
**PENNSYLVANIA MA CASE-MIX REIMBURSEMENT
SYSTEM**



RESIDENT DATA REPORTING MANUAL

Revised 10-01-2019

Department of Human Services and Myers and Stauffer LC

Contents

1 INTRODUCTION	1-1
BACKGROUND	1-1
“INFORMED MDS USER” ASSUMPTION	1-2
MDS INFORMATION RESOURCES	1-2
Websites	1-2
Manuals	1-3
Phone, Fax and E-Mail	1-4
2 PA-SPECIFIC MDS	2-1
MDS SECTIONS	2-1
SECTION S	2-1
SECTION S FORMS	2-2
PA-SPECIFIC MDS SPECIFICATIONS	2-14
Data Specifications	2-14
Active on ISCs	2-15
Section S Items Not Required	2-16
MA for MA Case-Mix Purpose	2-17
Acceptable Item Values	2-17
Transition	2-18
Software	2-19
Vendor Testing	2-19
3 MA FOR MA CASE-MIX	3-1
MA FOR MA CASE-MIX STATUS	3-1
Transition	3-1
Evaluating for MA for MA Case-Mix Status	3-2
Non-MA Status	3-3
CODING FOR MA FOR MA CASE-MIX STATUS	3-4
MA STATUS CONTINUUM	3-5
MA PENDING	3-5
MA Pending Examples	3-5
DAY-ONE MA ELIGIBLE	3-7
4 DATA SUBMISSION	4-1
GETTING STARTED	4-1
Change of Provider Information	4-2
SUBMISSION PROCESS	4-3
Submission Deadlines	4-3
Replication to the NIS	4-3
Resident Identification Information	4-4
Records with the Same Effective Date	4-4
PICTURE DATE SUBMISSIONS	4-5
Picture Date Submission and Correction Deadlines	4-5
5 RUG CLASSIFICATION	5-1
RUG-III, VERSION 5.12	5-1

ELIGIBLE ASSESSMENTS.....	5-2
RUG WORKSHEET	5-2
INTRODUCTION TO THE MDS 3.0 RUG-III v. 5.12 44-GROUP CLASSIFICATION TOOL.....	5-3
6 CMI REPORTS	6-1
CASE-MIX INDEX.....	6-1
CMI REPORT GENERATION	6-1
Initial CMI Report Transition	6-1
Subsequent CMI Reports.....	6-2
CMI Report File Names.....	6-2
Picture Date Transition.....	6-3
REVIEWING CMI REPORTS	6-3
Residents	6-3
Discharge – Return Anticipated.....	6-5
MA for MA Case-Mix Status	6-6
Assessments	6-6
Non-Valid Assessments.....	6-7
Duplicate Resident Entries	6-8
Occupancy Calculations	6-9
Supplemental Ventilator and Tracheostomy Care Payment (SVTCP).....	6-10
Reformatting of the CMI Report	6-10
CERTIFICATION PAGE SUBMISSION DEADLINE	6-11
PICTURE DATE CALENDAR.....	6-12
PICTURE DATE CLOSURE	6-13
7 MA CASE-MIX RATES	7-1
OVERVIEW OF MA CASE-MIX REIMBURSEMENT	7-1
COUNTY NURSING FACILITY REIMBURSEMENT	7-2
8 HELPDESK	8-1
MYERS AND STAUFFER HELPDESK	8-1
HELPDESK ASSISTANCE.....	8-2
PROBLEMS NOT SUPPORTED	8-2
9 FIELD OPERATIONS REVIEW	9-1
ABOUT BUREAU OF PROVIDER SUPPORT FIELD OPERATIONS REVIEWS.....	9-1
PREPARING FOR A FIELD OPERATIONS TEAM VISIT.....	9-1
DOCUMENTATION GUIDANCE.....	9-2
Disclaimer	9-2
APPEALING FIELD OPERATIONS REVIEWS	9-2
DOCUMENTATION GUIDELINES.....	9-4
Column Explanations	9-4
Documentation Guidelines	9-5
10 GLOSSARY	10-1
COMMON TERMS AND ABBREVIATIONS	10-1
11 ACRONYMS	11-1
COMMON ACRONYMS	11-1

1 INTRODUCTION

BACKGROUND

The Department of Human Services (formerly the Department of Public Welfare) (the Department) initially published 55 Pa. Code Chapter 1187: Nursing Facility Services; Case-Mix Reimbursement System on October 14, 1995 in the [Pennsylvania Bulletin](#). These regulations set forth, among other things, resident data reporting requirements that must be met in order to receive payment for Medical Assistance (MA) nursing facility services. This manual provides guidance for the accurate and timely satisfaction of these requirements and explains how the results are used in the nursing facility's (NFs) MA Case-Mix Reimbursement rate.

Since March 1993, the Department has been collecting Minimum Data Set (MDS) data electronically for use in MA Case-Mix Reimbursement rates. There were federal regulations already in place at that time mandating that the MDS be completed for all residents residing in NFs receiving Title XVIII (Medicare) and Title XIX (Medicaid) funding; the Department then mandated the electronic submission of this data for use in MA Case-Mix Reimbursement rates.

In late 1997, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), published regulations regarding computerization of the MDS. These regulations required NFs to encode the MDS 2.0, ensure that the data passed standardized edits defined by the CMS and the state, and transmit the MDS in a standardized format in accordance with specifications provided by the CMS. With the adoption of these regulations, the Department specified a PA-Specific MDS based on MDS 2.0 and began using MDS data submitted in accordance with these regulations in the MA Case-Mix Reimbursement rates.

On June 24, 2006, new regulations were released modifying Chapter 1187 Nursing Facility Services and creating Chapter 1189 relating to County Nursing Facility Services to institute a new rate setting methodology for these facilities. Changes in these regulations affecting resident data reporting are incorporated into this manual. The regulation may be found at <http://www.pabulletin.com/secure/data/vol36/36-25/1194.html>

In the Final Rule for the Medicare Program Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010 (<http://edocket.access.gpo.gov/2009/pdf/E9-18662.pdf>), CMS mandated that a new assessment instrument, MDS 3.0, must be used by Medicare

and Medicaid participating nursing facilities beginning October 1, 2010. To accommodate this change, the Department implemented RUG-III v. 5.12 44 Group classification, selection of the latest classifiable assessment for creation of the CMI Report, and use of a new set of PA Normalized Nursing Only CMIs. These changes were effective for the rate setting year beginning July 1, 2010. The PA-Specific MDS is described in this manual, along with any additional submission requirements beyond those defined by the CMS.

The CMS has continued to refine the MDS 3.0 instrument and the associated RAI Manual. Further revisions were put in place for October 1, 2019, with a requirement to use MDS 3.0 Version 1.17.1. This manual has been updated to coordinate with these latest requirements.

This version of the manual provides information necessary to assist Pennsylvania's MA participating nursing facilities in understanding how MDS 3.0 is used in the PA MA Case Mix Reimbursement rate setting system.

“INFORMED MDS USER” ASSUMPTION

The MA facility's resident data reporting requirements are linked closely to the federal requirements for completion and submission of MDS 3.0. Because of this relationship, this manual concentrates on those reporting requirements that are beyond the requirements and scope of the federal regulation and apply only to the MA Case-Mix Reimbursement System or additional resident data reporting requirements beyond those required by the CMS. The assumption is that the user of this manual understands and is proficient in completion of the MDS 3.0 and federal submission requirements. Therefore, any terms and concepts that apply to these areas and are commonly defined elsewhere have not been duplicated in this manual.

MDS INFORMATION RESOURCES

While this manual concentrates on resident data reporting beyond that which is required federally, the following list of resources may be beneficial to aid in the correct completion and submission of the MDS 3.0 to fulfill federal requirements. However, these resources do change over time; it's recommended that facilities view the websites periodically to determine if any updates to the listed manuals and question and answer documents have been made. In addition, local and state provider or nursing associations may be helpful in providing training and materials.

Every effort is made to assure that the information provided in this manual is accurate. However, the MDS is an assessment instrument implemented by the federal government. If later guidance is released by the CMS that contradicts or augments guidance provided in this manual, this more current information from the CMS becomes the acceptable standard.

Websites

- www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html.

This site is maintained by the CMS and provides extensive information about the MDS, data submission, Medicare PPS RUG classification, etc.

- Support is provided to each state in managing their NFs' MDS submissions and maintains a provider helpdesk for users of jRAVEN. It is referred to by the CMS as their Quality Improvement and Evaluation System (QIES) Technical Support. <https://qtso.cms.gov/software/jraven>. This website contains information on the MDS submission process, manuals, etc.
- <http://www.health.pa.gov/facilities/Consumers/Health%20Facilities/Nursing%20Homes/Nursing%20Homes/Pages/default.aspx#.V-Exgx3D-ot>. This site provides information about the Department of Health (DOH) activities in NFs.
- <http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm#>. This site provides information about long term care and case-mix issues.

Manuals

- Long-Term Care Facility Resident Assessment Instrument 3.0 (RAI) User's Manual Version 1.17.1 effective October 1, 2019. This manual provides information about the completion of the MDS and is available from various publishers, CMS www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Changes to this manual are released periodically by the CMS; monitor the CMS site for the latest information. Procedures for correcting MDS 3.0 assessments are included in this manual.
- Provider User's Guide. This manual provides information about the electronic submission of MDS 3.0 from the facility to the CMS MDS 3.0 Data Collection System database and obtaining Validation Reports from the CASPER Reporting system. It is available at <https://qtso.cms.gov>. It includes information about the edit messages facilities receive on their Final Validation Reports as well.
- CASPER Reporting User's Guide for MDS Providers. This user's guide provides specific instructions for obtaining Final Validation Reports and generating many other MDS 3.0 analysis reports. It is available on the MDS Welcome Page just below the submission keyholes or at <https://qtso.cms.gov>.
- MDS 3.0 Data Submission Specifications. This document describes item-by-item edits for each element of the MDS 3.0 as well as describing sequencing, timing, date consistency and Record Types. The document and updates are available on the CMS website at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

- MDS 3.0 Quality Measures User's Manual. This manual details the calculation of the Quality Measures which are used in the Survey and Certification process and are posted on Nursing Home Compare. The latest version (v12.0) is available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.

Phone, Fax and E-Mail

- Department of Health (DOH) - 1-717-787-1816. This department provides answers to questions concerning completion of the MDS and interpretation of the Quality Measures. Questions may also be submitted to qa-mds@pa.gov.
- Myers and Stauffer Helpdesk - 1-717-541-5809 (phone), 1-717-541-5802 (fax), pahelpdesk@mslc.com (e-mail). This firm is a contractor to the Department and provides technical assistance for the submission of MDS 3.0. Refer to Section 8 for more information about help desk services.
- CMSNet/Verizon Helpdesk - 1-888-238-2122. This helpdesk provides necessary connection software and passwords to allow connectivity to the CMS MDS 3.0 Data Collection System.
- Medicare Administrative Contractor (MAC) – 1-877-235-8073 or www.novitas-solutions.com. These organizations process Medicare claims for the NF. In PA, Novitas Solutions is the MAC. They can be contacted for questions about Medicare PPS assessments, HIPPS codes and the UB-04 billing document.
- Department of Human Services (DHS) – 1-800-932-0939. This department provides answers to questions concerning MA Case-Mix Reimbursement rates, MA billing and extensions for Picture Date deadlines.
- Community HealthChoices (CHC) Provider Helpdesk- 1-800-932-0939. This helpdesk assists with questions regarding CHC participants and their specific healthplan.

