

Aug. 3, 2016

Upcoming MDS 3.0 Changes: Section GG and More

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MDS 3.0 Updates and New Quality Measures

- ❑ CMS has released the updates to the RAI Manual and added 2 new sections to the MDS.
- ❑ Although these are still in draft form, CMS isn't expected to make significant changes.
- ❑ Along with the new sections and revisions, they have released 3 new Quality Measures that directly tie into the revised MDS process.

Objectives

- At the end of this presentation, each participant will be able to...
 - ▣ Verbalize a basic understanding of the changes that will occur Oct. 1, 2016;
 - ▣ Differentiate between the new sections of MDS 3.0; and
 - ▣ State where they can obtain more information regarding the 3 new Quality Measures.

Update to the RAI/MDS

4

- Each October usually brings a new version of the RAI manual, new MDS sections or changes to existing sections.
- With these updates, occasionally the changes are significant. (Remember COT's [Change of Therapy assessments]?)

Update to the RAI/MDS (cont.)

5

- This October is no different! There has been a lot of anxiety over Section GG and we are going to spend the majority of our time, we have available today to explain this section.
- But let's cover the other changes first...(easy part!)

Changes to Sections C, J and M

- Section C: They have removed Psychomotor Retardation and have added a new item C1310A: Acute Onset Mental Status Change.
- “Is there evidence of an acute change in mental status from the resident’s baseline?”
- They have also deleted C1300 and C1600 and replaced it with the above item sets.
- This will change how the Delirium CAT is triggered, as it will pull from the new items.

Changes to Sections C, J and M (cont.)

- 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 needs to be done to indicate that serious injury.
- 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 the fall.”
- Example:
 - Resident falls, suspected hip fracture, goes out to the hospital and is admitted with a confirmed fracture. The MDS will need to be modified to confirm the fracture.

Sections C, J and M (cont.)

- Section M: This update clarifies the “Present on Admission” instructions and gives some very good examples.
- The instructions stated that, “If a resident who has a pressure ulcer that was ‘Present on Admission’, (not acquired in the facility), is hospitalized and returns with the pressure ulcer at the same numerical stage, the pressure ulcer is still coded as ‘Present on Admission’ because it was still acquired outside the facility and has not changed in stage.”

Sections C, J and M (cont.)

- A very good example that CMS gives is the following:
 - Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a facility acquired PU and is “Not present on admission.” Ms. K is hospitalized and returns with the same stage 2 PU. 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.
 - This is a Quality Measure item and facilities need to ensure they are coding this correctly to avoid manipulating the QM data.

Section GG

- First a little background!
 - ▣ The IMPACT Act is the driving force behind the implementation of Section GG.
 - ▣ As part of the IMPACT Act, the SNF Quality Reporting Program was initiated.

Section GG (cont.)

- ❑ The SNF QRP will begin collecting data from MDS assessments beginning October 1, 2016.
- ❑ There are also 6 new Quality Measures that collect data from MDS assessments.
- ❑ 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.
- ❑ This is why we now have Section GG and must understand how to code it and what the submission guidelines are!

Section GG (cont.)

- Section GG focuses on 2 areas...the resident's self-care and mobility.
- GG assesses the following 3 things:
 - ▣ The resident's Admission Performance;
 - ▣ Their discharge goals; and
 - ▣ Their performance at the time of discharge.

Section GG (cont.)

- There is some good news about Section GG...it only applies to residents admitted to a skilled stay!
- It must be completed at the time of admission and at the time of discharge. Let's talk about the admission assessment first. (If you are combining an Admission with a 5 day, you will complete both Sections G and GG!)
- This assessment is designed to assess the residents current level of functioning at the time of admission, 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, Start of Most Recent Medicare Stay.

Section GG (cont.)

- GG0130: Self-Care Steps for Assessment
 - The instructions tell us to assess the resident's self-care status based upon direct observation, the resident's self-report, family reports and direct care staff reports documented in the residents medical record during the 3 day assessment period, (days 1-3).
 - The resident should be allowed to perform activities as independently as possible, as long as they are safe.
 - If "helper" assist is required because the resident's performance is unsafe or of poor quality, only consider staff assistance when scoring according to the amount of assistance provided.

Section GG (cont.)

- “Helper” is a new term to us...it is defined as “facility staff who are direct employees and facility contracted employees, (example: therapy staff or agency staff).
- It does not include individuals hired, compensated or not, by individuals outside of the facilities management and administration such as hospice staff, nursing or CNA students, etc.
- This would also include family members and “sitters” hired by the family.

Section GG (cont.)

- GG0130: Self-care Item Rationale:
 - “During a Medicare Part A SNF stay, a resident may have self-care limitations on admission. In addition, residents may be at risk for further functional decline during their stay in the SNF.”
 - That is why this assessment is so important! It is looking at the residents current baseline, assessing what their goals are and then looks at the resident again when they discharge from Part A services.

