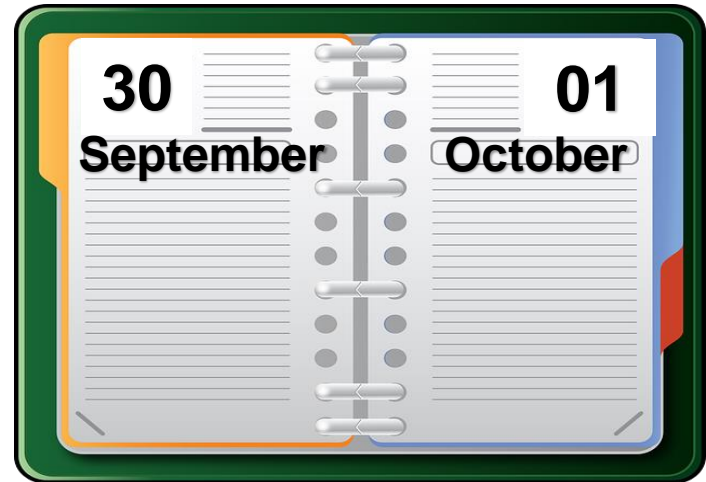


MDS/RAI Changes and PDPM Policy Updates for October 1, 2019

Presented for the DOH by
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Myers and Stauffer LC

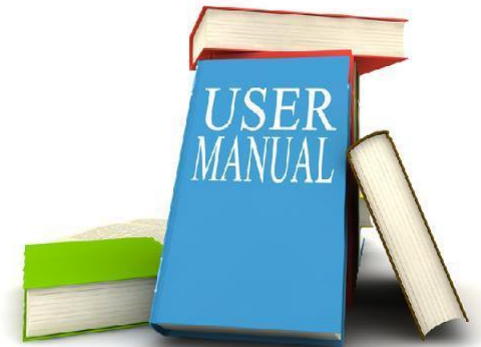
Agenda

- Overview of MDS/RAI Manual Updates/Changes
 - Global Changes
 - Chapter 2
 - Chapter 3
 - Chapter 6
- PDPM Policies
 - Transition
 - Interrupted Stay Policy
 - Administrative Presumption
 - Unchanged Medicare/PPS Policies
 - PA State Updates for October 1, 2019



Why are changes made to the MDS and RAI Manual?

- IMPACT Act – Standardized Patient Assessment Data Elements (SPADE).
- Align content of items that support cross-setting measures (e.g., pressure ulcer/injury).
- Reduce provider burden.
- Quality measure changes.
- Survey and certification.
- Patient Driven Payment Model (PDPM).



Overview of RAI Manual Changes

Sections with Changes

- Chapter 2- MDS Assessments and Scheduling
- Chapter 3- MDS Section Item Changes

Section A

Section K

Section C

Section O

Section D

Section V

Section GG

Section X

Section I

Section Z

Section J

Unchanged Sections

- Chapter 3- MDS Section Items with No Changes

Section B

Section L

Section E

Section M

Section F

Section N

Section G

Section P

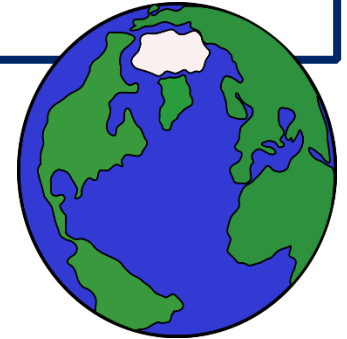
Section H

Section Q

New Section

- Chapter 6- Patient Driven Payment Model and PDPM Calculation Worksheets

Global Changes



- Acronyms have been spelled out the first time they are used with the acronym to follow.
- URLs have been updated.
- Typographical and grammatical errors have been fixed.
- Where page numbers were used as reference, replaced with Section/Chapter reference.
- Standardized acronym for Quality Improvement Evaluation System Assessment Submission and Processing system, as “QIES ASAP system.”
- “Pressure ulcer” revised to “pressure ulcer/injury” where appropriate.

Global Changes

- Guidance added throughout the manual in relation to the two new item sets.
- The term, “Medicare,” revised to Prospective Payment System, “PPS,” where appropriate.
- Any and all references to the following have been removed throughout the entire RAI Manual:
 - PPS 14-, 30-, 60-, and 90-Day Assessments.
 - Other Medicare Required Assessment (OMRA) (Start, End, Start and End of Therapy, and Change of Therapy) Assessments.
 - Swing Bed (SB) Clinical Change Assessment.