2 PA-SPECIFIC MDS

MDS SECTIONS

The CMS provides states with the ability to designate their own MDS 3.0 document, as long as the document contains the minimum federally required sections. Pennsylvania has designated a document, the PA-Specific MDS, which contains Section A – Q, S, V, X and Z of the MDS 3.0 (Version 1.17.1 required beginning October 1, 2019). For quarterly and PPS assessments, the identical federally designated Item Subsets are used in Pennsylvania with no additions except Section S.

Rather than specific forms, MDS 3.0 designates Item Subset Codes (ISCs) based on the responses to A0310 Type of Assessment. Data entry software should present the MDS items to be completed based on those responses. All ISCs may be found on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html> and in Appendix H of the RAI Manual.

SECTION S

Pennsylvania has designated Section S as a state-specific section of the PA-Specific MDS. Portions of Section S are required on the Comprehensive subset (NC), Quarterly subset (NQ), Medicare PPS subset (NP), Discharge subset (ND), and the Tracking subset (NT).

The Signatures of Persons Completing the Assessment or Entry/Death Reporting (Z0400) should be signed by the person completing the required portions of Section S on whatever type of record is being completed.

SECTION S FORMS

Section A through Section Q and Sections V, X and Z of the MDS 3.0 may be found on the CMS website with all the various ISC formats, as well as being available in Appendix H of the RAI Manual. Section S is included in this manual on the following pages along with instructions for completion.

Effective October 1, 2017, several items were added to Section S to gather information related to NF Transition and Community HealthChoices programs. New items include:

- S0113 Resident Living Situation Prior to Admission,
- S0114 Support Person,
- S0521 Primary Reason for Admission,
- S9085A Is the resident enrolled in CHC?,
- S9085B CHC Effective Date,
- S9085C CHC Plan and
- S9085D CHC Member ID

All information necessary to utilize these items is included in this chapter. All Section S items previously required are still included with no changes in their completion requirements.

**Pennsylvania
MDS 3.0 Section S**

Section S	Pennsylvania Specific Items
Demographic and Background	
S0113. Resident Living Situation Prior to Admission Complete only if A0310A = 01.	
<input style="width: 30px; height: 20px;" type="text"/>	01. Resident lived alone without services 02. Resident lived alone with services 03. Resident lived with caregiver in the home who is able to assist with daily medical and custodial needs 04. Resident lived in congregate situation 99. None of the above
S0114. Support Person Complete only if A0310A = 1 – 6 or A0310F = 10	
<input style="width: 30px; height: 20px;" type="text"/>	Resident has one or more support person(s) who are positive towards discharge. 0. No 1. Yes
S0120. ZIP Code of Prior Primary Residence Enter the first five digits of the zip code. Complete only if A0310F = 01,12	
	<input style="width: 30px; height: 20px;" type="text"/>
S0123. County Code of Prior Primary Residence Enter the three-digit code from table. Complete only if A0310F = 01,12	
	Code 999 if out-of-state <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
S0521. Primary Reason for Admission Complete only if A0310A = 01	
<input style="width: 30px; height: 20px;" type="text"/>	01. Significant change in functional status 02. Deterioration in cognitive status 03. Change in the availability/status of primary caregivers 04. Difficulty arranging or paying for needed in-home care or support 05. Failed to succeed in residential care home 06. Short term rehabilitation or skilled care 99. None of the above
Discharge After Discharge	
S8010H1. Picture Date Reporting Complete only if A0310F = 11	
Check if applies <input style="width: 30px; height: 20px;" type="text"/>	Check this item if the assessment is a Discharge Return Anticipated assessment (DRA) AND is to be used as a Discharge Return Not Anticipated (DRNA) for Picture Date reporting requirements

Payment

S9080. Source of Payment

Enter Code

A. Is the resident Medical Assistance for MA CASE-MIX? (see instructions)

- 0. No
- 1. Yes

B. Date of change to/from Medical Assistance for MA CASE-MIX

Month		Day		Year		

C. Recipient Number from PA ACCESS Card Must be completed if S9080A = 1

--	--	--	--	--	--	--	--	--	--	--	--

D. MA NF Effective date from PA/FS 162

Month		Day		Year		

Enter Code

E. Is the resident DAY ONE MA Eligible?

- 0. No
- 1. Yes

Community Health Choices (CHC)

S9085. CHC Enrollment Details

Enter code

A. Is the resident enrolled in CHC?

- 0. No → Skip S9085B, C and D
- 1. Yes → Complete S9085B, C and D

B. CHC Effective Date Must be completed if S9085A = 1

Month		Day		Year		

C. CHC Plan Enter the two-digit code from table. Must be completed if S9085A = 1

--	--

D. CHC Member ID Must be completed if S9085A = 1

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MDS 3.0 Section S Manual

SECTION S: PENNSYLVANIA SPECIFIC ITEMS

Intent: The intent of items in this section is to collect additional demographic and Pennsylvania Medical Assistance case-mix payment information. Portions of Section S must be completed with all MDS 3.0 OBRA and PPS assessments (A0310A Federal OBRA Reason for Assessment = 01 – 06, A0310B PPS Assessment = 01); Discharge assessments (A0310F = 10, 11); and Tracking forms (Entry Record [A0310F = 01] and Death in facility record [A0310F = 12]). S8010H1Picture Date Reporting must be completed on any assessment when A0310F = 11 Discharge Return Anticipated regardless of the ISC being completed. Section S is not required with the stand-alone Nursing Home Part A PPS Discharge assessment (A0310A = 99; A0310B = 99; A0310H = 1) unless combined with a Discharge assessment.

For each Picture Date, the latest classifiable OBRA or PPS assessment will be selected for inclusion on the CMI Report. If this assessment does not accurately reflect the resident's MA for MA CASE-MIX status at S9080A as of the Picture Date, the assessment should be modified using the procedures found in Chapter 5 of the MDS 3.0 RAI Manual. The new information in S9080A and S9080B will then be used to define the resident's MA for MA CASE-MIX status for the CMI Report. A resident for whom the last record is a Discharge Return Anticipated (A0310F = 11) with a Discharge Date (A2000) on or before the Picture Date will automatically be converted to non-MA status; no modification is necessary.

S0113 Resident Living Situation Prior to Admission

S0113. Resident Living Situation Prior to Admission Complete only if A0310A = 01.

--	--

01. Resident lived alone without services
02. Resident lived alone with services
03. Resident lived with caregiver in the home who is able to assist with daily medical and custodial needs
04. Resident lived in congregate situation
99. None of the above

Definitions

- Awareness of the resident's prior living situation enables the Interdisciplinary Team to evaluate resident needs and evaluate possible discharge requirements.
- Lived alone without services: No other person shares the residence and no services are received.
- Lived alone with services: No other person shares the residence but resident received services such as Home Health or Meals on Wheels.
- Resident lived with caregiver in the home who is able to assist with daily medical and custodial needs. Another person shares the residence who is able to provide all needed assistance.
- Resident lived in congregate situation: Resident lived in assisted living, residential care home, etc.

Coding Instructions

- Enter the two-digit code that most closely describes the resident's previous living arrangements and availability of caregiver assistance prior to admission.

- Complete with Comprehensive Admission assessment (ISC = NC; A0310A Federal OBRA Reason for Admission = 01 Admission).
- This item must be completed on all Admission records; it may not be skipped or dash filled.

S0114 Support Person(s)

S0114. Support Person Complete only if A0310A = 1 – 6 or A0310F = 10

Resident has one or more support person(s) who are positive towards discharge.

- 0. No
- 1. Yes

Definitions

- Support person(s) can be a spouse, one or more family members, significant others, or friends.

Coding Instructions

- Code 0 No if there is no indication that the resident has one or more support person(s) or the support person(s) are unwilling or unable to support the resident's discharge.
- Code 1 Yes if the resident has a support person(s) who are positive towards discharge.
- Complete with record types NC – Comprehensive; NQ – Quarterly and ND - Discharge.

S0120 ZIP Code of Prior Primary Residence

S0120. ZIP Code of Prior Primary Residence Enter the first five digits of the zip code. Complete only if A0310F = 01,12

--	--	--	--	--

Definitions

- Prior Primary Residence is the community address where the resident last resided prior to nursing facility admission. A primary residence includes the primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing facility or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing facility, etc.

Coding Instructions

- Enter the first five digits of the zip code. Enter one digit per box beginning with the left most box.
- Enter dashes if the ZIP Code is unknown.
- Complete with record type NT – Tracking.

S0123 County Code of Prior Primary Residence

S0123. County Code of Prior Primary Residence Enter the three-digit code from table. Complete only if A0310F = 01,12

Code 999 if out of state

--	--	--

Definitions

- County Code is a numerical identifier assigned to each Pennsylvania county listed below in alphabetical order starting with Adams 001 and ending with York 067. See S0120 for definition of Prior Primary Residence.

Coding Instructions

- Enter the three digits from the following table that indicate the County Code of the Prior Primary Residence.
- Enter 999 if the resident is from out of state.
- Enter dashes if the County is unknown.
- Complete with record type NT – Tracking.