Section GG Item Set Coding

- Item set coding for Section GG is very different from what we are used to seeing in Section G.
- For those of you that have been involved in SNF for a longer time period, you might be more familiar with the coding as it seems to be therapy lingo and functionally driven.
- This is a true functional assessment and you need to involve your therapy team when you are coding these items.
- The terminology and the actual coding items will take some time to get used to but, the instructions are actually very clear! (Unlike G...that's another issue!)

Section GG Item Set Coding (cont.)

- GG uses a 6-point scale...again this is very different from Section G.
- Plus, it's backwards from the current coding in G!
- 06: Independent: if the resident completed the activity by him/herself with no assistance from a helper.
- 05: Setup or clean-up assistance: If the helper SETS-UP or CLEANS UP; resident completes the activity. Helper assists only prior to or following the activity, but not during the activity.
- 04: Supervision or touching assistance: if the helper provides verbal cues or touching/steadying assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

Section GG Item Set Coding (cont.)

- 03: Partial/Moderate Assist: if the helper does less than half of the effort. Helper lifts, holds or supports trunk or limbs but provides less than half of the effort.
- 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 the effort.
- 01: Dependent: If the helper does ALL of the effort. Resident does none of the effort to complete an activity, or the assistance of two or more helpers is required for the resident to complete the task.

Section GG Item Set Coding (cont.)

- ❑ In addition to the 6 point scale there are a couple of other responses that can be coded.
- ❑ 07: Resident Refused: if the resident refused to complete the activity.
- ❑ 09: Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation or injury. (Resident was non-ambulatory before fall that led to hospital stay.)
- ❑ 88: NOT ATTEMPTED DUE TO MEDICAL CONDITION OR SAFETY CONCERNS: If the activity was not attempted due to medical condition or safety concerns.
- ❑ I highlighted this code in particular, because it seems as CMS has place special emphasis on this response.

Section GG Item Set Coding (cont.)

- At the recent RAI Training in Baltimore, instructors seemed to emphasize this in particular, they were explicit in stating that at no time should dashes be used unless there are no other options.
- Dashing a response instead of using the appropriate corresponding coding could result in your QM data not being generated which could result in a loss of payment.
- For example: A resident has a G-Tube and is fed 100% by this process. On the Eating section of GG, GG1030A, on the Admission performance , GG1030A1, it would be coded as an 88, Activity not attempted due to Medical condition or safety concerns. (Feeding is not medically safe.)
- A dash ("-") indicates "No information." CMS expects dash use for quality indicator items to be a rare occurrence. Use of dashes for quality items may result in a payment reduction. If the reason the item was not assessed was 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 ("-").

Section GG Item Set Coding (cont.)

<p>GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01</p>		
<p>Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.</p>		
<p>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. <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 or TOUCHING/STEADYING 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.</p> <p>88. Not attempted due to medical condition or safety concerns.</p>
1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
□ □	□ □	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.

Section GG Item Set Coding (cont.)

□ Coding Tips:

- Assistive Devices: Activities can be completed with or without an assistive device. Use of assistive devices should not impact the coding on the activity.
- Residents should be coded performing activities based upon their “usual performance” or baseline performance, which is defined as the residents usual activity/performance for any of the self-care or mobility activities, NOT the most independent performance and NOT the most dependent performance over the assessment period.
- Read each instruction for the coding of item sets very carefully...Section GG of the RAI, Chapter 3, GG 1-31, offers very clear instructions and some excellent examples on coding.
- Do not record the staff’s assessment of the residents capability to do an activity...only code the actual performance.

Section GG Item Set Coding (cont.)

1. Admission Performance		2. Discharge Goal	
↓ Enter Codes in Boxes ↓			
<input type="text"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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 not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. No , and walking goal is 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"/>	<input type="checkbox"/>	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"/>	<input type="checkbox"/>	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"/>	<input type="checkbox"/>	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"/>	<input type="checkbox"/>	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

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

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.**

Section GG Item Set Coding (cont.)

- Let's talk about the second column on this section which is the residents discharge goals.
- Using GG0170K-Walk 150 Feet as an example...let's say Mr. Jones was admitted to us after a fall with a humeral fracture. He used a walker prior to his fall and that is his baseline activity. Section GG0170K column 1 Admission Performance might be a 03: Partial/Moderate assist, but his goal for his skilled stay is to get back to the walker, so column 2 Discharge Goal, would be coded as a 06 because he hopes to be become independent again.
- Remember this is the resident's goal, along with what therapy hopes to accomplish during a skilled stay.

GG0130 Discharge End of SNF PPS Stay

- This assessment is completed when a resident has a planned discharge from the SNF Part A stay.
- It is not completed when a resident discharges out to the hospital BUT, the GG Admission assessment is required with each new admission/re-admission.
- When the resident has a planned discharge, the look-back period for this assessment is the last 3 days prior to the discharge, including the discharge date. (Last 3 days of SNF stay ending on date coded in A2400C)
- These items will indicate the resident's performance ability at the time of their discharge from a SNF stay.

GG0130 Discharge End of SNF PPS Stay (cont.)