Chapter 2

Overview

RAI Manual-Chapter 2

- Chapter 2-
 - OBRA Instructions- There are no significant changes to the OBRA Sections 2.1 through 2.7
 - PPS Instructions- Sections 2.8 through 2.14 are completely new.
 - There are many details and examples regarding MDS scheduling within the RAI Manual.

Chapter 2 – MDS Assessments

- OBRA Schedule- No Changes
- PPS Schedule
 - PPS assessments retired- 14,30,60 and 90-day,SOT,COT and EOT
 - Required PPS Assessments
 - 5-Day
 - PPS Discharge
 - Optional Assessments
 - PPS-Interim Payment Assessment (IPA)
 - Optional State Assessment (OSA)

PPS Required: 5-Day Assessment

- Is the first *PPS*-required assessment to be completed when the resident is admitted/readmitted to the facility *for a Part A stay*.
- *A 5-Day assessment is not required at the time when a resident returns to a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption (facility discharge, resident no longer skilled, payer change, etc.).*

PPS Required: 5-Day Assessment

- The PPS 5-Day assessment has defined days within which the Assessment Reference Date (ARD) must be set.
- The ARD must be a day within the prescribed window of days 1 through 8 of the Part A stay.
- The ARD must be set on the MDS form itself or in the facility software before this window has passed.

Assessment Reference Date (ARD)						
SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

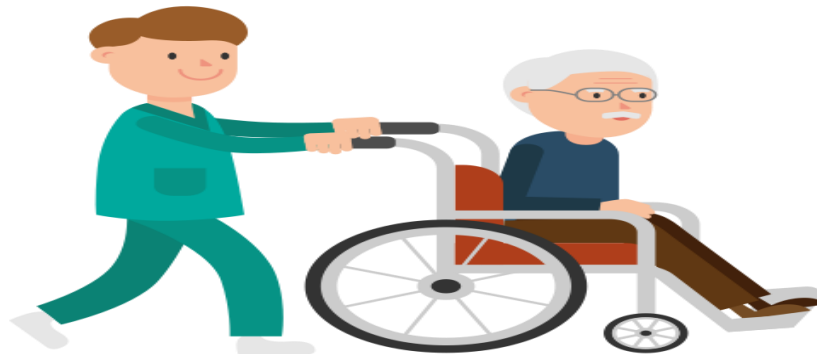
PPS Required: 5-Day Assessment

- ARD (*item A2300*) must be set *for Days 1 through 8* of the Part A SNF covered stay.
- Must be completed (*item Z0500B*) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment *for entire PPS stay (except in cases when an IPA is completed.)*
- Is the first *PPS*-required assessment to be completed when the resident is first admitted for a SNF Part A stay.
- The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes *and for purposes of the variable per diem adjustment.*

PPS Required: Discharge Assessment

Part A PPS Discharge Assessment (A0310H):

- – The Part A PPS Discharge (NPE) assessment is **completed when a resident's Medicare Part A stay ends. *(unless it is an instance of an interrupted stay)***.



PPS Optional: Interim Payment Assessment (IPA)

There are situations when a SNF provider may complete an optional assessment *after* the 5-Day assessment.

This assessment is an unscheduled assessment called the Interim Payment Assessment. (Item A0310B=08)

When deemed appropriate by the provider, this assessment may be completed to capture changes in the resident's status and condition potentially resulting in a **payment change**.

PPS Optional: Interim Payment Assessment (IPA)

Interim Payment Assessment (optional)

- ARD may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for remainder of the PPS stay, beginning on the ARD.
- Must be submitted 14 days after completion (Item Z0500B) (completion + 14 days).
- The ARD for an IPA may not precede that of the 5-Day assessment.
- May not be combined with any other assessments (PPS or OBRA).

Optional IPA : Example

Resident Admitted- Post Elective Left Hip Replacement with no other current health issues. 10 days after admission he developed a wound infection needing IV antibiotics and a stage 4 pressure injury to the left heel. He is now depressed with the setbacks in his recovery. With his set-backs his ADL score becomes a 8. An IPA is completed with ARD of day 11.