County Code	County Name	County Code	County Name	County Code	County Name
001	Adams	024	Elk	047	Montour
002	Allegheny	025	Erie	048	Northampton
003	Armstrong	026	Fayette	049	Northumberland
004	Beaver	027	Forest	050	Perry
005	Bedford	028	Franklin	051	Philadelphia
006	Berks	029	Fulton	052	Pike
007	Blair	030	Greene	053	Potter
008	Bradford	031	Huntingdon	054	Schuylkill
009	Bucks	032	Indiana	055	Snyder
010	Butler	033	Jefferson	056	Somerset
011	Cambria	034	Juniata	057	Sullivan
012	Cameron	035	Lackawanna	058	Susquehanna
013	Carbon	036	Lancaster	059	Tioga
014	Centre	037	Lawrence	060	Union
015	Chester	038	Lebanon	061	Venango
016	Clarion	039	Lehigh	062	Warren
017	Clearfield	040	Luzerne	063	Washington
018	Clinton	041	Lycoming	064	Wayne
019	Columbia	042	McKean	065	Westmoreland
020	Crawford	043	Mercer	066	Wyoming
021	Cumberland	044	Mifflin	067	York
022	Dauphin	045	Monroe	999	Out of State
023	Delaware	046	Montgomery		

S0521 Primary Reason for Admission

S0521. Primary Reason for Admission Complete only if A0310A = 01

--	--

01. Significant change in functional status
02. Deterioration in cognitive status
03. Change in the availability/status of primary caregivers
04. Difficulty arranging or paying for needed in-home care or support
05. Failed to succeed in residential care home
06. Short term rehabilitation or skilled care
99. None of the above

Definitions

- Many issues may influence a resident's decision to enter a nursing facility. Identification of the primary reason for this decision may guide discharge planning and lead to a swifter return to the community.
- Significant change in functional status: Inability to perform Activities of Daily Living at baseline level.
- Deterioration in cognitive status: Resident's cognitive status, skills, or abilities have deteriorated as compared to the baseline level.
- Change in the availability/status of primary caregivers: Primary caregiver no longer willing or able to provide services.
- Difficulty arranging or paying for needed in-home care or support: Costs of care exceed resident's personal resources or finances or no provider is available.
- Failure to succeed in residential care home: Current placement no longer appropriate for resident's community living option.
- Short term rehabilitation or skilled care: Resident's medical condition requires skilled nursing or therapy services with an expectation that s/he will be discharged within 100 days.

Coding Instructions

- Enter the two-digit code that most closely reflects the primary reason for admission.
- Complete with Comprehensive Admission assessment (ISC = NC; A0310A Federal OBRA Reason for Assessment = 01 Admission).
- This item must be completed on all listed record types; it may not be skipped or dash filled.

S8010H1 Picture Date Reporting

S8010H1. Picture Date Reporting Complete only if A0310F = 11

Check if applies

Check this item if the assessment is a Discharge Return Anticipated assessment (DRA) AND is to be used as a Discharge Return Not Anticipated (DRNA) for Picture Date reporting requirements

Definitions

- Residents who have been Discharged Return Anticipated (A0310F = 11) and have not exceeded 30 days absence after the discharge date by the Picture Date will appear on the non-MA list on the CMI Report. If the NF knows the resident will not be returning, e.g., has died, discharged to another facility or home, use this item to convey this information to remove the resident from the CMI Report.

Coding Instructions

- Complete only if A0310F = 11 (Discharge return anticipated).
- Do not check this item (submit as 0) if:
 - this is an original assessment (A0050 = 1) or
 - this discharge assessment is being modified (A0050 = 2) for reasons other than using this DRA as a DRNA for Picture Date reporting requirements or
 - the Assessment Reference Date of the assessment is more than 30 days before the Picture Date.
- Check this item (submit as 1) to use this DRA as a DRNA for Medical Assistance Picture Date reporting requirements. Code A0050 = 2 Modification.
- Skip this item (^) if A0310F does not = 11.
- If A0310F = 11, complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; ND – Discharge.

S9080 Source of Payment

S9080. Source of Payment	
Enter Code <input type="checkbox"/>	A. Is the resident Medical Assistance for MA CASE-MIX? (see instructions) 0. No 1. Yes
	B. Date of change to/from Medical Assistance for MA CASE-MIX <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> Month </div> <div style="text-align: center;"> <input type="text"/><input type="text"/> Day </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year </div> </div>
	C. Recipient Number from PA ACCESS Card Must be completed if S9080A = 1 <input type="text"/> <input type="text"/>
	D. MA NF Effective date from PA/FS 162 <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> Month </div> <div style="text-align: center;"> <input type="text"/><input type="text"/> Day </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year </div> </div>
Enter Code <input type="checkbox"/>	E. Is the resident DAY ONE MA Eligible? 0. No 1. Yes

A. Is the resident Medical Assistance for MA CASE-MIX?

Definitions

- The resident is considered to be Medical Assistance (MA) for MA Case-Mix if one of the following applies to the day of care:
 - the Department pays 100% of the MA rate for an MA resident;
 - the Department and the resident and/or third party pay other than Medicare Part A pay 100% of the MA rate for an MA resident;
 - a Managed Care Organization (MCO) under contract with the Department or an LTCCAP/LIFE provider (see NOTE below) that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care;
 - the resident and either an MCO under contract with the Department or LTCCAP/LIFE provider that provides managed care to an MA resident pays 100% of the negotiated rate or fee for an MA resident's care;
 - the Department pays for care provided to an MA resident receiving hospice services in a nursing facility. As long as MA is being billed for the day of care for a resident receiving hospice services, whether through MA or Medicare, the resident is MA for MA Case-Mix.

NOTE: LTCCAP/LIFE is an acronym describing the MA Long Term Care Capitated Assistance Program provided through Pennsylvania Living Independence for the Elderly (LIFE), nationally known as the PACE (Program for All-Inclusive Care for the Elderly).

(<http://www.dhs.pa.gov/citizens/alternativestonursinghomes/lifelivingindependencefortheelderly/>)

Coding Instructions

- Enter a 0 if No; 1 if Yes.
- The resident must have a valid Recipient Number (S9080C). A resident who is MA pending is not considered to be MA for MA Case-Mix.
- The resident is not considered to be MA for MA Case-Mix if any portion of the day of care is paid by Medicare Part A. Medicare Part B payments for ancillary services are not considered as payment for a day of care.
- A resident participating in any statewide mandatory Medicaid managed care program is considered to be MA for MA Case-Mix. An MA resident funded through a LTCCAP/LIFE provider is MA for MA Case-Mix.
- For an Admission assessment (A0310A = 01), the determination of MA for MA Case-Mix should reflect the resident's status as of the Entry Date (A1600). For all other assessments, responses should reflect the resident's status as of the Target Date: Assessment Reference Date (A2300); Entry Date (A1600); and Discharge Date (A2000).
- For Discharge assessments/tracker, complete this item as if the discharge date was a billable day.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; and ND – Discharge.
- This item must be completed on all listed record types; it may not be skipped or dash filled.

B. Date of change to/from Medical Assistance for MA CASE-MIX

Definitions

- Date of change to/from Medical Assistance for MA CASE-MIX is the beginning date applicable to any change in the resident's Medical Assistance for MA CASE-MIX status.

Coding Instructions

- Enter the 2-digit month, 2-digit day and the 4-digit year.
- If a resident has never been MA for MA Case-Mix, the date of change would be the resident's latest admission/reentry date in order to demonstrate that since admission, the resident has never been MA for MA Case-Mix.
- When a resident becomes MA for MA Case-Mix and the date of change to MA for MA Case-Mix does not coincide with the next assessment reference date, complete a modification of the latest assessment to indicate S9080A = 1 and change the S9080B date to the date the resident met the MA for MA Case-Mix status definition.
- On an Entry Tracking record, enter the current date of Entry/Reentry and report the resident's MA for MA Case-Mix status as of that date.
- If an existing resident remains MA for MA Case-Mix for a following assessment, the date of change to/from MA for MA Case-Mix should be carried forward from the prior assessment (or the prior assessment modification, if applicable).
- An MA for MA Case-Mix resident on therapeutic leave continues to be classified as MA for MA Case-Mix and no modification is necessary.
- The date of change to/from MA for MA Case-Mix should be on or after the date in S9080D if S9080D is completed.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; and ND – Discharge.
- This item must be completed on all listed record types; it may not be skipped or dash filled.

C. Recipient Number from PA ACCESS Card (if applicable)

Definitions

- The Pennsylvania ACCESS card is a permanent plastic identification card issued to all recipients eligible for public assistance benefits. The ten-digit MA recipient number is found on this card and may be used by MA providers to verify an MA consumer's eligibility for MA services through the Eligibility Verification System.

Coding Instructions

- Enter the 10-digit MA recipient number found on the PA ACCESS card, if available.
- If the resident does not have an MA recipient number, skip this item (enter caret [^] marks).
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; and ND – Discharge.
- Must be completed if S9080A = 1.

D. MA NF Effective Date from PA/FS 162

Definitions

- A PA/FS 162 is a state specific form used by the County Assistance Offices to notify applicants of eligibility for MA payment and, if appropriate, the amount the applicant is responsible for paying toward the cost of their care in a nursing facility. It identifies the date that the applicant is eligible for nursing facility care.
- The Effective Date is the date applicable for this admission specified on the “Notice to Applicant” (PA/FS 162) listed as the “Effective Date” or “Eff. Date”. This may not initially be available for residents covered by MA MCOs or LTCCAP/LIFE.

Coding Instructions

- Enter the 2-digit month, 2-digit day and the 4-digit year.
- If the resident does not have an applicable PA/FS 162 effective date, skip this item (enter caret [^] marks).
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; and ND – Discharge.

E. Is the resident DAY ONE MA eligible?

Definitions

- A Day One MA eligible resident is an individual who:
 - is or becomes eligible for Medical Assistance within 60 days of the first day of the month of admission to the nursing facility; or
 - will become eligible for Medical Assistance upon conversion to MA from payment under a Medicare or a Medicare supplement policy if applicable,
 - is enrolled in an MA MCO or LTCCAP/LIFE program upon admission to the nursing facility, or is determined by the Department or an independent assessor, based upon information available at the time of assessment, as likely to become eligible within 60 days of the first day of the month of admission to the nursing facility or upon conversion to MA from payment under Medicare or a Medicare supplement policy, if applicable.

Coding Instructions

- Enter a 0 if No, 1 if Yes.
- The proper response should be identified for the first Entry tracking form when the resident enters the NF. This same response should be entered each time the item must be completed until either the resident is Discharged Return Not Anticipated (A0310F = 10) or the resident is Discharged Return Anticipated (A0310F = 11) and does not return within 30 days. In either of these cases, if the resident returns to the NF, the resident’s MA Day One eligibility status would be evaluated related to the new stay.
- A resident in the facility for respite care under a PDA waiver is MA Day One eligible. However, he/she is not MA for MA Case-Mix (see p. 3-4).
- Complete with record type NT – Tracking.

S9085 Community HealthChoices (CHC)

S9085. CHC Enrollment Details	
Enter Code <input type="text"/>	A. Is the resident enrolled in CHC? 0. No → Skip S9085B, C and D 1. Yes → Complete S9085B, C and D
	B. CHC Effective Date Must be completed if S9085A = 1 <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> Month </div> <div style="text-align: center;"> <input type="text"/><input type="text"/> Day </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year </div> </div>
	C. CHC Plan Enter the two-digit code from table. Must be completed if S9085A = 1 <input type="text"/> <input type="text"/>
	D. CHC Member ID Must be completed if S9085A = 1 <input type="text"/> <input type="text"/>

A. Is the resident enrolled in CHC?

Definitions

- The resident is considered to be participating in CHC if they are enrolled with a CHC plan and have a member card with a member ID.

Coding Instructions

- Code 0 No if there is no indication that the resident is enrolled with a CHC plan, and/or CHC is not active in the nursing facility's county. Skip S9085B, C and D.
- Code 1 Yes if the resident has a CHC member card indicating enrollment.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; ND – Discharge.

