ACHCA
American College of Health Care Administrators

Operationalizing MDS Changes

Presented by

Maureen McCarthy, RN, BS, RAC-MT, QCP-MT, DNS-MT, RAC-MTA

President, Celtic Consulting

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Objectives

- Discuss the FY24 CMS changes to MDS due 10/1/2023
- Display CMS rationale behind the changes
- Explain the impact to the acuity payment systems
- Illustrate MDS sections that will change
- Identify changes to the SNFQRP and SNFVBP programs as a result of the new sections
- Provide Operations Alerts and best practices to prepare the interdisciplinary team

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MDS Item Sets for 10/1/2023

- Comprehensive- NC
  - Admission, Annual, Significant Change
- Quarterly- NQ
- Discharge- ND
  - Return anticipated, Return not anticipated, death
- Entry tracking- NT
- PPS- NP, IPA
- End of PPS- NPE

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Operations Alert

- Optional State Assessment (OSA) was removed which is the MDS used for case mix acuity in Medicaid case mix states.
  - CMS sources expect this item set to be released soon
  - OSA assessments will utilize the federal repository to house these assessments
  - The OSA is a stand-alone assessment; consider the workload of the NAC

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OBRA MDS Assessments

Type	Timing
Admission	14th day of admission
Quarterly	Every 92 days
Significant Change	14th day after determination
Annual	Every 366 days

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Operations Alert

- OBRA MDSCs will need to learn how to utilize a case mix acuity-based system for MDS scheduling
- Preparation should begin at least 6 months from Go Live date
- Likely a PDPM based system, considering CMS is phasing out RUG 3 and 4 based support
- Begin tracking scores to assist with determining revenue changes

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Assessment Type Options (Item sets)

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

01. **5-day** scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

08. **IPA** - Interim Payment Assessment

Not PPS Assessment

99. **None of the above**

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SPADES

- **Standardized Patient Assessment Data Elements**
  - Assessment data elements standardized for all PAC Providers
- Expansion of 5 new SPADES for 10/1/23 MDS 1.18.11
  - Race, ethnicity, preferred language, health literacy, social isolation
  - Outcomes can be measured regarding Health Equity
- Data collected on Admission and Discharge Assessments

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SPADE/TOH Delay in Reporting

- Delay in the Compliance Date of the Transfer of Health Information Measures and Certain SPADEs Adopted for the SNF QRP
- CMS will require SNFs to begin collecting data on the two TOH Information Measures beginning with discharges on October 1st of the year that is at least 2 full fiscal years after the end of the COVID–19 PHE
- NPRM proposes, SNFs will be required to begin collecting data on these measures beginning with patients discharged on October 1, 2023, on the MDS 1.18.11.

SPADES (Standardized Patient Assessment Data Elements)

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MUC for Future SNFQRP Updates

TABLE 16: Future Measures and Measure Concepts Under Consideration for the SNF QRP

Quality Concepts
Cross-Setting Function
Health Equity Measures
PAC – COVID-19 Vaccination Coverage among Patients

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Operations Alert

- As new sections are added to the MDS that had not been collected previously, operations managers will likely need to consider collection, tracking, capture and eventually coding of the new data sections
- Consider policy impact
  - New
  - Revised

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Operations Alert

- Consider the following when determining data collection processes:
- Who
- What
- When
- How
- Where

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Ethnicity Section Expanded

Section A	Identification Information

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

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Race Section Expanded

A1010. Race
What is your race?

↓ **Check all that apply**

- ☐ **A.** White
- ☐ **B.** Black or African American
- ☐ **C.** American Indian or Alaska Native
- ☐ **D.** Asian Indian
- ☐ **E.** Chinese
- ☐ **F.** Filipino
- ☐ **G.** Japanese
- ☐ **H.** Korean
- ☐ **I.** Vietnamese
- ☐ **J.** Other Asian
- ☐ **K.** Native Hawaiian
- ☐ **L.** Guamanian or Chamorro
- ☐ **M.** Samoan
- ☐ **N.** Other Pacific Islander
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond
- ☐ **Z.** None of the above

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Operations Alert

- Must be self-reported by the resident
- If the resident is unable to respond, you can ask family/significant other
- If resident can't respond and no family/significant other, can use medical record documentation
  - Would check "resident unable to respond"
- May impact:
  - Care planning
  - Need for interpreter
  - Current process

