



MDS 3.0 - Updates

Effective October 1, 2016

Webinar on October 19, 2016

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Objectives

At the end of this webinar the learner shall be able to: Be able to verbalize a basic understanding of the changes that occurred October 1, 2016;

- **Section A:** Understand changes for coding a Medicare A PPS stay
- **Section C:** Understand changes to delirium assessment and scoring methodology
- **Section GG:** Understand intent of Section GG; the steps for assessment for each GG item; and the charting and coding requirements for Section GG

Objectives

- **Section J:** Understand changes to coding fall-related injuries
- **Section M:** Understand how to determine whether a pressure ulcer is considered present on admission.
- **Quality Measures:** Know where more information can be found on CMS' Quality Measures & WA State's Quality Measure Incentive Program
- **Resources:** Know where different MDS resource material can be found.

Need for MDS Accuracy

The MDS drives everything we do in long-term care facilities.

- Successful care delivery
- Provision of Proactive care
- Ensure compliance with federal and state minimum standards
- Quality monitoring systems
- Appropriate payment of care and services provided

“TIPS” for Accuracy

- Have current manuals available for all staff involved with the RAI
- Involve all staff in learning about the MDS
- Use an interdisciplinary approach
- Review the MDS before submitting
- Read and respond to the transmission reports
- Consider developing policies for RAI completion

Background of RAI Updates

Each October usually brings a new version of the RAI manual, new MDS sections or changes to existing sections and this year is no different.

This year's updates are a result of legislation passed in 2014, called the **IMPACT Act**.

- **IMPACT ACT:** A bipartisan passed in October 2014 **Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)**.

IMPACT ACT

Goals of the National Quality Strategy

- **Better Care:** Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People, Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality healthcare for individuals, families, employers, and government.

IMPACT Act

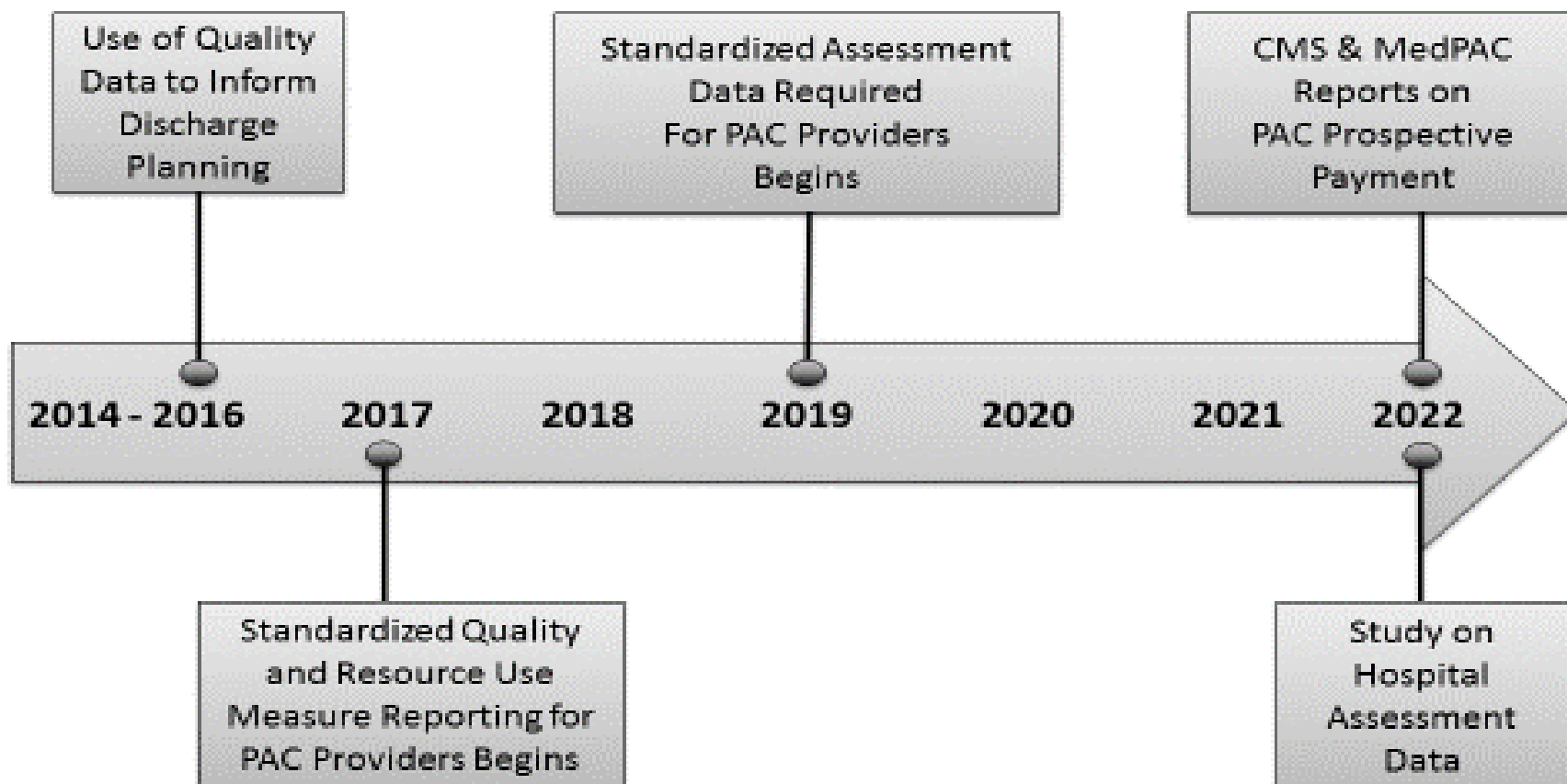
- **IMPACT Act** requires standardized resident assessments and Quality Measure data amongst post-acute care providers:
 - Long Term Care Hospitals (LTCHs),
 - Skilled Nursing Facilities (SNFs),
 - Home Health Agencies (HHAs), and
 - Inpatient Rehabilitation Facilities (IRFs).
- **IMPACT ACT** will use the common data objectives for quality of care, improved outcomes, discharge planning, and care coordination.
- **IMPACT ACT** and the SNF Quality Reporting Program (QRP)