B. CHC Effective Date

Definitions

- The CHC Effective Date is the first date that the resident was enrolled with the current CHC plan. It is found on the CHC member card.

Coding Instructions

- Enter the 2-digit month, 2-digit day and the 4-digit year.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; ND – Discharge.
- This item must be completed on all listed record types if S9085A = 1. If the resident is not enrolled in a CHC plan, skip this item (enter caret [^] marks).

C. CHC Plan

Definitions

- Enter the two digits from the following table that indicate the resident's CHC plan.

Coding Instructions

- Enter the two-digit code from the following table.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; ND – Discharge.
- This item must be completed on all listed record types if S9085A = 1. If the resident is not enrolled in a CHC plan, skip this item (enter caret [^] marks).

CHC Code	CHC Plan
01	AmeriHealth Caritas/Keystone First
02	Pennsylvania Health and Wellness (Centene)
03	UPMC for You

D. CHC Member ID

Definitions

- Each CHC participant is assigned a member ID which may be found on the member card.

Coding Instructions

- Enter the member ID found on the CHC member card without spaces or dashes.
- Complete this item when CHC services begin in the nursing facility's county.
- Complete with record types NC – Comprehensive; NQ – Quarterly; NP – PPS; NT – Tracking; ND – Discharge.
- This item must be completed on all listed record types if S9085A = 1. If the resident is not enrolled in a CHC plan, skip this item (enter caret [^] marks).

PA-SPECIFIC MDS SPECIFICATIONS

Data Specifications

The partial data specifications contained in this section are taken from the CMS Data Submission Specifications and identify the record and data elements necessary to develop data encoding software for Pennsylvania nursing facilities. For all elements, including Section S, the CMS Data Submission Specifications must be used to develop validation and consistency checks. The specifications may be obtained from CMS's MDS 3.0 website at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html. The items included in this section are additions to the Data Submission Specifications for Section S. The items noted in the supplemental data specifications are defined as follows:

Specification Item	Definition
Item ID	The “Item ID” column gives the standard label for the field and a short description.
Item Values	Indicates the CMS approved Values that may be reported for the Item.

Active on ISCs

This section of the supplemental data specifications contains information on ISCs for which the field is required to be active. When a field is active, then the value for the field is required to conform to specified consistency specifications.

The following table lists each of the Section S items, the Type of Assessment (A0310) on which the item is active, i.e. must be completed, and the associated ISC. An MDS 3.0 record is assigned an ISC by the facility software based on the coded responses to A0310 Type of Assessment and following the CMS Data Submission Specifications.

Section S	Section S Item	A0310 A	A0310 B	A0310 F	Type of Assessment	ISC Type
S0113	Resident Living Situation Prior to Admission	01	01, 99	10, 11, 99	Comprehensive	NC
S0114	Support Person	01 - 06	01, 99	10, 11, 99	Comprehensive, Quarterly, Discharge	NC, NQ, ND
S0120	ZIP Code of Prior Primary Residence	99	99	01, 12	Tracking	NT
S0123	County Code of Prior Primary Residence	99	99	01, 12	Tracking	NT
S0521	Primary Reason for Admission	01	01, 99	10, 11, 99	Comprehensive	NC
S8010H1	Picture Date Reporting	01 – 06, 99	01, 99	11	Comprehensive, Quarterly, PPS, Discharge	NC, NQ, NP, ND
S9080A	MA for MA Case-Mix?	01, 03 – 05	01, 99	10, 11, 99	Comprehensive	NC
S9080B	Date of Change to/ from MA	02, 06	01, 99	10, 11, 99	Quarterly	NQ
S9080C	Recipient Number from PA ACCESS card	99	01	10, 11, 99	PPS	NP
S9080D	MA NF Effective Date from PA/FS 162	99	99	10, 11	Discharge	ND
S9080D	MA NF Effective Date from PA/FS 162	99	99	01, 12	Tracking	NT
S9080E	Day One MA Eligible?	99	99	01, 12	Tracking	NT
S9085A	Is the resident enrolled in CHC?	01, 03 – 05	01, 99	10, 11, 99	Comprehensive	NC
S9085B	CHC Effective Date	02, 06	01, 99	10, 11, 99	Quarterly	NQ
S9085C	CHC Product/Provider Name	99	01	10, 11, 99	PPS	NP
S9085C	CHC Product/Provider Name	99	99	10, 11	Discharge	ND
9085D	CHC Member ID	99	99	01, 12	Tracking	NT

Section S Items Not Required

No Section S Items are required on the following ISCs: IPA- Interim Payment Assessment; NPE – Nursing Home Part A PPS Discharge; and XX Inactivation.

MA for MA Case-Mix Purpose

A basic element in Pennsylvania's Case-Mix Reimbursement System is the concept of MA for MA Case-Mix to determine if a resident's data is used to establish the MA CMI and Total Facility CMI, or only the Total Facility CMI. The resident's MA for MA Case-Mix status is established on Entry and is reported on all NC, NQ, NP, ND and NT assessments/records submitted. The status will be continued forward until the next assessment/record confirms or changes the MA for MA Case-Mix status. Reporting changes in MA for MA Case-Mix status between assessments will be discussed in Section 3. Otherwise, only if the resident is discharged will the status be changed in the state database. This status is not linked only to the four Picture Dates.

Acceptable Item Values

The following table indicates the CMS-defined Acceptable Item Values for Section S.

Item ID	Item Values
S0113 Resident Living Situation Prior to Admission	01 – 04, 99; caret (^) mark indicating skipped when A0310A <>01
S0114 Support Person	0 No 1 Yes; caret (^) mark indicating skipped when A0310A = 99 and A0310F <>10
S0120 Residence prior to Admission: ZIP Code	5 digits; dashes indicating unknown
S0123 County code of prior residence	3 digits; dashes indicating unknown
S0521 Reason for Admission	01 – 06, 99; caret (^) mark indicating skipped when A0310A <> 01
S8010H1 Picture Date Reporting	0 No 1 Yes; caret (^) marks indicating skipped
S9080A Is the resident MA for MA CASE-MIX?	0 No 1 Yes
S9080B Date of change to/from MA	YYYYMMDD
S9080C Recipient Number from PA ACCESS Card	10 digits; caret (^) marks indicating skipped
S9080D MA NF Effective date from PA/FS 162	YYYYMMDD; caret (^) marks indicating skipped
S9080E Is the resident DAY ONE MA eligible?	0 No 1 Yes; caret (^) marks indicating skipped
S9085A Resident Enrolled in CHC?	0 No 1 Yes; caret (^) marks indicating skipped
S9085B CHC Effective Date	YYYYMMDD; caret (^) mark indicating skipped when S9085A = 0
S09085C CHC Plan	01 – 03; caret (^) mark indicating skipped when S9085A = 0
S9085D CHC Member ID	Text with maximum length of 14; caret (^) mark indicating skipped when S9085A = 0

Transition

On April 1, 2011, CMS updated the data specifications for MDS 3.0. For items S0120 ZIP Code of Prior Primary Residence and S0123 County Code of Prior Primary Resident, dashes meaning Unknown became valid values. Warning -3808 was no longer placed on the Final Validation Report if dashes were used.

Similarly, caret marks (^) meaning that the item has been skipped became valid values for S9080C Recipient Number from PA ACCESS Card and S9080D MA NF Effective Date from PA/FS 162. This response is used when the resident is not a Medical Assistance recipient.

In March 2012, CMS issued new guidance regarding the handling of records needing inactivation and submission of multiple discharge assessments for the same discharge date. No longer could a nursing facility inactivate a Discharge Return Anticipated assessment and resubmit the same data designated as a Discharge Return Not Anticipated. Submitting a second discharge assessment for the same date but as a Discharge Return Not Anticipated was also not allowed. Both these procedures had been used for many years in Pennsylvania to remove permanently discharged residents from the CMI Report.

Beginning October 1, 2012, S8010H1 Picture Date Reporting was added to Section S. If the resident was discharged return anticipated (A0310F = 11) during the month before the Picture Date and the facility has knowledge that the resident will not be returning, modify (code A0050 = 2) the Discharge Return Anticipated, checking S8010HI and submit the assessment. This directs the database to use this assessment as a Discharge Return Not Anticipated for Picture Date reporting requirements and the resident will not be included on the CMI Report.

Beginning May 19, 2013, CMS reversed this policy requiring Inactivation to correct Target Dates and Reasons for Assessment. These items may be changed using the Modification process as long as the ISC does not change. A discharge return anticipated (A0310F = 11) may be converted to a discharge return not anticipated (A0310F = 10) to ensure creation of an accurate CMI Report.

For the May 1 and August 1, 2012 Picture Dates, the Discharge after Discharge Change form was used. After the August 1 Picture Date, Item S8010H1 is used.

Beginning October 1, 2016, CMS implemented a new version of the MDS - v. 1.14.1. CMS added Item Subset Code NPE – Nursing Home Part A PPS Discharge assessment, item A0310H Is this a SNF Part A PPS Discharge Assessment? and Section GG Functional Abilities and Goals to this version. No Section S items are required with the NPE, and the other items do not affect the calculation of any Pennsylvania Medical Assistance items.

Beginning October 1, 2017, CMS implemented a new version of the MDS – v. 1.15.1. Items added in Section N Medications and Section P Restraints and Alarms did not affect the calculation of any Pennsylvania Medical Assistance items. Pennsylvania chose to add the following

items to Section S: S0133 Resident Living Situation Prior to Admission; S0114 Support Person; S0521 Primary Reason for Admission; S9085A Is the resident enrolled in Community HealthChoices?; S9085B CHC Effective Date; S9085C CHC Product/Provider Name; S9085D CHC Member ID. Details about these items may be found in this chapter and in CMS Data Specifications. All previous Section S items continue to be required with no changes in specifications.

Beginning October 1, 2018, CMS implemented a new version of the MDS – V.1.16.1. Items added in Sections GG Functional Abilities and Goals, M Skin Conditions, I Active Diagnosis, N Medications and J Health Conditions, as well as items retired from section M Skin Conditions, do not affect the calculation of any of the Pennsylvania Medical Assistance items. CMS has also made the completion of Section K Nutritional Status, Column One items optional for the following; K0510C Mechanically altered diet, K0510D Therapeutic diet, K0710A Proportion of total calories resident received through parenteral or tube feeding and K0710B Average fluid intake per day by IV or tube feeding. These Section K items do not affect the calculation of any Pennsylvania Medical Assistance item, and will be optional for completion in the State of Pennsylvania. A dash is appropriate in these items.