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New Arrangement for Language

A1110. Language

Enter Code ☐

A. What is your preferred language?

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes**
9. **Unable to determine**

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Operations Alert

- Consider the survey tags if facility is unable to provide the interpreter for languages less often spoken
- Much research has been done regarding social isolation as a result of the PHE, the inability to converse with others may cause isolation

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New Transportation Section

A1250. Transportation (from NACHC©) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1	
↓ **Check all that apply**	
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

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Operations Alert

- May want to consider developing a new questionnaire or add a section to currently existing Social Service assessment tools to collect the new data
- May want to ensure the timeframe used on admission matches what is used at discharge
- May Impact:
  - Discharge planning
  - Care plan
  - Current policy/process

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Expanded Entry Section Options

A1805. Entered From

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

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Discharge Destination Options Expanded

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

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Operations Alert

- Recommendations for best practice
  - Review current applications for admission and make changes as needed
  - Assess current referral forms and determine if the additional data can be obtained, or if changes will be needed
  - Add data collection items to current tools to include the additional section questions
  - Alert team members as to where the data will be kept and how to access

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Section A- New QRP Measures

- Transfer of health information FY24 to begin with MDS 1.18.11
  - Delayed from 10/1/20 due to PHE, CMS proposing 10/1/23 start date
  - Reconciled medication list transferred to patient, downstream provider
  - Collected on Discharge MDS

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New Medication List Reconciliation Section to Downstream Provider Did you do it?

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

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New Medication List Reconciliation Section-Provider How did you do it?

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

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Medication Reconciliation List to Patient Did you do it?

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1

Enter Code ☐	At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?
	0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
	1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

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Medication Reconciliation List to Patient
How did you do it?

Section A	Identification Information

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver. Complete only if A2123 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

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Operations Alert

- Must consider SDOH data collected in Sections B and D when determining the best route to provide the resident with the health information
- Likely just the beginning of the data expected to be shared
- May impact:
  - Policies
  - Current process/forms
  - Care plan
  - Discharge planning

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Section B- Health Equity

- Evidence that a treatment or outcome is affected by underlying healthcare disparities
- Considers Social Risk Factors (SFR)- **Health Literacy**
- SPADES will be expanded 10/1/23 to add this information to MDS
  - Race, ethnicity, preferred language, transportation, **health literacy**, social isolation

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Section B- Health Literacy (SDOH)

Section B	Hearing, Speech, and Vision
B1300. Health Literacy Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1	
Enter Code ☐	How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 7. **Resident declines to respond** 8. **Resident unable to respond**
The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.	

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Operations Alert

- Social Determinants of Health (SDOH) need data collected on social risk factors in order to determine which factors have the biggest impact on health outcomes
- Once data is collected, it can be used to make changes in the care delivery system to improve outcomes and overcome barriers
- May impact:
  - Current process
  - Policy
  - Care plan
  - Discharge plan

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Section D- PHQ2 vs. PHQ9

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

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PHQ2 Scoring Changes- Interview ONLY

PHQ Staff Assessment Remains a 9 Question Section

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 02 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

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PHQ-2 to 9 Cue Card

PHQ-2 to 9 Cue Card
SYMPTOM FREQUENCY
Never or 1 day
2–6 days (several days)
7–11 days (half or more of the days)
12–14 days (nearly every day)

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Operations Alert

- Update current interview tools and cue cards to reflect the new response order to match with MDS coding changes
- No direction form CMS at this time on how old PHQ9 scores will compare to new PHQ2 scores. There is the ability to take the PHQ2 responses from previous MDS assessments and compare to current, or black out comparison until at least two PHQ2 interviews are obtained
- May impact:
  - Current policies
  - Processes
  - Care plan

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Section D- Health Equity Measure

- To provide evidence as to whether a resident is affected by underlying healthcare disparities
- Considers Social Risk Factors (SFR)- **Social Isolation**
- SPADES will be expanded 10/1/23 to add this information to MDS
  - Race, ethnicity, preferred language, transportation, health literacy, **social isolation**

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Section D- Social Isolation (SDOH)

D0700. Social Isolation	
Enter Code ☐	How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond

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Operations Alert

- This data will be collected at discharge as well, may negatively effect those in isolation/quarantine depending on the length of time they were isolated
- May impact:
  - Policies
  - Process
  - Care plan

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Section G is Gone!