IMPACT ACT

- **IMPACT Act** enhances the Five-Star rating system,
- **IMPACT Act** collects payroll data,
- **IMPACT Act** is the first step to move from **Fee-For-Service to Value-Based Purchasing**. The goal is for more affordable care by assessing medical costs during PAC (Post-Acute Care) episodes of care with care coordination.

IMPACT Act

Timeline of Major Deliverables in the IMPACT Act of 2014



Admission/Re-admission of a SNF Medicare A Resident

A0310. Type of Assessment

Enter Code

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B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment

02. **14-day** scheduled assessment

03. **30-day** scheduled assessment

04. **60-day** scheduled assessment

05. **90-day** scheduled assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clir

Not PPS Assessment

99. **None of the above**

Admission: Start of SNF PPS Stay

First Day of Medicare Part A Stay:

- Item A2400.A is coded '1', Yes to a Medicare Stay
- Item A2400.B is the Start of Medicare Stay date
- By completing these items in this manner, your technical specification in your software will open Section GG.

A2400. Medicare Stay

Enter Code

1

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

Part A PPS Discharge (NPE) Item Set

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING *Nursing Home Part A PPS Discharge (NPE) Item Set*

A discharge assessment developed to inform current and future SNF QRP measures and the calculation of these measures.

A0310. Type of Assessment

Enter Code

1 | 0

or

1 | 1

F. Entry/discharge reporting

- 01. Entry tracking record
- 10. Discharge assessment-return not anticipated
- 11. Discharge assessment-return anticipated
- 12. Death in facility tracking record
- 99. None of the above

Enter Code

☐

G. Type of discharge - Complete only if A0310F = 10 or 11

- 1. Planned
- 2. Unplanned

Enter Code

☐

H. Is this a SNF Part A PPS Discharge Assessment?

- 0. No
- 1. Yes

Part A PPS Discharge (NPE) Item Set: A0310.H

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING *Nursing Home Part A PPS Discharge (NPE) Item Set*