Beginning October 1, 2019, CMS implemented a new version of the MDS – V.1.17.1. CMS has retired the RUGS IV based payment system for PPS reimbursement and replaced it with the Patient Driven Payment Model (PDPM). With this change, CMS has also retired the scheduled PPS 14, 30, 60 and 90 day assessments as well as the unscheduled PSS assessments EOT, SOT and COT. In lieu of these retired assessments CMS has given each state the option to use the Optional State Assessment (OSA) in order to generate a RUG III/IV calculation for these assessments as may be needed for Medicaid reimbursement purposes. Pennsylvania has chosen not to use the OSA at this time, instead continuing to calculate a RUG III value based on the latest classifiable assessment. (ISC = NC, NQ, NP; A0310A = 01-06 and/or A0310B= 01). The RUG calculation is completed by the NIS for all classifiable assessments.

Software

Most NFs use proprietary software that performs many functions beyond basic MDS data entry and submission capabilities. In transition periods, some softwares may not yet be available or may not perform perfectly. CMS has produced a basic software product, jRAVEN, that will allow data entry of MDS 3.0 records, enforce CMS defined edits and create appropriate submission files. It is available free at <https://qtso.cms.gov/software/jraven>. Several manuals are provided to guide both installation and use.

Vendor Testing

Two software products are available to assist vendors in testing their products. The Validation Utility Tool (VUT) (<https://qtso.cms.gov/software/jraven>) is a software utility that can be used to validate MDS 3.0 submission files in XML format. jRAVEN (<https://qtso.cms.gov/software/jraven>), a submission software created by the CMS, may be used to upload files created in vendor software and have data checked for possible errors.

As of October 1, 2013, it is no longer possible to submit test records to the CMS database by coding PRODN_TEST_CD in the Control Section of the individual record as T Test submission. This change prevents test records being mistakenly sent as P Production, which required expunging them from the database using the Manual Record Correction Request detailed in Section 5 of the RAI Manual.

3 MA FOR MA CASE-MIX

MA FOR MA CASE-MIX STATUS

The MA or non-MA status of a resident at any point during the resident's stay is important in determining a correct Case-Mix Reimbursement rate for a facility. The concept was developed to identify and designate those residents for whom the facility provided an "MA Day of Care." Chapter 1187.2 was amended so that effective 01/01/2004, an "MA Day of Care" is defined as one of the following: (1) the Department pays 100% of the MA rate for an MA resident; (2) the Department and the resident pay 100% of the MA rate for an MA resident; (3) a Managed Care Organization (MCO) under contract with the Department or a LTCCAP/LIFE provider that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care; (4) the resident and either an MCO under contract with the Department or LTCCAP/LIFE provider that provides managed care to an MA resident pays 100% of the negotiated rate or fee for an MA resident's care; (5) the Department pays for care provided to an MA resident receiving hospice services in a nursing facility. Furthermore, §1187.93 (2)(ii) states that a hospital reserved bed day may not be counted as an MA day of care. A therapeutic leave day will be counted as an MA day of care. However, if the MA resident on therapeutic leave no longer meets the conditions of § 1187.104(2), e.g., has exceeded the 30 days allowed leave, the resident will be included in the census of the nursing facility as a non-MA resident.

The resident's MA for MA Case-Mix status is reported in Section S at S9080A and completed on Comprehensive assessments (NC), Quarterly assessments (NQ), PPS Assessments (NP), Discharge assessments (ND) and Entry/Death in facility Tracking forms (NT). If the resident's status changes, the most recent assessment before the Picture Date should be modified to reflect the new MA for MA Case-Mix status. Consider the scenario where a resident reaches the end of his Medicare Part A benefits and starts coverage under a private insurance policy. The facility would not complete a modification in this scenario because the response to S9080A did not change, even though the source of payment did change.

Transition

Reporting a change in MA for MA Case-Mix status may now be done only with the use of the modification process. Use of MA Change Tracking Forms is no longer appropriate since MDS 3.0 Item Subset

Codes do not include an MA Change Tracking Form. The modification process will be used to report changes in MA for MA Case-Mix status in items S9080A – B. On page 5-10 of the MDS 3.0 RAI Manual, modifications are discussed including demographic errors. While technically a change to the Section S Source of Payment information is not a correction, CMS has approved the modification of Pennsylvania's Section S to indicate a change to or from MA for MA Case-Mix. First, identify the latest assessment prior to the Picture Date. Create a modification by coding A0050 as 2 Modification, complete the assessment and then complete the items in Section X so that the prior submitted assessment can be found in the national database.

Change S9080A to reflect the MA for MA Case-Mix status and the date of the change in S9080B. The change in the MA for MA Case-Mix status for a modification is accurate on the date coded in S9080B Date of change to/from MA for MA Case-Mix. The modified assessment, which includes the updated Section S information, is then submitted as usual.

Depending on the resident's movements, it may be necessary to do more than one modification to be certain the resident's MA for MA Case-Mix status is accurately represented on the CMI Report. If you are having problems, contact the Myers and Stauffer Helpdesk for assistance.

Beginning January 2018, DHS implemented the Community HealthChoices (CHC) program. This is an initiative to enable elderly and disabled Pennsylvanians to remain in the community. Managed Care Organizations (MCOs) coordinate physical health care and long term services and supports (LTSS) for older people with physical disabilities and people who are eligible for both Medicare and MA. If a resident served by a CHC-MCO in this program requires nursing facility care, they are considered to be MA for MA Case-Mix.

Evaluating for MA for MA Case-Mix Status

Many factors must be considered in evaluating whether the resident is MA for MA Case-Mix. The facility makes the ultimate decision and reports it accordingly as "yes" or "no" at S9080A:

"Is the resident Medical Assistance for MA Case-Mix?"

What standards must be met in order to consider a resident MA for MA Case-Mix? Must be a resident of an MA facility.

- The resident must have a Medical Assistance number from the PA ACCESS card.
- The resident must have a NF eligibility date from the PA/FS 162 – Notice to Applicant. However, this standard does not have to be met for the first 30 days in a NF by residents served by an MA HMO. See the bullet below.
- The resident must be physically in the facility or on therapeutic leave.
- Residents served by an MA HMO (either mandatory or voluntary) are considered MA for MA Case-Mix during their first 30 days in the NF even though they do not have a PA/FS 162 with a NF Effective Date. They become MA Pending on

Day 31 and are no longer MA for MA Case-Mix if a PA/FS 162 has not been received.

- Residents participating in CHC are considered MA for MA Case-Mix.
- New types of MA HMO insurance programs have been developed that designate the number of days covered, e.g., 60-day plan or 120-day plan. The resident is considered MA for MA Case-Mix for the number of days covered by the plan. The resident would become MA Pending on the day after plan coverage ceased, e.g., Day 61 or Day 121.
- An MA resident funded through the LTCCAP/LIFE program is MA for MA Case-Mix. This is an MA financed program that is handled through a capitated payment system (one negotiated payment to be used to meet all the resident's care needs) rather than through the MA per diem payment system. The LTCCAP/LIFE provider is responsible to pay all NF bills for the duration of the resident's stay. If the MA resident is funded through an LTCCAP/LIFE provider, he is MA for MA Case-Mix. The LTCCAP/LIFE provider is responsible to provide the facility with a copy of the resident's PA/FS 162.
- NOTE: Some LTCCAP/LIFE providers also serve clients funded through private pay or other insurance. If a client does not have an ACCESS card or a PA/FS 162, she is not MA for MA Case-Mix even though covered by the LTCCAP/LIFE program.
- A resident participating in MA hospice is considered MA for MA Case-Mix.
- A resident who is receiving Medicare Part A hospice services but the facility is billing MA for the day of care is considered MA for MA Case-Mix.
- A resident receiving some services from a Medicare hospice but the facility is billing MA for the day of care is considered MA for MA Case-Mix.
- MA must be paying 100% of the resident's day of care or the day of care is paid partially by MA combined with resident pay and/or third party pay other than Medicare Part A to equal 100%.

Non-MA Status

Some situations disqualify a resident from being considered MA for MA Case-Mix:

- An MA Pending resident is not MA for MA Case-Mix. MA Pending is the resident's status while the application for MA benefits is in process. The resident may be in the NF for an extended period before the PA/FS 162 – Notice to Applicant is issued by the County Assistance Office (CAO). Until the PA/FS 162 is received from the CAO, the MA Pending resident is not MA for MA Case-Mix.

- A resident funded through the PDA Waiver who is in the NF for respite care is not MA for MA Case-Mix. They are considered Day One MA Eligible (see p. 2-12).
- A resident funded by an out-of-state MA program is not MA for MA Case-Mix.
- A resident receiving any payment from Medicare Part A (Medicare per diem) is not MA for MA Case-Mix. This includes residents participating in Medicare Part A hospice where Medicare is paying for the day of care. However, payments may be received from Medicare Part B (ancillaries).
- A resident for whom a provider is not receiving any funds from MA is not MA for MA Case-Mix. Some part of the day of care must be paid by MA. There are infrequent situations where, though the resident has an MA number and MA NF effective date, other sources are paying the total facility bill. If the facility is not billing MA for any part of the day of care, the resident is not MA for MA Case-Mix.
- A resident who has been discharged (A0310F = 10, 11, 12) is not MA for MA Case-Mix. However, when completing S9080A on a Discharge assessment, the resident's MA for MA Case-Mix status should be reported at S9080A as if that Discharge day was a billable day. When a Discharge assessment is submitted, the resident's status is converted to non-MA in the NIS as of the discharge date (A2000). The nursing facility will report the correct status on the Entry tracking form when the resident returns.
- An MA resident who is out of the facility on therapeutic leave but has exceeded the 30 days leave allowed in § 1187.104(2) is not MA for MA Case-Mix.
- An MA resident who has been identified as sustaining a Preventable Serious Adverse Event (PSAE) on the Picture Date is not MA for MA Case-Mix.
(<http://www.pabulletin.com/secure/data/vol44/44-37/1932.html>)
- A resident whose assessment does not contain a response for S9080A or S9080B is completed with dashes (--) or blank (^) is not MA for MA Case-Mix.

Further guidance on determining MA for MA Case-Mix status may be found in the Section S instructions beginning on page 2-5.

CODING FOR MA FOR MA CASE-MIX STATUS

MA for MA Case-Mix status is completed on the Comprehensive assessment (NC), Quarterly assessment (NQ), PPS assessment (NP), Discharge assessment (ND) or Entry/Death in facility tracking forms (NT) by placing a "1" for MA for MA Case-Mix in S9080A or "0" for non-MA. The date that applies to the MA for MA Case-Mix status coded in S9080A is coded in S9080B. If either S9080A or S9080B is left blank (^) or filled with a dash, the resident is assumed to be non-MA when generating the CMI Report.

MA STATUS CONTINUUM

The MA status of the resident is reported by the facility on five ISCs creating the ability to determine the status on a particular “day of care.” At S9080B, the NF reports the Date of Change to/from MA. MA for MA Case-Mix status is established at these various points during the resident’s NF stay. It carries forward from that point until there is submission of a record to the CMS MDS 3.0 Data Collection System of a change and the applicable date of that change falls after the date of the last MA status change.