Section GG	Functional Abilities and Goals
GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury Complete only if A0310B = 01	

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury Complete only if A0310B = 01
↓ **Check all that apply**

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Well, Maybe Not <u>All</u> of It…

GG0115. Functional Limitation in Range of Motion		
Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days		
Coding: 0. **No impairment** 1. **Impairment on one side** 2. **Impairment on both sides**	↓ **Enter Codes in Boxes**	
	☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
	☐	**B. Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices	
↓ **Check all that were normally used in the last 7 days**	
☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

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Changes to Self-Care-Personal Hygiene G0110J

Section GG	Functional Abilities and Goals - Admission
GG0130. Self-Care (Assessment period is the first 3 days of the stay) Complete if A0310A = 01 or A0310B = 01. If A0310B = 01, the stay begins on A2400B **and** both columns are required. If A0310B = 99, the stay begins on A1600 **and** only column 1 is required.	
Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).	

☐☐	☐☐	**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

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Section GG Changes for Transfer

GG0170C – removed "with feet flat on floor"
GG01170FF tub/shower transfer - new question

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**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 and with no back support.
☐☐	☐☐	**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.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

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Operations Alert

- Update ADL flowsheets
  - EMR software will likely have a solution built in
  - Make sure the system generated reports are also updated to pull the new information as opposed to the old information based on Section G
    - Determine who you want the data collected by CNA, Nursing, Rehab, Combo
  - Integrate what CNA is doing under old Section G (ADLs) with the new tasks assigned from Section GG (Functional Score)
  - Already seeing denials based from Managed Care on GG data collection
  - May impact:
    - Policies
    - Process
    - Care plan

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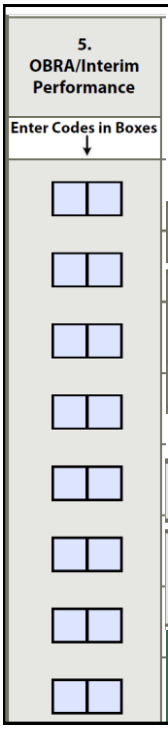
OBRA/Interim GG Coding (ARD-back 2 days)



Section GG	Functional Abilities and Goals - OBRA/Interim
GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days) Complete only if A0310A = 02 - 06 **and** A0310B = 99 or A0310B = 08.	
Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.	

Section GG	Functional Abilities and Goals - OBRA/Interim
GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days) Complete only if A0310A = 02 - 06 **and** A0310B = 99 or A0310B = 08.	

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Medical Record Documentation

"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." (RAI, Chapter 3, p. GG-21)

Each facility can decide how to meet this requirement.

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Operations Alert

- Section GG data is likely going to be the basis of many reporting items and comparisons
- Be sure data is timely and accurate
- Car transfer items may be used to determine transportation mode
  - Chair car vs. ambulance

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Collaborating for Section GG – Safeguard Revenue

Best Practice

- Determine Section GG Assessment Team Leader
- Identify **all** Part A residents requiring GG data
- What is the process for documenting Section GG items & who is responsible?
- How & when will the "usual" performance and discharge goals be determined?
- Who will care plan the goals once determined?
- How will the plan of care & functional goal be communicated to the direct care staff?

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Best Practice for Nursing in Managing GG

- Check nursing documentation daily during the 3-day lookback periods. Note any variations or concerns & discuss/clarify with nursing staff during the 3-day documentation period.
- Develop a routine in discussing nursing & therapy documentation of admission performance & DC goals during meetings with Therapy Manager. Know your therapy short & long term goals on eval.
- Goals should be periodically reviewed throughout the stay to determine progress toward the goal. If a goal is determined to need revision based on resident needs or changes, the plan of care should be updated.
- Once the Usual Performance on admit & DC goals are determined, add this information to your weekly Medicare meeting.
  - Continue through 30-day window.