5 Day Assessment-

NTA-Score 0 pts = 57.92/day

Nursing- Reduced Physical Function=156.76/day (ADL Score-5)

5-Day Per Diem Payment= 214.68/day from Day 1 to Day 10

IPA (ARD DAY 11)-

NTA-Score 8 pts =148.03/day (Wound infection (2pts), Stage 4 pressure injury (1pt), IVs (5pts))

Nursing- Special Care Low = 238.87/day (Wound Care, IVs and Depression, ADL Score-8)

IPA Per Diem Payment= 386.90/day from Day 11 thru end of stay

Increased Payment of 172.22/day

Or 15,499.80/increase over stay of 100 days

Optional State Assessment (OSA)

- Pennsylvania is choosing **NOT** to use the OSA at this time.
- Pennsylvania CMI will continue to be calculated using all OBRA and Required PPS assessments.



Combining PPS and OBRA Assessments

Combining *PPS* Assessments and OBRA Assessments.

- This section is basically the same with the exception of the additional information related to the IPA, which cannot be combined with any other assessment.
- Be careful in selecting the ARD for an OBRA Admission assessment combined with a 5-Day assessment. For the OBRA Admission, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For the 5-Day, the ARD must be set for days 1 through 8.

(Avoid a late assessment by choosing an ARD between days 1 through 8 when combining these assessments.)

Chapter 2

CMS Changes Table for Chapter 2-

Chapter 2 has been extensively revised for this year's RAI Manual (v1.17). Due to the scope of the revisions, individual changes have not been recorded and tracked in the Change Tables provided by CMS.

Users are encouraged to review the chapter in its entirety.

Chapter Overview



Section A: A0310B- PPS Assessment

- A0310B, PPS Assessment.
 - **Code 01.** 5-Day Scheduled Assessment.
 - **Code 08.** *IPA – Interim Payment Assessment.*
 - **Code 99.** None of the above.

Section A	Identification Information
A0310. Type of Assessment	
<div>Enter Code <input type="text"/><input type="text"/></div>	A. Federal OBRA Reason for Assessment <ul style="list-style-type: none">01. Admission assessment (required by day 14)02. Quarterly review assessment03. Annual assessment04. Significant change in status assessment05. Significant correction to prior comprehensive assessment06. Significant correction to prior quarterly assessment99. None of the above
<div>Enter Code <input type="text"/><input type="text"/></div>	B. PPS Assessment <p><u>PPS Scheduled Assessment for a Medicare Part A Stay</u></p> <ul style="list-style-type: none">01. 5-day scheduled assessment <p><u>PPS Unscheduled Assessment for a Medicare Part A Stay</u></p> <ul style="list-style-type: none">08. IPA - Interim Payment Assessment <p><u>Not PPS Assessment</u></p> <ul style="list-style-type: none">99. None of the above

A0310G1. Is This a SNF Part A Interrupted Stay?

G1. Is this a SNF Part A Interrupted Stay?

- 0. No
- 1. Yes

A0310. Type of Assessment - Continued	
Enter Code <input type="checkbox"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 <ul style="list-style-type: none">1. Planned2. Unplanned
Enter Code <input type="checkbox"/>	G1. Is this a SNF Part A Interrupted Stay? <ul style="list-style-type: none">0. No1. Yes
Enter Code <input type="checkbox"/>	H. Is this a SNF Part A PPS Discharge Assessment? <ul style="list-style-type: none">0. No1. Yes

Coding A0310G1

- This item allows providers to indicate whether or not an interrupted stay has occurred.
- You will code **0. No.** If the resident was discharged from SNF care but **did not** resume SNF care at the same SNF within the interruption window.
 - This means that an interrupted stay did **not** occur.
- You will code **1. Yes.** If the resident was discharged from SNF care but **did**
 - resume SNF care at the same SNF within the interruption window.
 - This means that an interrupted stay **did** occur.

A2400- Medicare Stay

A2400. Medicare Stay Complete only if A0310G1 = 0	
Enter Code <input type="checkbox"/>	A. Has the resident had a Medicare-covered stay since the most recent entry? 0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent Medicare stay
	B. Start date of most recent Medicare stay: [] [] - [] [] - [] [] [] [] Month Day Year
	C. End date of most recent Medicare stay - Enter dashes if stay is ongoing: [] [] - [] [] - [] [] [] [] Month Day Year

- Completed only when A0310G1 = 0.
- When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- Items A2400A–A2400C are not active when the OBRA Discharge assessment indicates the resident has had an interrupted stay (A0310G1 = 1).

Section C: 0100/Cognitive Patterns

Because a PDPM cognitive level is utilized in the speech language pathology (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 of 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.

Section D: D0350 and D0650

Safety Notification

Items removed:

- These items were completed when a responsible staff member or provider was informed there was a potential for resident self-harm.