MA PENDING

Reporting the resident’s MA for MA Case-Mix status becomes difficult when the resident has been in the facility for a long period of time before the PA/FS 162 establishing the resident’s MA eligibility is received from the CAO. During that time, he is considered MA Pending (non-MA), but the stay may have been interrupted by discharges and reentries as well as periods of coverage by Medicare Part A. To reconstruct the resident’s actual MA status on specific dates can be very complicated.

When you do receive the PA/FS 162, the latest assessment before the Picture Date (PD) should be modified to report the new status. The date entered in S9080B should be the **first date** the resident qualified as MA for MA Case-Mix. This might be the Entry Date if the resident has never been covered by any other pay source, or the day after a Medicare stay that began his residency in the NF. This first date of MA for MA Case-Mix eligibility should be reported even though there may have been other assessments completed indicating non-MA status or intervening discharges with return anticipated. This will provide the NIS with the essential information to identify the resident’s MA for MA Case-Mix status whenever necessary. All modifications are saved in NIS so previous records can be utilized to identify the proper status.

Future assessments would carry the same status and date until a new Entry record must be completed. At that point, the reentry date would be entered and the appropriate MA for MA Case-Mix status indicated.

MA Pending Examples

The following examples will identify the various situations that may occur during the time that a resident is MA Pending. It is not necessary to modify previously submitted assessments to include the MA recipient number from the PA ACCESS card; simply begin including it on future records.

Assumptions:

Date of Entry (A1600) - January 1

MA NF Effective Date (PA/FS 162) - January 1

PA/FS 162 received - March 12

- An MA Pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the PA/FS 162, the facility should modify the latest assessment (NC, NQ, NP, NT) before the PD to report this status change

with S9080A = 1, and S9080B = January 1 and S9080D = January 1.

- An MA Pending resident was admitted to the facility from the hospital. Medicare Part A is still covering his NF stay on March 12 when the PA/FS 162 form is received. From January 1 through March 12, the resident is non-MA both due to receipt of Medicare Part A benefits and the MA Pending status. On March 13 the resident continues to be non-MA because of the continued Medicare Part A benefits. No modification should be completed until the Part A stay ends because the response to S9080A has not changed. When the Part A stay ends, modify the latest assessment (NC, NQ, NP or NT) before the PD with S9080A = 1 Yes, S9080B = the day after Medicare Part A stopped, and S9080D = January 1.
- An MA Pending resident was admitted to the facility from the hospital. Medicare Part A covered his stay through January 15. From January 1 through January 15, the resident is non-MA both due to receipt of Medicare Part A benefits and the MA Pending status. On January 16, the resident remains non-MA due to the MA Pending status. After receipt of the PA/FS 162, the facility should modify the latest assessment (NC, NQ, NP or NT) before the PD with S9080A = 1 Yes, S9080B = January 16 and S9080D = January 1.
- An MA Pending resident was admitted to the facility from the hospital. Medicare Part A covered his stay through January 15. He died February 10. A modification of the latest NC, NQ, NP or NT with an ARD on or before the Picture Date should be submitted even though the PA/FS 162 was received several weeks after the discharge with S9080A = 1; S9080B = January 16 and S9080D = January 1. A new CMI Report will be generated including him in the proper MA section.
- An LTCCAP/LIFE resident was admitted to the facility from the community with no prior hospital stay. The LTCCAP/LIFE provider provides a PA/FS 162 dated two years previously. Due to the LTCCAP/LIFE status, the resident is MA for MA Case-Mix immediately upon entry and the resident's Entry tracking form should be completed with S9080A = Yes, S9080B = January 1 and S9080D = effective date on PA/FS 162 received from the LTCCAP/LIFE provider.
- An MA HMO resident was admitted to the facility with no prior hospital stay. Due to the MA HMO status, the resident is MA for MA Case-Mix immediately upon entry for 30 days. The resident's Entry tracking form should be completed with S9080A = 1, S9080B = January 1 and S9080D = blank (^). No PA/FS 162 is necessary on admission. However, if the PA/FS 162 is not received by Day 30, the resident becomes MA Pending on January 31 (Day 31). A modification of the latest assessment (NC, NQ, NP or NT) before the PD should be completed with S9080A = 0, S9080B = January 31 and S9080D = blank (^).
- An MA Pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the

PA/FS 162, the facility should complete a modification of the latest assessment (NC, NQ, NP or NT) prior to the PD with S9080A = 1, S9080B = January 1 and S9080D = January 1. The resident starts to receive Medicare Hospice services such as medications and counseling on April 1, but the facility is billing MA for the day of care. No modification should be completed because the response to S9080A has not changed. The resident is still MA for MA Case-Mix even though he is receiving Medicare Part A Hospice services.

- An MA Pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the PA/FS 162, the facility should complete a modification of the latest assessment (NC, NQ, NP or NT) before the PD with S9080A = 1, S9080B = January 1 and S9080D = January 1. The resident starts to receive MA Hospice services on April 1. No modification should be completed because the response to S9080A has not changed. The resident is still MA for MA Case-Mix since he is receiving MA Hospice services.
- A resident who is eligible for both MA and Medicare enters the facility under Medicare Part A hospice. The resident is receiving “ancillary” services such as medications and counseling from Medicare Part A and Medicare Part A is also paying for the day of care. The Entry tracking form should be completed with S9080A = 0 and S9080B = January 1.

In these examples, the facility received the PA/FS 162 during the February Picture Date submission and correction period. For the February Picture Date, the modification of the latest NC, NQ, NP or NT assessment before the Picture Date must be submitted on or before the February Picture Date deadline.

If the PA/FS 162 had not been received before the Picture Date deadline, the resident would properly appear in the non-MA section for the February Picture Date; the facility did not have knowledge that he was MA for MA Case-Mix during the February Picture Date submission and correction period. If the correction period had been extended by the Department, the facility would be responsible to see that the modifications were submitted, a new CMI Report generated and a new Certification Page signed and submitted.

DAY-ONE MA ELIGIBLE

“Is the resident Day-One MA eligible?” is item S9080E on the state-specific Section S that must be completed for every tracking form (A0310F = 01, 12). The response for this item should be determined by assessing the resident’s MA for MA Case-Mix status. The response to “Is the resident Day-One MA eligible?” should be “Yes” if the facility believes the resident will be, or anticipates they may become, MA for MA Case-Mix for one or more days within the first 60 days of the resident’s stay. If the MA resident is enrolled in an MA MCO or LTCCAP/LIFE program upon admission to the facility, the response is “Yes.”

The proper response should be identified for the first Entry tracking form when the resident enters the NF. This same response should be entered each time the item must be completed until either the resident is Discharged Return Not Anticipated (A0310F = 10) or the resident is Discharged Return Anticipated (A0310F = 11) and does not return within 30 days. In either of these cases, if the resident returns to the NF, the resident's Day-One MA eligibility status would be evaluated related to the new stay.

4 DATA SUBMISSION

GETTING STARTED

In order to be eligible to participate in the PA Medical Assistance (MA) program, providers shall be currently licensed by the PA Department of Health and enrolled as a provider with the Department.

Provider enrollment forms can be obtained by calling 800-932-0939 or available online at

<http://www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm>.

After a new nursing facility is enrolled in the MA program, the Department mails an enrollment letter to the facility and sends a copy of the letter to Myers and Stauffer, the Department's case-mix contractor. This letter is usually mailed to the facility within 3 or 4 months of the date of the facility's certification; however, the process may take longer for some facilities.

The new facility must contact the CMSNet/Verizon helpdesk (888-238-2122) and complete an application for a new account. An account is the only method a facility may use to connect to the CMS MDS 3.0 Data Collection System. Instructions on how to set up the account will be provided by the helpdesk and may also be found at

<https://qtso.cms.gov/access-forms>.

Since January 1, 2008, all providers are required to use a broadband submission process. While the Internet may not be used to submit data, the facility must connect through an internet service provider (ISP) to use the broadband connection. More information may be found about this at <https://qtso.cms.gov>.

The new facility must also obtain MDS 3.0 data entry software. This software may be developed internally or purchased from a software vendor. Facilities participating in the MA program may use the free jRAVEN software provided by the CMS for the purpose of completing

their MA Case-Mix Reimbursement resident data reporting requirements. PA Section S items are included in this software.

Once the new facility has set up the account and received the Password and Connectivity letter from the contractor, up to two people must obtain personal login ID and passwords in order to do MDS 3.0 submissions, view report data such as the Final Validation Report (FVR), and access CASPER Reports. This can be done from the MDS Welcome Page by clicking on MDS Forms Page in the MDS Personal Login ID Maintenance Forms section or at <https://qtso.cms.gov> under MDS (Long Term Care) Personal Login ID Maintenance Forms. Click on MDS Individual Users Account Request.

When the facility has obtained software, the new facility is now ready to submit records to the CMS MDS 3.0 Data Collection System. All assessments that have been completed since the facility's certification date (assessments where item Z0500B, Date RN Assessment Coordinator Signed As Complete, is on or after the facility's certification date) must be submitted. Since there is usually a time lag of several months between the certification date and the receipt of the Password and Connectivity letter, there will initially be a large number of assessment records to submit.

For Picture Dates that occur during the time lag between the effective date of the facility's certification and the receipt of the Password and Connectivity letter, the statewide average MA CMI for a Picture Date will be used in a facility's MA Case-Mix Reimbursement rate calculation. If the facility receives their Password and Connectivity letter prior to a Picture Date, the facility is expected to complete the submission and CMI Report requirements for the Picture Date that are detailed in Section 6 CMI REPORTS of this manual and §1187.33 "Resident Data Reporting Requirements."

Change of Provider Information

When a facility changes its information such as facility name or address, or undergoes a change of ownership, the facility must notify the Department of the change in writing on facility letterhead. Once the Department has processed the information change, it mails an update letter to the facility and sends a copy of the letter to the contractor. This letter is usually mailed to the facility within 3 or 4 months of the date of the information change; however, the process may take longer for some facilities.

The contractor may only update the system and mail an updated Password and Connectivity letter after receiving the update letter from the Department. The facility may continue to submit data using the old PROMISE provider number and other information until the new Password and Connectivity letter is received. For change of ownership situations, there is no need for the facility to resubmit records created and/or submitted with the old PROMISE provider number after receiving

notification of their new number. The NIS and the CMS MDS 3.0 Data Collection System connect these records to the new account.

SUBMISSION PROCESS

The MDS 3.0 assessments and tracking forms are submitted to a CMS national database using the CMS instructions found in the Provider User's Guide. Daily, the data submitted by Pennsylvania nursing facilities is downloaded to the server previously provided to each state by the CMS in order to enable the state to access MDS data. The MDS data is then transferred to the state-owned NIS server so that the data can be used for state purposes. This national database is referred to in this manual as the CMS MDS 3.0 Data Collection System. Chapter 1187.33(a)(1) "Resident Data Reporting Requirements" also requires data to be submitted electronically. The Department has designated that these submission requirements mirror the federal requirements for submission. Thus, all records submitted by MA facilities to fulfill the resident data reporting requirements are submitted to the CMS MDS 3.0 Data Collection System.