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Operations Alert

- Best Practice
  - Development of Policies and Procedures to mirror the available MDS sections
    - Replace the old type of documentation references or data collection locations
    - Old flowsheet set up no longer effective
  - Develop systems and processes on how and when to collect the new data
  - Educate on new systems replacing ADL data
  - Implement new processes and monitor for effectiveness

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Managed Care Denials GG -$1,103

Claim ID	Patient DOB	Service Start Date	Service End Date	Billed HIPPS / Revenue Code	Validated HIPPS / Revenue Code
[redacted]	[redacted]	01/21/2020	01/31/2020	KAPE1	LAQE1
CMS Reference	Denial Reason 4 - Unable to validate coding of Section GG				
Rationale	5 day assessment, ARD 1/28/2020 paying for 1/21/2020-1/31/2020. Billed PDPM score KAPE1 x 11 days. Validated PDPM score LAQE1 x 11 days. As per CMS RAI User Manual Chapter 6.6, the documentation provided does not support coding of all Section GG payment items which results in a reduction of the PT/OT and nursing components of the validated PDPM score.				

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Claim #2 -$1,395 for next month

Claim ID	Patient DOB	Service Start Date	Service End Date	Billed HIPPS / Revenue Code	Validated HIPPS / Revenue Code
[redacted]	[redacted]	02/01/2020	02/15/2020	KAPE1	LAQE1
CMS Reference	Denial Reason 4 - Unable to validate coding of Section GG				
Rationale	5 day assessment, ARD 1/28/2020 paying for 2/1/2020-2/15/2020. Billed PDPM score KAPE1 x 14 days. Validated PDPM score LAQE1 x 14 days. As per CMS RAI User Manual Chapter 6.6, the documentation provided does not support coding of all Section GG payment items which results in a reduction of the PT/OT and nursing components of the validated PDPM score.				

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Section I: Active Diagnoses

- The items in this section are intended to code diseases that have a direct relationship to the resident's –
  - current functional status, cognitive status, mood/behavior status,
  - medical treatments,
  - nursing monitoring,
  - or risk of death.
- There are <u>two look-back periods</u> for this section:
  - Diagnosis identification: (Step 1) is a 60-day look-back period.
  - Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except UTIs, which use a 30-day look-back period).

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ICD-10-CM Official Coding Guidelines FY 2019 I.A. 19 (page 4)

- Code assignment and Clinical Criteria
- The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

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Capturing Diagnoses and Conditions

- Documentation Review for diagnoses identification
  - Hospital/transfer documents
  - Consults
  - Resident/family report
  - Medication
- Query MD/APRN

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OIG Memo Findings

Released November 2022

- Additionally, over time the number of unsupported schizophrenia diagnoses increased and in 2019 was concentrated in relatively few nursing homes. Specifically, ***we found that from 2015 through 2019 the number of residents reported in the MDS as having schizophrenia but lacking a corresponding schizophrenia diagnosis in Medicare claims and encounter data increased by 194 percent. In 2019, the unsupported reporting of schizophrenia was concentrated in 99 nursing homes in which 20 percent or more of the residents had a report of schizophrenia in the MDS that was not found in the Medicare claims history.***

U.S. Department of Health and Human Services
Office of Inspector General

Long-Term Trends of Psychotropic Drug Use in Nursing Homes

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Schizophrenia Coding Requirement

- In order to use the diagnosis of schizophrenia on the MDS an evaluation/assessment must be completed by a physician or extender & documented in the medical record. ***S&C memo dated 6/29/22*** QSO-23-05-NH
- This has been written into the MDS Accuracy tag F641, making it part of every survey.

Note*: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to* ***State Medical Boards or Boards of Nursing***

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Operations Alert

- CMS will give leniency for those who have audited and corrected erroneous data
  - *For facilities that admit miscoding after being notified of impending audit, but prior to the start of the audit, CMS will consider a lesser action related to their star ratings than those listed, such as suppression of the QM ratings (rather than downgrade).*
- Develop system to identify and assess current documentation and MDS coding
- Make modifications to MDS coding that is not supported by documentation ASAP

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Example:

RAI Example:

The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

Coding & Rationale:

Schizophrenia item (I6000), would not be checked.

Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

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Section I- Healthcare Associated Infection

- HAI-Infection acquired during SNF stay, or related to an invasive device, severe enough to require hospitalization
  - Catheters, Lines
- Data updated once annually
- Claims based measure- hospital and SNF
- Principal Dx and Present on Admission (POA) determining factors
- Baseline year FY22 (10/1/21-9/30/22)

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HAI Criteria

- Measures from day 4 of admission through day 3 post SNF discharge
  - Includes deaths
- **Excludes**: LOS less than 4 days, non-PPS stays, no hospital stay, D/C to federal hospital, foreign hospital stay, missing data
- **Excluded Infections**: diagnosed at ER or in Observation stay, chronic infections, long acting/presenting diagnoses, related to prior hospital stay, sequela, secondary infections, community or animal acquired, acquired outside US, pre-existing (repeat) infections
- "In diseases classified elsewhere"

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HAI Risk Adjustment

- Age
- Sex
- Procedure in hospital
- Principal diagnosis/ HCC code
- LOS
- Number of hospital stays in 12 months
- ICU/CCU

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Operations Alert

- Consider system to track and identify when facility is affected or triggered
- Develop identification systems for early detection
- Consider combining with rehospitalization efforts to reduce HAIs
- Strengthen ICIP programs and protocols
- Use the facility assessment
- May impact:
  - Infection prevention and control practices
  - Need for staff competencies
  - More time dedicated to the IP role

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OLD:

Section J Pain Interview Order Revised

J0400. Pain Frequency

Enter Code

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0410. Pain Frequency

Enter Code

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
9. **Unable to answer**

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Section J- Pain Interview Effect Changes

J0510. Pain Effect on Sleep

Enter Code

Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

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Section J Pain Effect continued

Section J	Health Conditions

Pain Assessment Interview - Continued

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

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Operations Alert

- CMS is expecting more voice and choice from residents and less input from others if resident can communicate
- Surveyor interviews likely the tool to be used to assess compliance
- Although pain is not currently part of the 5-star rating program, it is still being tracked
- If data reflects a decline, pain will likely be added back as a reported QM on either 5-star or Care Compare
- May impact:
  - Care plan
  - Pain management policies/processes

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Section K Changes

K0520. Nutritional Approaches
Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

Check all that apply

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

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Operations Alert

- Few items are allowable in the hospital lookback, the 'while not a resident' section captures those that are allowable
- Adjust admission tools and forms on admission to collect the new items in the allowable window
- Data in the first 3 days
- Data in the last 14 days
- Data in the last 3 days
- May impact:
  - Policies/practices

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Section K Changes-continued

Section K	Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

	2. While a Resident	3. During Entire 7 Days
2. While a Resident Performed ***while a resident*** of this facility and within the ***last 7 days*** **3. During Entire 7 Days** Performed during the entire ***last 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**	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. **500 cc/day or less** 2. **501 cc/day or more**	☐	☐

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Section N Changes

N0415. High-Risk Drug Classes: Use and Indication

1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days **2. Indication noted** If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
A. Antipsychotic	☐	☐
B. Antianxiety	☐	☐
C. Antidepressant	☐	☐
D. Hypnotic	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. Antibiotic	☐	☐
G. Diuretic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

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Operations Alert

- Significant change given the increase in recent schizophrenia audits CMS is proposing
- Will impact star ratings for **6 months** (1star for QMs)
- Will impact antipsychotic medication ratings for **12 months**
- Audit and correct data as appropriate ASAP
- May impact
  - Need for staff competency on these medications
  - Care plan

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Section O Changes

Section O	Special Treatments, Procedures, and Programs		
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed			
a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B **b. While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days*** **c. At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	**a. On Admission**	**b. While a Resident**	**c. At Discharge**
	Check all that apply ↓	↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐		☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐

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Section O Changes- continued

Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐		☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐		☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐		☐
G3. CPAP	☐		☐
Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐		☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
O0110 continued on next page			

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Section O Changes- continued

Section O	Special Treatments, Procedures, and Programs		
O0110. Special Treatments, Procedures, and Programs - Continued Check all of the following treatments, procedures, and programs that were performed			
a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B **b. While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days*** **c. At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	**a. On Admission**	**b. While a Resident**	**c. At Discharge**
	Check all that apply ↓	↓	↓
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐		☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care		☐	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐		☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			

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Operations Alert

- Splits meds and services out by type when reporting
- Update data collection tools and forms to capture the new data points
- Alert hospital liaisons and others to collect the information where appropriate

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Physician Orders and Visits

- Section O600- MD orders, removed
- Section O700- MD Examinations (visits) also removed

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Isolation Coding- Section O

Code for “strict isolation” only when **all** of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet
2. Precautions are transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. They are in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that services be brought to the resident (therapy, activities, dining, etc.).