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code

☐

Was responsible staff or provider informed that there is a potential for resident self harm?

0. No

1. Yes

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code

☐

Was responsible staff or provider informed that there is a potential for resident self harm?

0. No

1. Yes

Section GG

- Additional Column (Column 5) added to accommodate IPA
- These columns are collapsed and include only the section GG items need to produce a PDPM case mix group assignment.
- There have been many updates and guidance additions/revisions to the coding tips and scenarios in Section GG

GG:0130 and 0170 (IPA)

Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

- For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column “Interim Performance,” which will capture the interim functional performance of the resident.
- The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.
- The IPA does not affect the variable per diem schedule.

GG0130: Self-Care (3-day assessment period) Interim Performance (Interim Payment Assessment - Optional)

GG0130. Self-Care (Assessment period is the last 3 days)

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

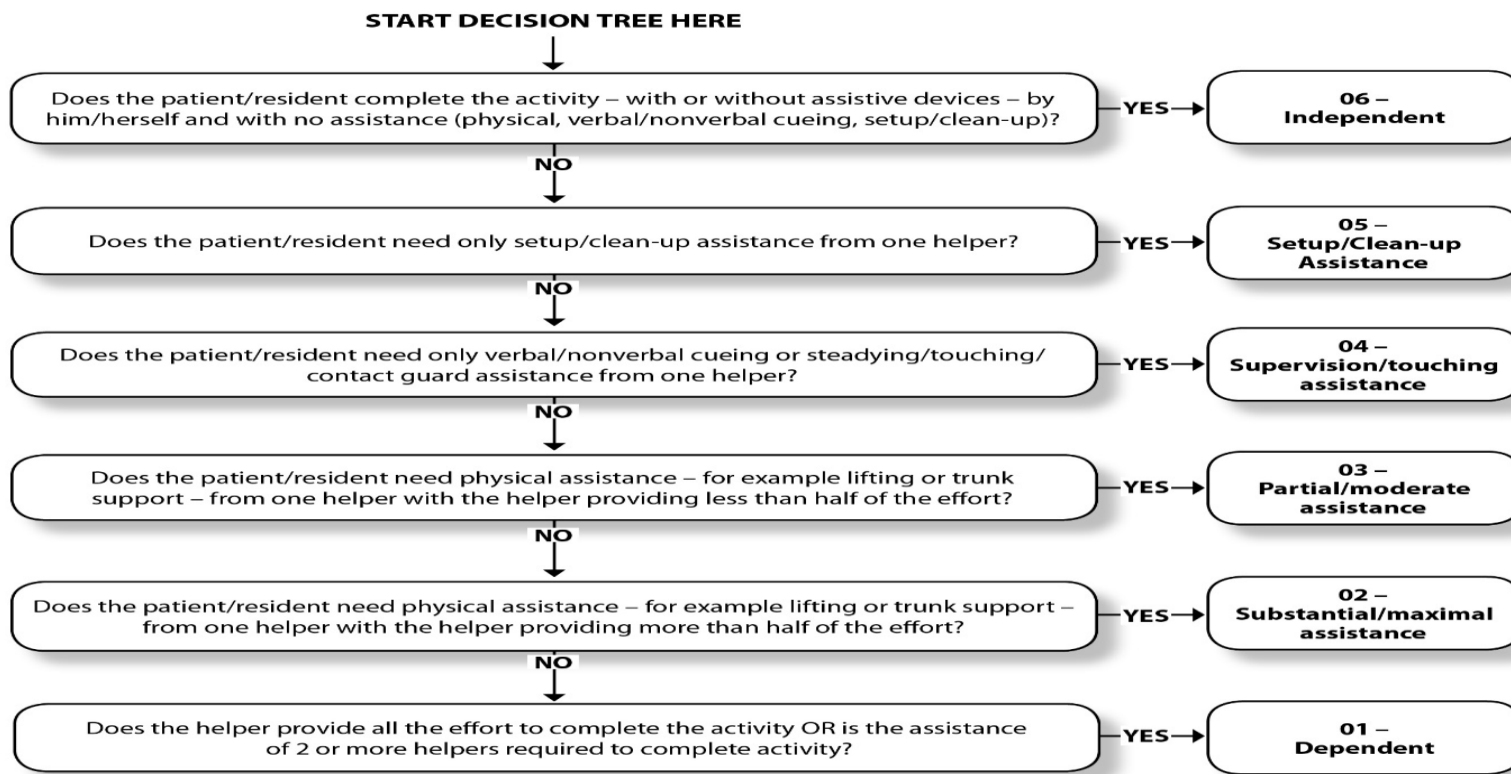
5. Interim Performance Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="text"/> <input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/> <input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

