425 will track therapy minutes with the Discharge Assessment, when will the Therapy sections in O0400 be discontinued?	There is no plan at this time to remove O0400 from any of the item sets.
234	PDPM	With the inclusion of NTA allowing for higher reimbursement for high-cost medications, will that eliminate the need for carve-out requests?	No, providers should still consider and submit recommendations for exclusions from consolidated billing.
235	PDPM	For an interrupted stay, does the count to the next decrease in payment of 2 percent stop and restart upon return or continue every 7 days with no break in the 7-day count?	In an interrupted stay, the variable per diem schedule continues from the point just prior to discharge. Refer to Chapter 6 of the RAI Manual for more information on interrupted stays and variable per diem schedule (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
236	PDPM	What do you do with observation stays and interrupted stay?	The interrupted stay policy applies regardless of the reason for the resident's discharge from a Part A covered stay, including observation stays.
237	PDPM	If there is an interrupted stay, how does it impact therapy? Does therapy need to redo the evaluation or continue with previous plan of care?	Facilities should make this decision based on a resident's clinical condition. If they feel that the reason for the interrupted stay or the interrupted stay itself justifies the need for another therapy evaluation, then another therapy evaluation should be conducted. As always, all should be documented.

#	Topic	Question	Response
238	PDPM	With the new PDPM model will there be a decreased need for MDS staff? For example, in a 120-bed facility, we have 1 MDS Coordinator and 1 MDS assistant. Will the MDS assistant still be needed?	This decision should be made by individual facilities.
239	PDPM	Do we need to do an OBRA Discharge assessment and Entry Tracking on interrupted stay when the resident leaves the facility?	Yes, that is correct.
240	PDPM	It appears that in PDPM there is no longer a Provider Liable status, just Default, correct? If a resident leaves the facility (for example, on Day 4) prior to the setting of the ARD, would the result be "default" because the ARD was not set prior to discharge?	PDPM makes no changes in the requirement to have the ARD set prior to the end of the ARD window. Per Chapter 6 of the MDS RAI Manual, if the provider fails to set the ARD on the assessment before the end of the resident's Medicare stay, then this would be considered a missed assessment and provider liability would occur. Refer to the missed assessment policy in Chapter 6 of the MDS RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
241	PDPM	If a 5-Day assessment ARD was set late and a default rate is in place, could a subsequent IPA be completed to adjust the payment to a higher payment than default?	The IPA is an optional assessment, completion of which is at the discretion of the provider.
242	PDPM	When/where can we expect answers to the questions asked during the training be posted?	A Q&A document including questions asked by participants of both the May and August 2019 SNF QRP Provider Trainings can be accessed on the SNF QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html.
243	PDPM	Will the health maintenance organization companies catch up with PDPM?	This question will have to be addressed to the health maintenance organization companies.
244	PDPM	When are the RUG III/IV States going to start using PDPM?	This question must be directed to each State's Medicaid agency.