A0310. Type of Assessment

Enter Code <input type="text" value="9"/> <input type="text" value="9"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above	Code 99 – If resident remains in the SNF after Medicare Coverage Ends
Enter Code <input type="text"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned	
Enter Code <input type="text" value="1"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes	

Part A PPS Discharge (NPE) Item Set: A0310.H

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Part A PPS Discharge (NPE) Item Set

Coding Tips

Do not complete if:

- Resident is discharged within 2 days of the start of stay
- Resident dies

A2400C = End of Medicare Stay Date

- Last covered day OR
- Day of discharge (whichever comes first)

Section GG:

- Look back period is 3 days prior to discharge or covered day
- Day 3 is the date at A2400C

Planned / Unplanned Discharge

A0310G: Type of Discharge

Section A	Identification Information
A0310. Type of Assessment - Continued	
Enter Code <input type="checkbox"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned

A0310G: Type of Discharge

- Complete A0310G when item A0310F = **10 or 11**
 - **'1' Planned**
 - Discharge is anticipated and discharge planning has occurred
 - **'2' Unplanned**
 - Acute-care transfer of the resident to a hospital or an emergency department to either stabilize a condition or determine if an admission is needed, **OR**
 - Resident unexpectedly leaves facility AMA, **OR**
 - Resident unexpectedly decides to go home or another setting

End Date of Most Recent Medicare Stay - A2400

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

Definition:
Medicare-Covered Stay
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

Item Rationale

- Identifies when a resident is receiving services under the scheduled PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.


End Date of Most Recent Medicare Stay - A2400

A2400. Medicare Stay																																									
Enter Code <input type="checkbox"/>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <p>0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent Medicare stay</p> <p>B. Start date of most recent Medicare stay:</p> <table border="0"><tr><td><input type="text"/></td><td><input type="text"/></td><td>–</td><td><input type="text"/></td><td><input type="text"/></td><td>–</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td></td><td colspan="2">Day</td><td></td><td colspan="4">Year</td></tr></table> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <table border="0"><tr><td><input type="text"/></td><td><input type="text"/></td><td>–</td><td><input type="text"/></td><td><input type="text"/></td><td>–</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td></td><td colspan="2">Day</td><td></td><td colspan="4">Year</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"/>	Month			Day			Year				<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	–	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month			Day			Year			
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The end of Medicare date is coded as follows, whichever occurs first:

- Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
- Date of last day covered as recorded on the effective date from the Notice of Medicare Non-Coverage (NOMNC); or
- The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
- Date the resident was discharged from the facility (see Item A2000, Discharge Date).

Discharge Reporting

- Complete when resident is:
 1. Discharged from facility,
 2. Is admitted to an acute care hospital, or
 3. Has a hospital observation stay longer than 24 hours
 -  4. Is Medicare Part A PPS and discharges from Medicare, but the resident does not leave the facility.
- **Not** associated with NH bed hold status or opening and closing of medical record
- Two categories
 1. Discharge assessments
 2. Death in facility record (not an assessment – a tracking record).

Discharge Assessment - ND and NPE

- More than a tracking form.
- The **ND** and **NPE** item sets consist of demographic, administrative **and** clinical items
 - MDS items are a subset of what is present on the comprehensive assessment.
- May be combined with OBRA or PPS assessment or as a stand-alone assessment
- Completed when a resident is:
 - Discharged either return anticipated or return not anticipated **A0310F = 10 or 11**
 -  — **Part A PPS** stay ends (planned), but resident remains in the facility **A0310F = 99, A0310H = 1, Yes**

Combining Assessments

- **Medicare Scheduled and Unscheduled**

- May be times when more than one Medicare MDS is due in the same time period
- Cannot combine 2 Medicare scheduled MDSs but can combine scheduled and unscheduled

- **Medicare and OBRA**

- When OBRA and PPS time frames coincide, one MDS can be used for both needs
- Most stringent rules will apply however

- **Part A PPS Discharge Assessment (NPE) Item Set**

- If the end date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge Assessment are both required and may be combined.

Combining OBRA and NPE Assessments

- May be combined with OBRA or PPS assessment or as a stand-alone NPE assessment.
- PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date.
- Remember unscheduled PPS assessments (COT, SOT, EOT, EOT-R) **cannot** be combined with a NPE assessment.