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Operations Alert

- Be sure documentation supports
  - Single room at least 1 day in the 14 day lookback
  - State that all services are brought to the room
  - State that the resident did not leave the room

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Section Q Changes- consolidation

Section Q	Participation in Assessment and Goal Setting

Q0110. Participation in Assessment and Goal Setting
Identify all active participants in the assessment process

↓ Check all that apply

☐	A. **Resident**
☐	B. **Family**
☐	C. **Significant other**
☐	D. **Legal guardian**
☐	E. **Other legally authorized representative**
☐	Z. **None of the above**

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Section Q- Streamlined, "Resident expects to.."

Q0310. Resident's Overall Goal
Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal for discharge established during the assessment process
1. **Discharge to the community**
2. **Remain in this facility**
3. **Discharge to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0310A
1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

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Section Q Clarification

Section Q	Participation in Assessment and Goal Setting
Q0550. Resident's Preference to Avoid Being Asked Question Q0500B	
Enter Code ☐	**A. Does resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**C. Indicate information source for Q0550A** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**
Q0610. Referral	
Enter Code ☐	**A. Has a referral been made to the Local Contact Agency (LCA)?** 0. **No** 1. **Yes**
Q0620. Reason Referral to Local Contact Agency (LCA) Not Made Complete only if Q0610 = 0	
Enter Code ☐	**Indicate reason why referral to LCA was not made** 1. **LCA unknown** 2. **Referral previously made** 3. **Referral not wanted** 4. **Discharge date 3 or fewer months away** 5. **Discharge date more than 3 months away**

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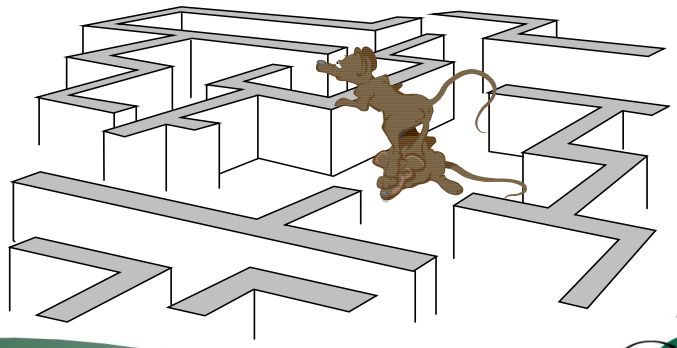
Communication & Teamwork



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Considerations for Morning Clinical Report

- Functional Changes
- Diagnoses/Condition Changes
- Medication Changes
- Consults/Follow-Up appointments
- Cognitive Changes
- Mood Changes
- Therapy updates
- Physician progress notes/orders
- Changes related to Food/Nutrition
- Interrupted Stay Dates, where applicable
- Clinical Treatment Changes
- Supportive Documentation Requests –
  - Hospital, Medical, Nursing, Therapy, etc.

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Strategies to Optimize Revenue

- Dedicated MDSC, focus on revenue and quality
- Hospital medical record documentation to support extensive services received in the acute care setting
- Accurate Functional/ADL coding by nurses/nursing assistants
- Coordination of services
  - Choosing MDS dates to maximize services
  - Treatments and conditions for category

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Reimbursement Strategies

- Staff awareness and on-going education
- Integration of facility functions:
  - Admissions
  - Clinical
  - Financial
- Organizational commitment to an appropriate, complete, and thorough documentation process

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Operations Alert

- Compliance is expected with Requirements of Participation
- Be sure that you have looked at systems and processes that haven't been reviewed since PHE

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Questions?

Maureen McCarthy, RN, BS, RAC-MT, QCP-MT, DNS-MT, RAC-MTA
President, CEO
Celtic Consulting
Phone (office): 860-321-7413
Email: mmccarthy@celticconsulting.org

www.celticconsulting.org
www.mdsrescue.com

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