GG0170: Mobility (3-day assessment period) Interim Performance (Interim Payment Assessment - Optional)

GG0170. Mobility (Assessment period is the last 3 days)																	
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.																	
<p>Coding:</p> <p>Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.</p> <p><i>Activities may be completed with or without assistive devices.</i></p> <p>06. Independent - Resident completes the activity by him/herself with no assistance from a helper.</p> <p>05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.</p> <p>04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p> <p>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused</p> <p>09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.</p> <p>10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)</p> <p>88. Not attempted due to medical condition or safety concerns</p>																	
<p>5. Interim Performance</p> <p>Enter Codes in Boxes</p> <p>↓</p> <table border="1"> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<p>B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</p> <p>C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.</p> <p>D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</p> <p>E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).</p> <p>F. Toilet transfer: The ability to get on and off a toilet or commode.</p> <p>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100C, Appliances</p> <p>J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.</p> <p>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.</p>
<input type="text"/>	<input type="text"/>																
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Section GG: Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper



I0020/I0020B: Indicate the Residents Primary Medical Condition Category

Section I	Active Diagnoses
I0020. Indicate the resident's primary medical condition category	
Enter Code	Indicate the resident's primary medical condition category that best describes the primary reason for admission Complete only if A0310B = 01
<input type="text"/>	<ul style="list-style-type: none"> 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions 14. Other Medical Condition If "Other Medical Condition," enter the ICD code in the boxes
I0020A. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Section I	Active Diagnoses
I0020. Indicate the resident's primary medical condition category	
Complete only if A0310B = 01 or 08	
Enter Code	Indicate the resident's primary medical condition category that best describes the primary reason for admission
<input type="text"/>	<ul style="list-style-type: none"> 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions
I0020B. ICD Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

I0020B

I0020B. ICD Code

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- Complete only if A0310B = 01 (Start of Part A Prospective Payment System (PPS) stay) or A0310B = 08 (Interim Payment Assessment).
- Enter the code that represents the primary medical condition that resulted in the resident's admission to the SNF and proceed to I0020B to enter the ICD Code (with decimal).
- Include the primary medical condition coded in Item I0020 in Section I0100 through I8000: Active Diagnoses in the Last 7 Days.

J2100: Recent Surgery Requiring Active SNF Care

This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Enter Code

☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

- 0. **No**
- 1. **Yes**
- 8. **Unknown**

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 1, Yes:** if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

J2300 – J5000: Recent Surgeries Requiring Active SNF Care

Surgical Procedures - Complete only if J2100 = 1	
↓ Check all that apply	
Major Joint Replacement	
<input type="checkbox"/>	J2300. Knee Replacement - partial or total
<input type="checkbox"/>	J2310. Hip Replacement - partial or total
<input type="checkbox"/>	J2320. Ankle Replacement - partial or total
<input type="checkbox"/>	J2330. Shoulder Replacement - partial or total
Spinal Surgery	
<input type="checkbox"/>	J2400. Involving the spinal cord or major spinal nerves
<input type="checkbox"/>	J2410. Involving fusion of spinal bones
<input type="checkbox"/>	J2420. Involving lamina, discs, or facets
<input type="checkbox"/>	J2499. Other major spinal surgery
Other Orthopedic Surgery	
<input type="checkbox"/>	J2500. Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)
<input type="checkbox"/>	J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)
<input type="checkbox"/>	J2520. Repair but not replace joints
<input type="checkbox"/>	J2530. Repair other bones (such as hand, foot, jaw)
<input type="checkbox"/>	J2599. Other major orthopedic surgery
Neurological Surgery	
<input type="checkbox"/>	J2600. Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)
<input type="checkbox"/>	J2610. Involving the peripheral or autonomic nervous system - open or percutaneous
<input type="checkbox"/>	J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices
<input type="checkbox"/>	J2699. Other major neurological surgery
Cardiopulmonary Surgery	
<input type="checkbox"/>	J2700. Involving the heart or major blood vessels - open or percutaneous procedures
<input type="checkbox"/>	J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic
<input type="checkbox"/>	J2799. Other major cardiopulmonary surgery
Genitourinary Surgery	
<input type="checkbox"/>	J2800. Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
<input type="checkbox"/>	J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
<input type="checkbox"/>	J2899. Other major genitourinary surgery
Other Major Surgery	
<input type="checkbox"/>	J2900. Involving tendons, ligaments, or muscles
<input type="checkbox"/>	J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
<input type="checkbox"/>	J2920. Involving the endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus - open
<input type="checkbox"/>	J2930. Involving the breast
<input type="checkbox"/>	J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
<input type="checkbox"/>	J5000. Other major surgery not listed above