#	Topic	Question	Response
245	PDPM	OSA for case-mix, why couldn't we continue to use the OBRA assessments for that payment system?	CMS expects that OBRA assessments will only continue to support RUG-III/IV calculations until October 2020, at which point the OSA will be necessary for calculating payment codes for these legacy systems.
246	PDPM	When needed, is the OSA used during the Part A stay only? Or can it be used at any time, even after the Part A stay?	The OSA is not a PPS assessment. It is only to be used for State payment purposes which are typically Medicaid-covered stays. PPS assessments are used for Part A stays.
247	PDPM	Does NHC generate a RUG-IV score? If it does, what is the benefit of the OSA? Would the primary use of the OSA be used for Change of Therapy, etc.?	The NHC will generate a RUG-IV score but likely only until October of 2020. The purpose of the OSA is to generate a legacy HIPPS code at times outside of the comprehensive windows (e.g., when a Change of Therapy would be necessary) and only for State payment purposes.
248	PDPM	Can you modify a 5-Day/Admission after October 1? If so, how will CMS look at that if the case-mix goes up?	Assessment completion and correction policies do not change as a result of PDPM.
249	PDPM	What about those residents who stay longer than 30 days, and we need to buy a new supply of drugs, do we get that increase in funds again?	No, the NTA component variable per diem schedule does not reset after 30 days.
250	PDPM	PDPM is going to cause significant changes to the managed plans and their audits. Can the managed plan choose to direct facilities to use the OSA for payment RUGs, and just not transmit them?	Please contact your Medicare Advantage plan for information as to what they will require.
251	PDPM	Interrupted stay: 1. If the resident gets admitted to the hospital then returns within the interrupted stay period, is the SNF responsible for the bill during the hospital stay? 2. If the NOMNC and SNF ABN have been served, does it affect the eligibility for interrupted stay?	The SNF is not responsible for hospital services furnished to the resident during the interruption window. The interrupted stay policy is unrelated to the NOMNC and ABN policies. Refer to page 37 of the PDPM FAQ document for more information about interrupted stays, NOMNC, and SNF ABN (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_FAQ_Final_v5.zip).

#	Topic	Question	Response
252	PDPM	If a resident entered the facility and discharged back to the hospital within a day or two before the 5-Day ARD, what assessment should be done and how would that affect payment?	In order to receive payment for any services provided during a Part A stay, a 5-Day assessment would be required.
253	PDPM	Can you please verify that the days involved in the interrupted stay are considered skip days?	The interrupted days are non-billable days.
254	PDPM	Is the IPA mandatory?	The IPA is an optional assessment, completion of which is at the discretion of the provider.
255	PDPM	For the Nursing piece of PDPM, if there is a resident with a Function Score of 12, behaviors, and 2 restorative programs, the case-mix group would be BAB2 (Case Mix Index of 1.04) However, a PBC2 is 1.21 (ADL range is 6–14) which score would the resident get—index maximization, or hierarchal?	Under PDPM, the resident will qualify for one and only one nursing group, which will be calculated by the Grouper software.
256	PDPM	Is the 25 percent concurrent and group limit by discipline or overall?	By discipline.
257	PDPM	With the new guidelines, are they required to receive at least one discipline 5 days a week or just can it be a combination of therapy 5 times a week, such as PT Monday, Wednesday, and Friday, and OT Tuesday and Thursday?	Under PDPM, there is not a required days of treatment per week (thus no End Of Therapy will be required); however, there is still a daily skilled care requirement for SNF Part A residents, as discussed in Chapter 8 of the Medicare Benefit Policy Manual, specifically in Section 30.6 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf).
258	PDPM	In PDPM, will you still be able to combine the 5-Day and OBRA Admission assessment?	Yes. Refer to section 2.10 of the MDS RAI Manual for guidance on combining PPS and OBRA assessments (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).

#	Topic	Question	Response
259	PDPM	Residents have been known to come in on a Friday evening and return to the hospital Saturday morning. On Monday could a 5-Day be done with the discharge with the ARD set up on Monday?	The ARD for the 5-Day assessment must be set for a covered SNF day.
260	PDPM	If a BIMS is missed, would the next step to "fix" that be to complete an IPA as soon as possible to get an actual HIPPS code?	It is up to the provider to ensure that the interviews and other items on the assessment are completed as required in the RAI Manual so that the assessment accurately reflects the resident's condition, and care and services needed based on the observation period of the assessment. Getting into the habit of using a subsequent assessment to rectify a "missed" interview is not advisable.
261	PDPM	A resident comes in under Managed Care and only an OBRA Admission is completed with an ARD set for Day 8. If at a later time we discover they were actually covered under Medicare Part A, will we be able to add a 5-Day and obtain the PDPM HIPPS code?	If the resident has already discharged from the building, then the assessment cannot be completed. As described in Section 2.12 of the RAI Manual https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf, if the SNF fails to set the ARD within the defined ARD window for a 5-Day assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified. The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA. For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 of the Part A stay and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed.
262	PDPM	What role is restorative therapy going to play in PDPM going forward?	Restorative nursing is a grouping classifier for the nursing case-mix groups. The nursing component under PDPM uses the same basic nursing classification structure as RUG-IV, with two modifications: new function scores based on Section GG items and collapsed functional groups. For details on how certain types of services factor into the calculation of a PDPM group, we would recommend reviewing the materials found on the PDPM website, which may be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