<p>GG0170. Mobility (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</p>	
<p>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.</p>	
<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. <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. 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.</p> <p>If activity was not attempted, code reason:</p> <p>07. Resident refused. 09. Not applicable. 88. Not attempted due to medical condition or safety concerns.</p>	
<p>3. Discharge Performance Enter Codes in Boxes</p>	
<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="checkbox"/>	H3. Does the resident walk? 0. No → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 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="checkbox"/>	Q3. Does the resident use a wheelchair/scooter? 0. No → Skip to H0100, Appliances 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="checkbox"/>	RR3. 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="checkbox"/>	SS3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

GG0130 Discharge End of SNF PPS Stay (cont.)

- It's easy to see why this new assessment is so important to the SNF Quality Reporting Measures.
- We are looking at what the resident's performance level is at the time of admission and if there has been progress when they discharge from the Skilled PPS stay.
- The Quality Measure that this directly feeds into is the following: Application of percent of long term care hospital patients with an Admission and Discharge Functional Assessment and a Care Plan that addresses function.
- The coding in this section will have an impact on reimbursement sometime in the near future and will guide future changes to the MDS and SNF PPS assessments.

GG0130 Discharge End of SNF PPS Stay (cont.)

- Again, these are draft rules...but coming from the RAI conference, it doesn't appear as if there will be significant changes to the draft.
- The submission time frames are unchanged from the previously stated rules. All assessments must be submitted within 14 days of completion.
- There is one other new assessment I'll briefly cover, it's the new Part A PPS Discharge Assessment. (NPE)
- This assessment is also tied to the new QRP/QM and is used to help with tracking of SNF residents. In this case, when a resident DC's from SNF but remains in the facility under LTC.
- It must be completed within 14 days after End Date of Most Recent Medicare Stay, (A2400C+14 calendar days)

GG0130 Discharge End of SNF PPS Stay (cont.)

- ❑ The SNF PPS Discharge Assessment, (NPE), is NOT required if the discharge was unplanned!
- ❑ But...if you complete an NPE on day 20 and then on day 21 the resident discharges to the hospital, the Discharge Return Anticipated/Not Anticipated assessment is still required and can be combined.
- ❑ Again, this is only required when a resident discharges from a Part A stay and remains in your facility!

Section GG Coding Tips

- Involve your therapy staff on Section GG.
 - They understand this lingo very well and can help you understand the functional assessments.
- Teach your direct care staff the basics.
 - It's very difficult to get them to code Section G now, but sometimes, teaching them new things are easier and you get better buy-in.
- If you aren't already having PPS meetings to discuss discharges, now is the time to start.
 - You should encourage your IDT team to become more involved because this is a big care plan area as well. You should be addressing your residents goals in the POC.

Notes from CMS RAI Training

- Section I and Diagnosis for Use of Antipsychotic Medications:
 - There was great discussion regarding the addition of Schizophrenia diagnosis in Section I as a result of the initiative to reduce AP medications.
 - The number of “newly” diagnosed Schizophrenia residents in LTC facilities is alarming.
 - These diagnoses are being added as a way to support the medications that are being utilized.
 - CMS agrees that this is not appropriate and will instruct surveyor’s to investigate to determine if these are being added solely to support the medication usage or in a much worse scenario; to circumvent the Quality Measure.

Notes from CMS RAI Training (cont.)

- Adding these diagnoses to a resident that is 80 years old, without a prior history of Schizophrenia is inappropriate.
- Remember in order to add a diagnosis to Section I, you must meet the following criteria...from the RAI, Chapter 3, Section I, page I-3,4.
- The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.
- Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

Notes from CMS RAI Training (cont.)

- Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.
- Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

Notes from CMS RAI Training (cont.)

- Think carefully before you just “add” a diagnosis to support a medication. It is very rare for an elderly resident to “suddenly” develop Schizophrenia.
- Besides being a potential survey issue, this could also be an issue with the OIG...Schizophrenia is a payment item. If you are coding it without a true foundation, that is fraudulent and puts you at risk for recoupment or worse.

Finally...

36

This is a lot of information but I want you to know how to find the resources to help you!

- **Quality Measures:**

- <https://www.cms.gov/Medicare/Quality-initiatives-patient-assessment-instruments/NursingHomeQualityInits/NHQIQualityMeasures.html>

- **Section GG:**

- <https://www.cms.gov/Medicare/Quality-Initiatives-patient-assessment-instruments/NursingHomeQualityInits/MDS30RAIManual.html>

- **SNF QRP/IMPACT Act:**

- <https://federalregister.gov/a/2015-18950> (Look for the SNF FY 2016 Final Rule)

- **Skilled Nursing Facility PPS:**

- <https://www.cms.gov/Medicare/Medicare-fee-for-service-payment/SNFPPS/index.html/redirect=/snfpps/>

Contact Info for Texas Providers

37

- I am always available to help you...that is my primary job, to serve as a help-desk for any MDS/PPS questions you might have.
 - **Shelly Nanney, RN, RAC-CT**
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New number...(979) 732-8507
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- Non-Texas providers: Please contact your local state MDS/RAI Coordinator

Questions & Answers

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