“LOOK BACK PERIODS” or “ARD”

The following items have different **Look Back** periods:

- **D0200 or D0500** - Mood items = **last 14 days**
- **I2300** – UTI = **last 30 days**
- **J0100 - J0850** Pain items = **last 5 days**
- **J1700 - J1900** Falls = **last month to 6 months ago**
- **K0310** - Wt. Loss and Wt. Gain in **past 30 and 180 days**
- **O0100** – Special Treatments/Procedures, **O0600** - Physician Visits and **O0700**-Physician Orders = **last 14 days**
- ➔ • **GG** – First 3 days and last 3 days of Medicare Part A PPS stay

C1310: Signs and Symptoms of Delirium (from CAM)

Section C: Psychomotor Retardation has been removed and a new item C1310A: Acute Onset mental Status Change has been added.

Delirium	
C1310. Signs and Symptoms of Delirium (from CAM®)	
Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record	
A. Acute Onset Mental Status Change	
<input type="checkbox"/>	Is there evidence of an acute change in mental status from the resident's baseline? 0. No 1. Yes
Enter Codes in Boxes	
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<input type="checkbox"/> B. Inattention- Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?
	<input type="checkbox"/> C. Disorganized thinking- Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/> D. Altered level of consciousness- Did the resident have altered level of consciousness as indicated by any of the following criteria? •vigilant- startled easily to any sound or touch •lethargic- repeatedly dozed off when being asked questions, but responded to voice or touch •stuporous- very difficult to arouse and keep aroused for the interview •comatose- could not be aroused

CAM Assessment Scoring Methodology

The **Confusion Assessment Method (CAM)** provides a standardized method to enable nonpsychiatrically trained clinicians to identify delirium quickly and accurately in clinical settings.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

Section GG: Background Review

First a little background review

- **The IMPACT Act** is the driving force behind the implementation of **Section GG**
- As part of the IMPACT Act, the SNF Quality Reporting Program (SNF QRP) was initiated.
- The SNF QRP will begin collecting data from MDS assessments beginning October 1, 2016.
- SNF's that do not submit the required quality measures data may receive a two percentage point reduction to their annual payment update for the applicable payment year.

Section GG: Facts

- **Section GG focuses on 2 areas....**the resident's self-care and mobility.
- **Section GG** assesses the following 3 things:
 1. The resident's Admission Performance;
 2. Their discharge goals; and
 3. Their performance at the time of discharge.
- **Section GG only** applies to residents admitted for a Medicare Part A PPS skilled stay.
- Complete only for Medicare Part A PPS resident with a **PLANNED DISCHARGE**.

KEY
Concepts

Section GG: Timing & Look-Back

- **Section GG**
 - It must be completed at the time of admission and at the time of discharge.
 - If you are **combining** an Admission assessment with a 5 day assessment, you will complete both Sections G and GG.
 - Section GG is designed to assess the resident's current level of functioning, **NOT the prior level of function** that we are used to assessing for our SNF residents.
 - The look-back period for this assessment is **days 1-3** starting with the date in A2400B, Most Recent Medicare Stay.

Section GG: Helper Definition

- **“Helper” is a new term ...**
- **Helper:** For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff).
 - It does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing or CNA students, etc.
 - And it does not include family members and “sitters” hired by the family.

Section GG: Start of SNF PPS Stay

Admission Performance and Discharge Goals

Section GG	Functional Abilities and Goals – Admission (Start of SNF PPS Stay)
GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01	
Code the usual performance at the start of SNF PPS stay for each activity using the 6 point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6 point scale.	

Section GG	Functional Abilities and Goals – Admission (Start of SNF PPS Stay)
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01	
Code the usual performance at the start of SNF PPS stay for each activity using the 6 point scale. If activity was not attempted at the start of the SNF PPS stay, code the reason. Code the patient's end of SNF PPS stay goal(s) using the 6 point scale.	

Section GG

- Assessment period is days 1 through 3 of the Medicare Stay
- Usual performance is determined over days 1 through 3
- Day one is the date in A2400B

Section GG: Coding

**Code
06**

Independent: Resident completes the activity by him/herself with no assistance from a helper.