J2300-J5000: Coding Instructions

Coding Instructions

- Code surgeries that are documented:
 - To have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission,
 - That have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.
- Check off each surgery requiring active SNF care as defined above.
 - Surgeries are listed by major surgical category: Major Joint Replacement, Spinal Surgery, Orthopedic Surgery, Neurologic Surgery, Cardiopulmonary Surgery, Genitourinary Surgery, Other Major Surgery.

J2300-J5000: Guidance

Surgery should be coded as requiring active care during the SNF stay when:

There is specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.

- Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

In the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:

- The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:
 - The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).
 - Daily skilled therapy to restore functional loss after surgical procedures.
 - Administration of medication and monitoring that requires skilled nursing.

Section K: K0510. and K0710.

Nutritional Approaches and Percent Intake by Artificial Route

- Items removed from both K0510 and K0710.
- Removed references to potential State requirements for completion of items no longer collected by CMS.
- Removed text within Section K (and elsewhere in the manual) regarding items no longer collected by CMS.

K0510. Nutritional Approaches

Removed items:

K0510C and K0510D from Column 1. While NOT a Resident.

K0510. Nutritional Approaches		OLD	
Check all of the following nutritional approaches that were performed during the last 7 days		1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) <i>IN THE LAST 7 DAYS</i> . If resident last entered 7 or more days ago, leave column 1 blank			
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>		↓ Check all that apply ↓	
A. Parenteral/IV feeding		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)		<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above		<input type="checkbox"/>	<input type="checkbox"/>

K0510. Nutritional Approaches		NEW	
Check all of the following nutritional approaches that were performed during the last 7 days		1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) <i>IN THE LAST 7 DAYS</i> . If resident last entered 7 or more days ago, leave column 1 blank			
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>		↓ Check all that apply ↓	
A. Parenteral/IV feeding		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)		<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)			<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)			<input type="checkbox"/>
Z. None of the above		<input type="checkbox"/>	<input type="checkbox"/>

K0710. Percent Intake by Artificial Route

Removed:

K0710 Column 1. While NOT a Resident.

OLD

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B			
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank	1.	2.	3.
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	While NOT a Resident	While a Resident	During Entire 7 Days
3. During Entire 7 Days Performed during the entire <i>last 7 days</i>	↓ Enter Codes ↓		
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	<input type="text"/>	<input type="text"/>	<input type="text"/>
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	<input type="text"/>	<input type="text"/>	<input type="text"/>

NEW

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B		
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	2.	3.
3. During Entire 7 Days Performed during the entire <i>last 7 days</i>	While a Resident	During Entire 7 Days
	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	<input type="text"/>	<input type="text"/>
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	<input type="text"/>	<input type="text"/>

O0425: Part A Therapies

O0425. Part A Therapies

Complete only if A0310H = 1

Enter Number of Minutes

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Enter Number of Minutes

--	--	--	--

Enter Number of Minutes

--	--	--	--

Enter Number of Minutes

--	--	--	--

Enter Number of Days

--	--	--

A. Speech-Language Pathology and Audiology Services

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)
5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425:Part A Therapies

Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1. Yes.

Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes) and consult with each of the qualified care providers to collect the information required for this item.

For detailed descriptions of how to code minutes of therapy and an explanation of skilled versus non-skilled therapy services, co-treatment, therapy aides, and students, please refer to these topic headings in the discussion of item O0400 in Section O of the RAI Manual.

O0430: Distinct Calendar Days of Part A Therapy

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C).

If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding item O0430.

Chapter Overview



Chapter 6: PDPM

- This chapter was extensively revised due to the change in the payment system.
- Patient Driven Payment Model
 - PDPM adjusts payment for each major element of a resident's SNF care, specifically for PT, OT, SLP, nursing, and NTA. In Chapter 6 of the RAI manual PDPM calculation worksheets are provided.
 - The calculation worksheets were developed to provide clinical staff with a better understanding of how PDPM works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system.