#	Topic	Question	Response
263	PDPM	Earlier in training session, I understood a resident with hip fracture who underwent surgical repair by hip replacement; however, during the PDPM calculation case study we were told to select Major joint replacement category. Can this be clarified please?	Under PDPM, hip replacement due to hip fracture is considered under the category of Major Joint Replacement. For more information on PT and OT clinical categories, refer to section 6.6. PDPM Calculation Worksheet for SNFs of the MDS RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
264	Integrated Coding and PDPM Case Study	In working through the case study, it is interesting that all information is therapy-based when this is to be collaborative between therapy and nursing as per RAI manual guidance.	Within the case study narrative, there is nursing, physician, and therapy documentation provided. The case study narrative is not meant to be all-inclusive of every conversation that would likely have occurred throughout the resident stay. This case study exercise was simply meant as an illustration of how to code the MDS and how to use that information to calculate a HIPPS code for PDPM.
265	Integrated Coding and PDPM Case Study	For A2400C in the PDPM Case Study, the discharge date is in the nursing note discharge note.	On the handout provided for the PDPM Case Study, Item A2400C was included for the Admission assessment only. Dashes were appropriate for the Admission assessment. For the Discharge assessment, no item A2400C was included to complete. For this case study, we focused on specific items for completion in both the Admission and Discharge sections; for Discharge, we focused on the completion of Section GG.
266	Integrated Coding and PDPM Case Study	There seems to be confusion. For item J2000 prior surgery, is the surgery to have occurred in the last 100 days or 30 days effective October 1, 2019? All the slides stated “30,” but this case study has 100 days.	J2000. Prior Surgery is an existing item that was effective prior to October 1, 2019. This item identifies whether the resident has had major surgery during the 100 days prior to the start of the Medicare Part A stay. J2100. Recent Surgery requiring active SNF care, which is effective as of October 1, 2019, identifies whether the resident had major surgery during the inpatient stay immediately preceding the start of the Medicare Part A stay (as documented in A2400B). For item J2100, the criteria for major surgery requires that the resident had an inpatient acute care hospital stay for at least 1 day in the 30 days prior to admission to the SNF (for the Part A stay), the surgery must have been performed in the immediately preceding inpatient stay, and the surgery carried some degree of risk to the resident’s life or the potential for severe disability. For item J2000, to qualify for major surgery, the resident had to have been an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the SNF (for the Part A stay), and the surgery carried some degree of risk to the resident’s life or the potential for severe disability.