**Code
05**

Setup or clean-up assistance: Helper sets up or clean ups; Resident completes activity. Helper assist only prior to or following the activity.

**Code
04**

Supervision or touching assistance: Helper provides verbal cue or touching/steadying assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently.

Section GG: Coding (continued)

**Code
03**

Partial/Moderate Assist: Helper does less than half of the effort. Helper lifts, holds or supports trunk or limbs but provides less than half of the effort.

**Code
02**

Substantial/Maximal Assist: If the helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort.

**Code
01**

Dependent: If the helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity.

Section GG: Coding (continued)

AND other responses that can be coded ...

**Code
07**

Resident Refused: If the resident refused to complete the activity.

**Code
09**

Not Applicable: If the resident did not perform this activity prior to the current illness, exacerbation or injury.

**Code
88**

Not attempted due to medical condition or safety concerns.

Section GG: Other Coding Info.

- **Dashes:** Coding a *dash* (“-”) in these items indicates “*No information.*” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items **may result in a 2% reduction in annual payment** update.
 - If the reason that the activity was not attempted is that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), **use these codes instead of a dash (“-”).**
- Do not record the staff’s assessment of the resident’s potential capability to perform the activity...only code the **actual performance** in column 1.

GG0130. Self Care & GG0170. Mobility Admission Performance

- The Item Set **A03010B** will be coded: **01** for 5 day PPS MDS
- **A2400B** = Start date
- **Assessment Period** is day 1 through day 3
- **Code the resident's usual performance**
- **Can be combined with OBRA MDS**

1. Admission Performance	2. Discharge Goal
↓ Enter Codes in Boxes ↓	
<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"/>

06 = Independence
05 = Setup or Clean Up
04 = Supervision or Touching
03 = Partial/Moderate
02 = Substantial/Maximal
01 = Dependent

GG0130. Self Care & GG0170. Mobility

Discharge Goal (at admission)

- Use the same scale that is used in Admission Performance. The 6 point **Safety and Quality Performance** scale
- **Discharge Goals:** Code one goal for each self-care and mobility item.
- **Do not use** codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

1. Admission Performance	2. Discharge Goal
↓ Enter Codes in Boxes ↓	↓ Enter Codes in Boxes ↓
<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"/>

06 = Independence
05 = Setup or Clean Up
04 = Supervision or Touching
03 = Partial/Moderate
02 = Substantial/Maximal
01 = Dependent

Remember this is the resident's goal, along with what therapy hopes to accomplish

GG0130. Self Care & GG0170. Mobility Discharge Goal (at admission)

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
<input type="text"/>	<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
<input type="text"/>	<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

06 = Independence
05 = Setup or Clean Up
04 = Supervision or Touching
03 = Partial/Moderate
02 = Substantial/Maximal
01 = Dependent

- **Use the same scale** that is used in Admission Performance. The 6 point **Safety and Quality Performance** scale
- **Discharge Goals:** Code one goal for each self-care and mobility item.
- **Do not use** codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

Remember this is the resident's goal, along with what therapy hopes to accomplish

Section GG0130. Self Care

Discharge (End of SNF PPS Stay) NPE Item Set

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)

Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, 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 or TOUCHING/STEADYING 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.**
- 88. **Not attempted due to medical condition or safety concerns.**

**3.
Discharge
Performance**

Enter Code

Enter Code

Enter Code

A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency.

B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Code
resident's
usual
performance
during the last
3 days of the
SNF PPS Stay



Section GG0170 Discharge End of SNF PPS Stay NPE Item Set

Code resident's
usual performance
during the **last 3**
days of the SNF PPS
Stay

This section looks at
the resident's
performance level
FROM the time of
admission to
planned discharge.
This section notes if
there has been
progress when they
discharge from the
Skilled PPS Stay.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to safely 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.
<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> H1. Does the resident walk? 0. No, and walking goal is <u>not</u> clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. No, and walking goal <u>is</u> clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. Yes → Continue to GG0170J, Walk 50 feet with two turns
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Q1. Does the resident use a wheelchair/scooter? 0. No → Skip to GG0130, Self Care (Discharge) 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

The coding in
this section **will**
have an impact
on
reimbursement
sometime in
the near future.