Chapter 6: Worksheets

PDPM Calculation Worksheets for SNFs

- Calculation of Cognitive Level.
- Worksheets guide providers through steps to identify:
 - Primary Diagnosis, Clinical Category, Function Score, Case-Mix Groups, and Payment Component tables for PT, OT, SLP, Nursing, and NTA.
 - Calculation of Variable Per Diem Adjustment.
 - Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate.

PDPM Policies

- Transition to PDPM
- Interrupted Stay Policy
- Administrative Presumption
- Unchanged PPS Policies under PDPM

RUG IV – PDPM Transition

- There is no transition period between RUG-IV and PDPM
 - RUG-IV billing ends September 30, 2019. For any admission prior to October 1, 2019, a 5-day assessment with and ARD no later than September 30, 2019, will be needed.
 - PDPM billing begins October 1, 2019. All providers will be required to complete an IPA with an ARD no later than October 7, 2017 for all SNF part A patients.
 - October 1, 2019 will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
 - Any “Transitional IPAs” with an ARD after October 7, 2019 will be considered late and relevant penalty for late assessments would apply

Interrupted Stay Policy

- With the introduction of the variable per diem adjustment under PDPM, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the variable per diem schedule.
- Frequent patient readmissions and transfers represents a significant risk to patient care, as well as a potential administrative burden on providers from having to complete new patient assessments for each readmission.
- To mitigate this potential incentive, PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window.

Interrupted Stay Policy

- If a patient is discharged from a SNF and readmitted to the same SNF **no more than 3** consecutive calendar days after discharge, then the subsequent stay is considered an **interrupted stay**:
 - Assessment schedule and Variable per diem schedule continues from the point just prior to discharge
- If patient is discharged from SNF and readmitted **more than 3** consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a **new stay**:
 - Assessment schedule and variable per diem schedule reset to day 1
- This policy applies not only in instances when a patient physically leaves the facility, but also in cases when the patient remains in the facility but is discharged from a Medicare Part A-covered stay.

Interrupted Stay Policy

Examples

- Part A patient discharges to home AMA, but returns to the same SNF 2 days later.

INTERRUPTED STAY

OBRA- OBRA Discharge return not anticipated, Entry, Admission assessment.

PPS- No required PPS D/C or 5-Day. Optional IPA if facility desires.

- Part A patient goes to hospital July 10 at 10:00 am is admitted, returns at 08:00 am July 11.

INTERRUPTED STAY

OBRA- OBRA Discharge return anticipated, Entry, Continue OBRA Schedule. Significant Change if appropriate.

PPS-No required PPS D/C or 5-Day. Optional IPA if facility desires.

More Interrupted Stay Examples

- Patient's Part A skilled stay ends on July 4, resident stays in facility. Placed back on Medicare A as of July 6.

INTERRUPTED STAY

OBRA-No OBRA assessments due

PPS-No required PPS D/C or 5-Day. IPA if facility desires.