#	Topic	Question	Response
267	Integrated Coding and PDPM Case Study	If a resident has a knee arthroplasty with direct admit to a nursing home, is this considered major surgery? Would any outpatient surgery with direct admit to a nursing home, have the letter "D" used if required?	The criteria for coding major surgery in items J2100 and J2300 to J5000 is that the resident was inpatient in an acute care hospital for at least 1 day in the 30 days prior to admission to the SNF (for the Part A stay) and the surgery carried some degree of risk to the resident's life or the potential for severe disability. A knee arthroplasty that was done in an outpatient setting with direct admission to a SNF does not qualify as major surgery because it does not meet the criteria as defined. The seventh character in the ICD-10 should be added as applicable. The "D" denotes a subsequent encounter, which describes any encounter after the active phase of treatment, when the resident is receiving routine care for the injury during the period of healing or recovery. (This generally includes rehabilitation therapy.) In the example provided, if a physician referred the resident to a SNF for rehabilitation after arthroplasty, the rehabilitation therapy would be considered part of the healing and recovery phase, so you would code for "subsequent encounter," and assign a "D". Other characters in the seventh position include "A" and "S." Please consult ICD-10 coding resources to determine which characters are appropriate.
268	Integrated Coding and PDPM Case Study	How did the resident in the PDPM Case study get 16 days of therapy if this is the 5-Day assessment?	The 16 days of therapy documented in the PDPM Case Study is related to the completion of Items O0425. Part A therapies, and O0430. Distinct calendar days. These items are only completed on the Part A PPS Discharge assessment and cover the entire Medicare Part A stay.
269	NHC	Please discuss the OSA and how PDPM will affect Medicaid case-mix States?	The OSA contains data elements required to calculate RUG scores and was created in order that Medicaid case-mix States could still generate a RUG score for their case-mix systems as a result of the changes made to PPS in the implementation of the PDPM. Questions related to the OSA and its implementation should be directed to the appropriate State RAI Coordinator. A list of RAI Coordinators can be located in Appendix B of the RAI Manual. This appendix is accessible in the Downloads section of the MDS 3.0 RAI Manual web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. The PDPM has no effect on Medicaid as the PDPM relates to the Medicare Part A prospective payment system.

#	Topic	Question	Response
270	NHC	Will the OSA have to be done at 5, 14, 30 days, etc.?	States are responsible for determining how they implement the OSA. Each State's Medicaid case-mix is different, so implementation may be different for each State. Questions related to the OSA should be directed to the appropriate State RAI Coordinator. A list of RAI Coordinators can be located in Appendix B of the RAI Manual. This appendix is accessible in the Downloads section of the MDS 3.0 RAI Manual web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
271	NHC	If an OSA is used for State case-mix calculations, will a separate assessment (MDS version v1.17.0) be required to fulfill the quarterly OBRA requirement?	The OSA allows for collection of data required for the calculation of RUGs for the purposes of State Medicaid case-mix reimbursement. The OSA does not affect OBRA assessment completion requirements. It is a standalone assessment and cannot be combined with any other type of assessment.
272	NHC	Can the OSA assessments be transmitted to QIES ASAP?	Providers will submit OSA records to the QIES ASAP system just as they submit all other MDS assessments. Please see Transmitting Date in Chapter 5 of the RAI Manual: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf.
273	NHC	If the reports are measure-based and the compliance for the APU is assessment-based, how do we know whether we are compliant or not for the 80 percent threshold?	The APU threshold is calculated by taking the number of assessments with 100 percent of the necessary data elements completed to calculate the SNF QRP QMs (numerator) divided by the number of successfully submitted assessments (denominator). The resulting number is multiplied by 100 to determine the threshold percentage. There are more than just measure-based reports available to providers. There are assessment-based reports that can assist the provider in determining whether the assessments submitted have missing data (NH Assessment Print Reports) or were submitted successfully (NH Validation Reports). Providers should use all the available SNF QRP reports to monitor their ongoing compliance with SNF QRP requirements.

#	Topic	Question	Response
274	NHC	What is the difference between <20 "Not Available" and other "Not Available" designations when displayed on NHC?	If the number of SNF stays in the measure denominator was less than 20 (<20), the facility score for this measure will display as "Not Available" on NHC. In this case, the number "13" will also display with hover text explaining that the number of cases/resident stays is too small to report. If data are not available for this reporting period, the data were suppressed by CMS for one or more quarters, or there were no data submitted for this reporting period, the facility score for the measure will display as "Not Available" on NHC. The numbers "14," "16," or "17," respectively, will also display with hover text explaining the reasons for the "Not Available" designation. Please note, State averages for the SNF QRP measures are not currently displayed on NHC. In place of the State average, "Not Available" is displayed. There is no additional hover text for this result.
275	NHC	When is NHC data QM updated? Or how often?	MDS 3.0 assessment-based QMs used in the SNF QRP are updated quarterly on NHC; quarterly updates are planned during the months of October, January, April, and July. Medicare Fee-For-Service claims-based quality measures used in the SNF QRP are updated annually on NHC; annual updates are planned during the month of October. For more information on the data collection periods used for the SNF QRP measures, please refer to the SNF QRP Spotlights and Announcements page: 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. For more information on the NHC display for NHQI measures, please contact the BetterCare Help Desk by email at bettercare@cms.hhs.gov.
276	NHC	What is CMS' purpose of collecting the claims-based Medicare Spending Per Beneficiary measure, and how does it affect the facility?	The Medicare Spending Per Beneficiary measure has several goals, including providing actionable, transparent information to support PAC providers' efforts to promote care coordination and improve efficiency of care provided to patients/residents; facilitating comparisons while accounting for patient/resident case mix through risk adjustment; encouraging improved coordination of care in PAC settings by holding providers accountable for the Medicare resource use within an "episode of care"; and creating a continuum of accountability between Medicare providers by measuring resource use through episodes of care. Facility-level data are publicly reported on the CMS website.