J1900: Number of Falls since Admission or Prior Assessment

- Section J clarifies that a significant injury may not be present at the time of the MDS: **Should a serious injury present after the ARD, a modification must be done to indicate that serious injury.**

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	<input type="checkbox"/>	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/>	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look-back period of the MDS.

J1900: Number of Falls since Admission or Prior Assessment

J1900 Level of Injury Instructions: “If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.”

- Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

Section M: M0300 and Determining Present on Admission

****UPDATE October 2016****

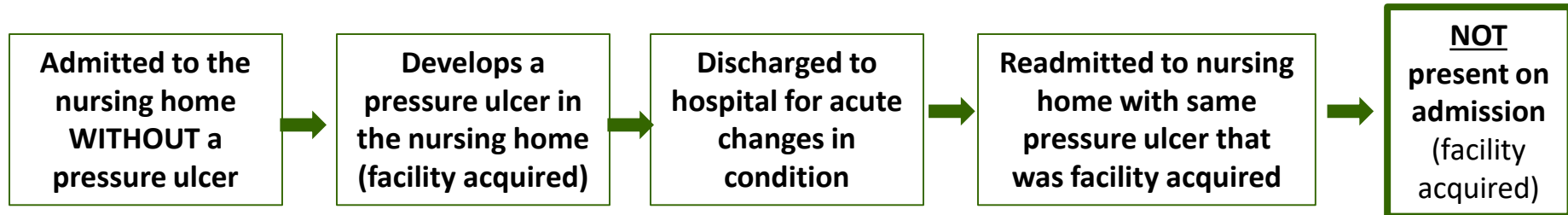
If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is **still coded as “present on admission”** because it was **originally acquired outside the facility** and has not changed in stage.

- This is a Quality Measure item and facilities need to ensure they are coding this item correctly to avoid manipulating the QM data.

Section M: M0300 and Determining Present on Admission

****UPDATE October 2016****

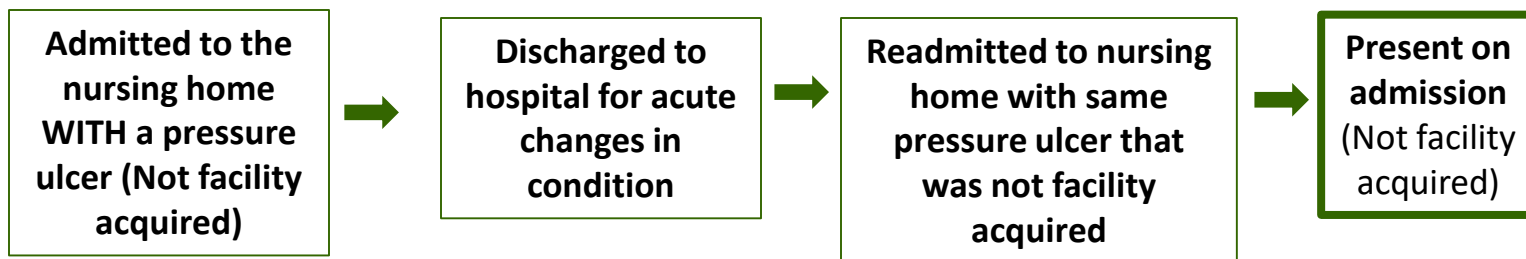
- Ms. K is admitted to this facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a **facility-acquired** pressure ulcer and was not **“present on admission.”** Ms K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home and should not be considered as “present on admission”** when she returns from the hospital.



Section M: M0300 and Determining Present on Admission

****UPDATE October 2016****

- Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as **“present on admission”** as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered “present on admission”** because it was **originally acquired outside the facility** and has not changed.



Resources

- **CMS - four-part video series on MDS 3.0 Section GG.** Available on the CMS YouTube Channel: This four-part video series presents MDS 3.0 Section GG, available on the CMS YouTube Channel: https://www.youtube.com/playlist?list=PLaV7m2-zFKpgYhG0FQv82l9dcqNI_9eO4
- **RAI Manual Version 1.14 October 2016**
<https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf>

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Thank-you!



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