Submission Deadlines

The deadline for submitting MDS and tracking form records for resident reporting requirements follows the federal guidelines of within 14 days of completion for most records. Beginning October 1, 2006, a newly admitted resident's initial MDS record must be submitted within 7 calendar days of the date the record is completed (§ 1187.22(18)). After reviewing the MDS 3.0 record types and federal requirements for completion and submission, the Department has decided that timely completion and submission of the Entry tracking form (A0310F = 01) will meet this requirement.

MDS Record	A0310F	Completion Date	Submission Date
Entry	01	Entry Date (A1600) + 7	Entry Date (A1600) + 14

The deadline for submitting any assessment or other tracking form that would affect the accuracy of a CMI Report is the lesser of 14 days of completion of the form or the end of the Picture Date submission and correction period. See Picture Date Submission and Correction Deadlines on page 4-5.

Replication to the NIS

MDS 3.0 records are submitted to the CMS MDS 3.0 Data Collection System. After processing the data, Final Validation Reports are placed in each submitting facility's CASPER folder. Then, the MDS 3.0 records which were accepted into CMS MDS 3.0 Data Collection System are downloaded to the existing federally-provided state servers on a daily basis. They are then replicated to the state-owned Nursing Home Information System (NIS). The NIS is the Department's program used to

manage all the types of data necessary to calculate an MA Case-Mix Reimbursement rate, including resident data.

Resident Identification Information

Each record for a specific resident should be submitted with identical identification information – name, birthdate, gender, SSN, Medicare number and Medicaid number. Variations in resident identification information will lead to a Warning (-1031) on the FVR alerting the facility that basic information has been submitted differently on this record. The resident table in the database has been updated with this new information.

At times, identification information changes are expected: a resident's Medicaid number is received so the entry at A0700 changes from the + (Pending) of previous records to a ten-digit number; or a resident dies, and the date of death is inserted into the Death Date field which was previously blank.

Too many changes in identification information, however, may result in the database creating a new resident, i.e. new Res_Int_ID (Resident Internal ID). Some records will be under one internal resident identification number, others will be linked to a different Res_Int_ID. The facility usually becomes aware of this problem due to the receipt of an unexpected sequencing error on the FVR (Inconsistent record sequence -1018) and a notice that a new resident has been created (-1027). Appropriate corrective action must be taken. Corrective action may include contacting the Myers and Stauffer Helpdesk and requesting that the data be merged.

Records with the Same Effective Date

Complications can arise when two (or more) records that were submitted in the same batch for the same resident have the same effective date and this effective date is closest to, or on, the Picture Date. When this occurs, the record that was processed last by the CMS MDS 3.0 Data Collection System is deemed to be the record that is closest to, or on, the Picture Date. Each record is assigned an Assessment Internal ID number by the CMS MDS 3.0 Data Collection System. The record with the highest Assessment Internal ID is the record that was processed last. The Assessment Internal ID may be found on the FVR.

For example, if a resident returned to the facility from the hospital on January 20, an Entry tracking form (A0310F = 01, A1700 = 2) would be completed with an Entry date in item A1600 of January 20. If the resident left the facility later that same day and return was not anticipated, a Discharge assessment (A0310F = 10) would be completed with a discharge date in item A2000 of January 20. If these two records are submitted to the CMS MDS 3.0 Data Collection System in the same batch, the record that is processed last will determine the residency status for the Picture Date. If the Entry tracking form is processed last, the resident will be deemed to be a resident of the facility for the February Picture Date, which is incorrect.

To prevent this situation from occurring, the facility should submit any resident's records that have the same effective date in separate batches. The records should be submitted in the order the facility wishes

them to be saved in the CMS MDS 3.0 Data Collection System. To continue the previous example, the Entry tracking form with an Entry date in item A1600 of January 20 should be submitted first and the Discharge assessment with a discharge date in item A2000 of January 20 should be submitted later in a separate batch. This would assure that the residency status of the resident would be correctly reported on the CMI Report.

This situation can also occur when the facility submits the Death in Facility tracking form (A0310F = 12) immediately upon the discharge of the resident and submits an assessment record with the same effective date in a later batch after it has been completed. When records are submitted with the same effective date, the record in the later batch establishes residency. In this situation, the Death in Facility tracking form (A0310F = 12) should not be submitted until the prior assessment record has been submitted in an earlier batch.

Submitting a resident's records with the same effective date in the same batch does not violate any CMS requirements and the data will be stored in the national database. Warning messages may appear on the FVR if records are processed in the incorrect order. Submitting these records in the same batch only causes problems in determining the residency status for the CMI Report. It is recommended that you follow the procedures outlined in this section to prevent this problem from occurring.

PICTURE DATE SUBMISSIONS

Chapter 1187 defines a Picture Date as the first day of the second month of each calendar quarter (February 1, May 1, August 1, November 1). The MA Case-Mix Reimbursement rate setting process uses the concept of this Picture Date to gather information about the facility population at four points during a year and to obtain acuity information from the MDS records on these dates. This is perceived to be reflective, on average, of the facility population and acuity for each quarter. Using data for a single date during the quarter simplifies reporting and review requirements. The full 24-hours of the Picture Date are included in selecting data for the CMI Report; the Picture Date ends at midnight.

Picture Date Submission and Correction Deadlines

The MA case-mix regulations at § 1187.33(a)(5) direct that the nursing facility shall sign and submit the CMI Report to the Department no later than five business days after the 15th day of the third month of the quarter. All records that apply to residents in the facility on a Picture Date must be submitted no later than one day prior to the Certification Page Submission Deadline. However, MDS and tracking forms are required by federal regulation to be submitted within 14 days of completion. In most cases, adhering to federal submission requirements will also meet Chapter 1187 Picture Date deadline requirements.

There are two cases in which complying only with the 14-day federal submission deadline will not also comply with the Department's regulatory Picture Date deadline requirements.

- If a PA/FS 162 is received on or before the last date for data submission (four business days after the 15th day of the third month of a calendar quarter) and the PA/FS 162 applies to a resident in the facility on the Picture Date, the facility must modify the latest NC, NQ, NP or NT assessment/record with a target date prior to the Picture Date detailing the MA for MA Case-Mix status and date of change, and submit the form before the end of the Picture Date deadline.
- If the Assessment Reference Date for a record is on or before a Picture Date for a resident in the facility on the Picture Date, but the completion date of the assessment is such that the 14-day federal submission deadline falls after the Picture Date deadline, the facility is required to submit the record on or before the Picture Date deadline.

On the day after the Picture Date, it is very important that the facility create a record of the residents and their MA for MA Case-Mix status on the Picture Date. It is easily done at this time, but harder to create at a later date. This will be the primary information used to check the accuracy of the CMI Report when it is generated (see Section 6 CMI REPORTS). Other data may change this information, e.g., a PA/FS 162 that arrives late in the submission period but has an effective date on or before the Picture Date, but this list will be critical to assuring correct MA for MA Case-Mix status and the correct residents applicable to the Picture Date.

A calendar containing important Picture Date milestones is posted on the DHS Long Term Care Case Mix Information site (http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_194243.pdf) and the Bulletins section of the Nursing Facility Report Portal.

5 RUG CLASSIFICATION

RUG-III, VERSION 5.12

In order to translate clinical information submitted for MA facility residents into MA Case-Mix Reimbursement rates, a Resource Utilization Group (RUG) category is calculated by the NIS for each MDS assessment that can be classified (ISC = NC, NQ, NP; A0310A = 01 – 06 and/or A0310B = 01) using a subset of the elements submitted on these assessments.

RUG-III classification version 5.12 44 Group is used for the MA Case-Mix Reimbursement System for Picture Dates that affect July 1, 2010 and beyond.

For each RUG category, a Case-Mix Index (CMI) is assigned. A CMI is a numerical score that describes the relative resource use for the average resident in each RUG category. The MA Case-Mix Reimbursement System uses state-specific CMIs that are based on the CMS nursing-only CMI set. These CMIs have been normalized to an average of 1.00 on a statewide basis based on the February 1, 2010 Picture Date and selection of the latest assessment.

The MA Case-Mix Reimbursement System also incorporates Index Maximization. If any resident's assessment qualifies for more than one RUG category, the assessment is assigned the RUG with the highest CMI, thus maximizing the CMI. If the assessment qualifies for two RUGs that have the same CMI, the assessment is assigned to the RUG that is higher in the hierarchy.

In the RAI Manual v. 1.15 effective October 1, 2017, on pages O-43 and O-44 for items O0600 Physician Examinations and O0700 Physician Orders, CMS states that it does not require completion of these items; however, some States continue to require their completion. Pennsylvania requires their completion as the responses are an integral part of the calculation of RUG-III v. 5.12 categories.

ELIGIBLE ASSESSMENTS

The RUG calculation is completed by the NIS for all classifiable assessments (ISC = NC, NQ, NP; A0310A = 01 – 06 and/or A0310B = 01). The RUG for the MA Case-Mix Reimbursement rate does not need to be calculated by the facility and submitted with the MDS record, but rather is calculated by the NIS and placed on CMI Reports.

RUG WORKSHEET

RUG-III v. 5.12 was originally created to use data taken from MDS 2.0 items. To enable states to easily continue to use this established system, the CMS created a crosswalk to indicate the appropriate values from MDS 3.0 items that could be used in the current MDS 2.0 classification programs. This crosswalk (also known as Mapping Specifications) is available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html in the RUG-III files.

Using this crosswalk, the following RUG Worksheet indicates the MDS 3.0 item responses used for classification. The following pages contain a worksheet that will aid the NF in understanding the factors that contribute to the placement of an assessment in a specific RUG.

INTRODUCTION TO THE MDS 3.0 RUG-III v. 5.12 44-GROUP CLASSIFICATION TOOL

This educational tool was developed to assist providers in understanding the Resource Utilization Group (RUG) III, version 5.12 44 Group logic when used with MDS 3.0 Version 1.17.1. This tool should not be used for software development; the detailed pseudocode is available on the WEB at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html in the RUG-III files. The Case Mix Index (CMI) set on which the PA Normalized Nursing Only CMIs are based is the federal Set B02 44 Group Nursing Only which is available on the same site. Select CMI Version 5.12A in the left-hand margin. These CMIs were normalized for Pennsylvania based on the population identified on the February 1, 2010 Latest Assessment Roster Report. The crosswalk (also known as Mapping Specifications) to MDS 3.0 items can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html> in the RUG-III files. If the resident's characteristics as identified on the MDS 3.0 qualify him for more than one Resource Utilization Group, final placement is made into the group with the highest CMI (Index Maximization). If the CMIs are the same, final placement is made into the group that is higher in the hierarchy.