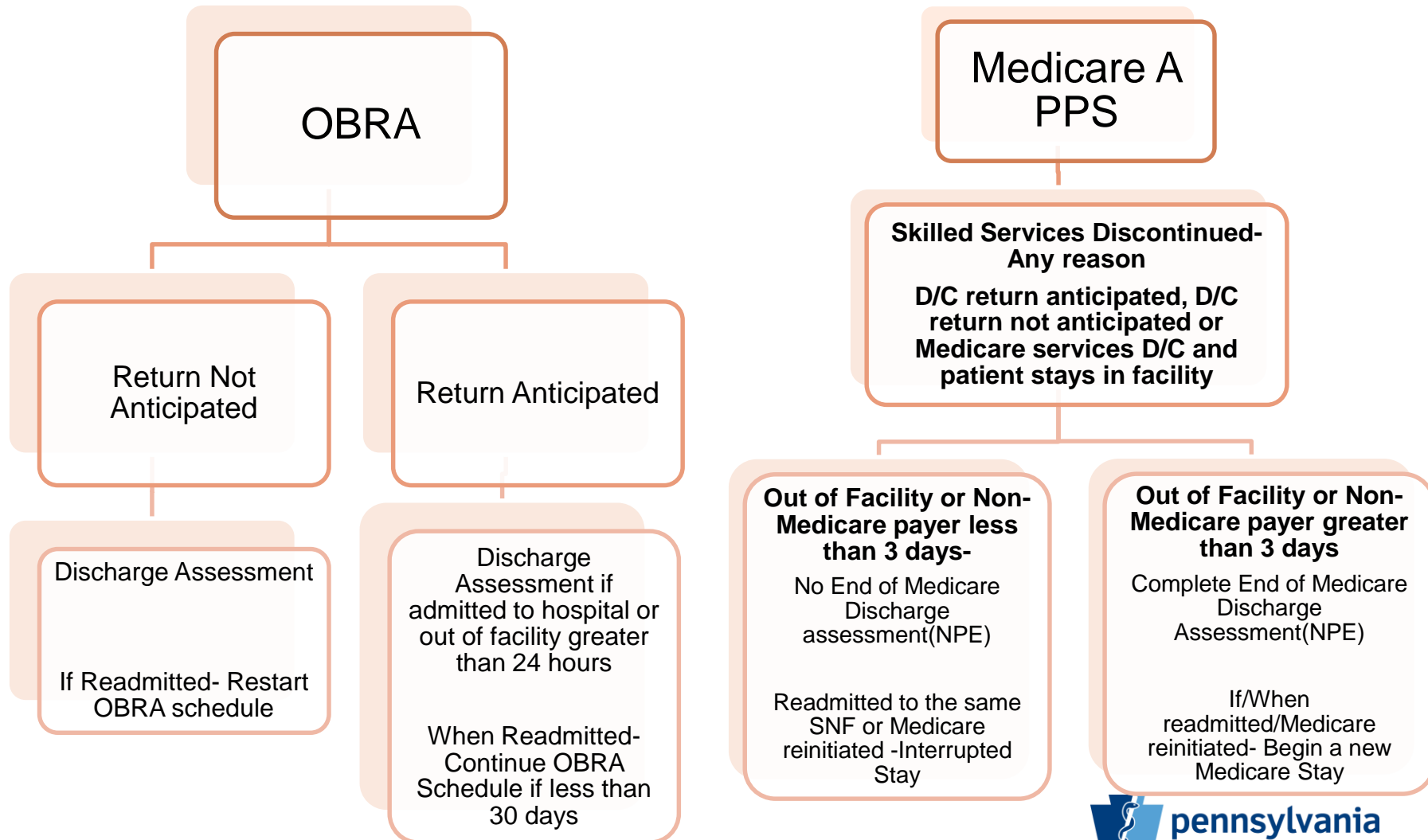
- Medicare Part A patient goes to the hospital returns 5 days later.

NO INTERRUPTED STAY

OBRA-OBRA Discharge return anticipated, Entry and Continue prior OBRA schedule. Significant Change if appropriate

PPS-Discharge PPS assessment and 5-Day upon return are both required.

Interrupted Stay Policy



Administrative Presumption

- The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring an SNF level of care through the assessment reference date for that assessment.
- Those beneficiaries not assigned one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition, but instead receive an individual determination using the existing administrative criteria.

Administrative Presumption: Classifiers

The following PDPM classifiers are designated under the presumption:

- Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
- PT & OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost (12+) comorbidity group

Unchanged PPS Policy

- There is no change to the definition of skilled services
- There is no change to the Medicare A- Physician Certification process
- There is no change to the NOMNC or any other coverage notice currently required by CMS
- PDPM pertains only to Medicare Fee for Service participants

Overview of RAI Manual Changes

Sections with Changes

- Chapter 2- MDS Assessments and Scheduling
- Chapter 3- MDS Section Item Changes

Section A

Section K

Section C

Section O

Section D

Section V

Section GG

Section X

Section I

Section Z

Section J

Unchanged Sections

- Chapter 3- MDS Section Items with No Changes

Section B

Section L

Section E

Section M

Section F

Section N

Section G

Section P

Section H

Section Q

New Section

- Chapter 6- Patient Driven Payment Model and PDPM Calculation Worksheets

PA State Specific Updates

Effective October 1, 2019

No changes to CMI process

Continue to complete, reconcile and upload CMI reports with no changes from the current process.

Optional State Assessment (OSA)

The OSA will **NOT** be used. Pennsylvania will continue to use all OBRA and Required/Scheduled PPS assessments in case mix calculation, as is the current practice.

No changes to Section S

Resources

PDPM website:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSPDPM.html>

Draft- RAI Manual v1.17, Effective October 1, 2019

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-RAI-Manual-v117_October-2019.zip

Medicare policy changes frequently, and links to the source documents have been provided for your reference. The information presented is current as of the date of this presentation.

Questions



- Questions can be submitted to qa-mds@pa.gov and will be answered in the next RAI Spotlight.
- The next teleconference will be held October 10, 2019