#	Topic	Question	Response
277	NHC	Is there a simple table that shows all new NHC QMs, and their associated measure codes that are used in the three NHC data files (MDS, Claims, and SNF QRP)? Can't seem to reconcile the download files with the listed QMs and their cut-points?	For a list of quality measures in the SNF QRP, please refer to the SNF QRP Measures and Technical Information web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html. For a list of QMs in the NHQI, please refer to the NHQI Measures web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.
278	NHC	Is there a lag between updates to data.Medicare.gov and data on NHC? If so, how long?	There is no lag between updates to Data.Medicare.gov and NHC for measures used in the SNF QRP. MDS 3.0 assessment-based QMs used in the SNF QRP are updated quarterly on NHC and on Data.Medicare.gov; quarterly updates are planned during the months of October, January, April, and July. Medicare Fee-For-Service claims-based QMs used in the SNF QRP are updated annually on NHC and on Data.Medicare.gov; annual updates are planned during the month of October.
279	General	Can the slides and scenarios from the SNF QRP in-person trainings be used as part of our trainings with our staff moving forward?	The May and August 2019 SNF QRP Provider Trainings are Train-the-Trainer sessions. We encourage providers to adapt the post-training materials which will be posted on the SNF QRP Training webpage to meet the needs of their facilities. The SNF QRP Training webpage is located here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html.
280	General	Will all the links to the materials be available post seminar (direct links)?	Materials from the May and August 2019 SNF QRP Provider Trainings are posted in the Downloads section of the SNF QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html.
281	General	Will this webinar be available for replay after the training is completed for future reference?	Video recordings of the presentations from the May and August 2019 SNF QRP Provider Trainings can be accessed via the CMS YouTube Channel. Specific URLs will be provided in announcements related to post-training materials on the SNF QRP Training webpage at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html.

#	Topic	Question	Response
282	General	When is the RAI Manual for October 1, 2019, going to be available?	The PDF file labeled "MDS 3.0 RAI Manual v1.17 October 1, 2019" is now available in the Related Links section of the MDS 3.0 RAI Manual Page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
283	General	Is there still a modification process?	Yes. Correction records (modification and inactivation records) are allowed. Please refer to Chapter 5: Submission and Correction of the MDS Assessments of the MDS RAI Manual for additional information regarding correction of MDS 3.0 records (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).
284	Other	Do we check diabetes mellitus on NTA also as hereditary metabolic immune disorder? Are you going to release what the diseases are in each generalized category such as connective tissue disorder, specified hereditary metabolic/immune disorder (asthma and diabetes mellitus) immune disorders, etc.?	No, diabetes mellitus is not considered under hereditary metabolic immune disorders in the PDPM. The conditions and categories associated with the NTA component were finalized in the FY2019 SNF PPS Final Rule. More details on this may be found on the PDPM website, which may be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html. For a list of NTA-related conditions and services, refer to Table 16 in Chapter 6 of the MDS RAI Manual (https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf). A mapping of NTA-related conditions and services to ICD-10 codes is a full and detailed listing of included NTA conditions. This mapping is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.