On the worksheet, enter the resident's identification information at the top, and the MDS item responses to the RUG elements listed at the bottom. Working through all ten steps in the instructions, use these responses to arrive at the final classification for this resident. The resident must meet every criteria to place in a RUG. Record information on the worksheet as directed.

READ ALL QUALIFICATIONS CAREFULLY to be certain you are classifying the resident properly.

- < When MDS data is submitted electronically, for a section with instructions to "Check all that apply", the blank boxes are submitted as "0"; the checked boxes are submitted as "1".
- < "AND" and "OR" are very powerful words typed in capitals to draw attention to the special classification requirements.
- < If there is no number in parentheses beside a RUG element listed in classification STEPS TWO through EIGHT, a checkmark ("1") in that square on the MDS is all that is required to satisfy the classification process. For example, in STEP THREE, five treatments are listed: Parenteral/IV (K0510A1,2), Suctioning (O0100D1,2), Tracheostomy care (O0100E1,2), Ventilator/respirator (O0100F1,2) and IV medications (O0100H1,2). No numbers are listed in parentheses, so a checkmark in either Column 1 or Column 2 for any of the items may qualify the resident for placement in the Extensive Services category.
- < If there is a number in parentheses beside a RUG element, that item response must be present to classify the resident. For example, in STEP FIVE, supporting elements for Diabetes (I2900) include Injections (N0300) (7) and Physician Orders (O0700) (2 or more). There must be 7 days of Injections and 2 or more days of Physician Orders to make Diabetes a classifying element.
- < Some RUG elements do not stand alone but must have supporting data to justify the resident's placement in a category. For example, under STEP FIVE, not only must Coma (B0100) be checked but four additional RUG elements must also be indicated. Feeding tube (K0510B1,2) is not a qualifier unless it is supported by the appropriate responses from Parenteral/enteral intake (K0710). Several diagnoses, e.g., Hemiplegia (I4900) in STEP FIVE, must have a RUG ADL Score ≥ 10 ; a lower ADL Score eliminates this condition as a qualifier for Clinically Complex.
- < The RUG ADL Score may eliminate the resident from placement in some categories. To be placed in the Extensive Services category, the resident's RUG ADL Score must be 7 or above. To be placed in the Impaired Cognition or Behavior Problems categories, the RUG ADL Score must be 10 or below.
- < Placement in the Extensive Services category is a complex process. First, the resident must have a qualifying condition (K0510A1,2; O0100D1,2; E1,2; F1,2; H1,2) and a RUG ADL Score of 7 or higher. Then, points are assigned for Parenteral/IV (K0510A1,2), IV medications (O0100H1,2), and qualifying for Special Care, Clinically Complex and Impaired Cognition categories. Final placement is determined by point count.

RUG Element Worksheet Using MDS 3.0, RUG-III version 5.12 44 Group and Nursing Only CMI

RESIDENT NAME _____

ASSESSMENT DATE _____

SSN _____

CALCULATING THE RUG ADL SCORE (STEP 1):

Bed Mobility ADL Score _____
 Transfer ADL Score + _____
 Toilet Use ADL Score + _____
 Eating ADL Score + _____

RUG ADL SCORE _____

NUMBER OF NURSING REHABILITATION ACTIVITIES (STEP 2) _____

CLINICALLY COMPLEX: DEPRESSED? (STEP 6):
 YES _____ NO _____

REHABILITATION (SPECIAL) (STEP 2):

Total Minutes _____ Days _____

CATEGORY	RUG	CMI
Clinically Complex (STEPS 5/6)		

SUB-CATEGORIES	RUG	CMI
Low Intensity		
Medium Intensity		
High Intensity		
Very High Intensity		
Ultra High Intensity		

CATEGORIES	RUG	CMI
Impaired Cognition (STEP 7)		
Behavior Problems (STEP 8)		
Physical Functions (Reduced) (STEP 9)		

Select the RUG group from the above tables which has the highest CMI (STEP 10). If the CMIs are the same, final placement is made into the group that is higher in the hierarchy:

FINAL RUG: _____ FINAL CMI: _____

Comatose	B0100	_____	Paren/IV fdg. – not a resident	K0510A1	_____	Trach care – not a resident	O0100E1	_____
Makes self understood	B0700	_____	Paren/IV fdg–while a resident	K0510A2	_____	Trach care – while a resident	O0100E2	_____
BIMS Score	C0500	_____	Feeding tube – not a resident	K0510B1	_____	Vent/resp. – not a resident	O0100F1	_____
Short term memory – staff	C0700	_____	Feeding tube–while a resident	K0510B2	_____	Vent/resp – while a resident	O0100F2	_____
Decision making – staff	C1000	_____	Total calories	K0710A3	_____	IV med – not a resident	O0100H1	_____
PHQ-9© score – resident	D0300	_____	Fluid intake	K0710B3	_____	IV med – while a resident	O0100H2	_____
PHQ-9-OV© score – staff	D0600	_____	Stage 1 pressure ulcers	M0300A	_____	Transfusions – not a resident	O0100I1	_____
Hallucinations	E0100A	_____	Stage 2 pressure ulcers	M0300B1	_____	Transfusions – while a res	O0100I2	_____
Delusions	E0100B	_____	Stage 3 pressure ulcers	M0300C1	_____	Dialysis – not a resident	O0100J1	_____
Physical behavioral symp	E0200A	_____	Stage 4 pressure ulcers	M0300D1	_____	Dialysis – while a resident	O0100J2	_____
Verbal behavioral symptoms	E0200B	_____	Pres. ulcer – slough/eschar	M0300F1	_____	ST – individual minutes	O0400A1	_____
Other behavioral symptoms	E0200C	_____	Venous/arterial ulcers	M1030	_____	ST – concurrent minutes	O0400A2	_____
Rejection of care	E0800	_____	Infection of the foot	M1040A	_____	ST – group minutes	O0400A3	_____
Wandering	E0900	_____	Diabetic foot ulcer(s)	M1040B	_____	Speech therapy – days	O0400A4	_____
Bed mobility – self-perf.	G0110A1	_____	Other open lesion(s) of foot	M1040C	_____	OT – individual minutes	O0400B1	_____
Bed mobility – support	G0110A2	_____	Open lesion(s)	M1040D	_____	OT – concurrent minutes	O0400B2	_____
Transfer – self-perf.	G0110B1	_____	Surgical wound(s)	M1040E	_____	OT – group minutes	O0400B3	_____
Transfer – support	G0110B2	_____	Burns	M1040F	_____	Occupational therapy – days	O0400B4	_____
Eating – self-perf.	G0110H1	_____	Pres. Red. Device – chair	M1200A	_____	PT – individual minutes	O0400C1	_____
Toilet use – self-perf.	G0110I1	_____	Pres. Red. Device – bed	M1200B	_____	PT – concurrent minutes	O0400C2	_____
Toilet use – support	G0110I2	_____	Turn/reposition program	M1200C	_____	PT – group minutes	O0400C3	_____
Current toileting program	H0200C	_____	Nutrition/hydration interven.	M1200D	_____	Physical therapy – days	O0400C4	_____
Bowel toileting program	H0500	_____	Pressure Ulcer care	M1200E	_____	Respiratory therapy – days	O0400D2	_____
Pneumonia	I2000	_____	Surgical wound care	M1200F	_____	ROM (passive)	O0500A	_____
Septicemia	I2100	_____	Dressings (not to feet)	M1200G	_____	ROM (active)	O0500B	_____
Diabetes mellitus	I2900	_____	Ointment/med (not to feet)	M1200H	_____	Splint/brace assistance	O0500C	_____
Aphasia	I4300	_____	Dressings to feet	M1200I	_____	Bed mobility training	O0500D	_____
Cerebral palsy	I4400	_____	Injections	N0300	_____	Transfer training	O0500E	_____
Hemiplegia/Hemiparesis	I4900	_____	Chemotherapy – not a res.	O0100A1	_____	Walking training	O0500F	_____
Quadriplegia	I5100	_____	Chemotherapy – while a res	O0100A2	_____	Dressing/grooming tng.	O0500G	_____
Multiple sclerosis	I5200	_____	Radiation – not a resident	O0100B1	_____	Eating/swallowing tng.	O0500H	_____
Fever	J1550A	_____	Radiation – while a resident	O0100B2	_____	Amputation/prosth. tng.	O0500I	_____
Vomiting	J1550B	_____	Oxygen ther – not a resident	O0100C1	_____	Communication training	O0500J	_____
Dehydrated	J1550C	_____	Oxygen ther – while a res	O0100C2	_____	Physician Examinations	O0600	_____
Internal bleeding	J1550D	_____	Suctioning – not a resident	O0100D1	_____	Physician Orders	O0700	_____
Weight loss	K0300	_____	Suctioning – while a resident	O0100D2	_____			_____

RUG-III Classification Instructions Using MDS 3.0, RUG-III version 5.12 44 Group and PA Normalized Nursing Only CMI

STEP ONE: CALCULATE THE RUG ADL SCORE

A. To find the ADL scores for Bed mobility (G0110A), Transfer (G0110B), and Toilet use (G0110I), compare the MDS item responses to CHART A.

	<u>Self-perf.</u>	<u>Support</u>	
Bed Mobility	G0110A1 _____	G0110A2 _____	
Transfer	G0110B1 _____	G0110B2 _____	
Toilet Use	G0110I1 _____	G0110I2 _____	

CHART A

IF AND

<u>Self-perf.</u> <u>(G0110-1) =</u>	<u>Support</u> <u>(G0110-2) =</u>	<u>ADL</u> <u>Score =</u>
'—', 0, 1 or 7	* (any number)	1
2	* (any number)	3
3 or 4	'—', 0, 1 or 2	4
3, 4 or 8	3 or 8	5

Enter the three ADL scores (one each for Bed mobility, Transfer, and Toilet use) on the RUG Element Worksheet.

B. To find the Eating ADL score, check the MDS item response to Parenteral/IV (K0510A) and Feeding tube (K0510B).

Parenteral/IV feeding	K0510A1,2 _____	
Feeding tube	K0510B1,2 _____*	
* (K0710A3 must = 51% or more OR K0710A3 = 26 – 50% AND K0710B3 >= 501cc)		

If either K0510A1 or 2 is checked ('1'), or K0510B1 or 2 is checked and the supporting data is present for Feeding tube, the Eating ADL score is 3. If neither is checked or Feeding tube is not supported, note the number from Eating self-performance (G0110H1) and find the ADL score from CHART B.

Eating G0110H1 _____

CHART B

<u>IF</u> <u>G0110H1 =</u>	<u>ADL</u> <u>Score =</u>
'—', 0, 1 or 7	1
2	2
3, 4 or 8	3

Enter this score on the worksheet. Add the four scores; the total is the RUG ADL Score.

Proceed to STEP TWO.

STEP TWO: SPECIAL REHABILITATION

1. For all assessments, add the number of therapy minutes in O0400A1-3, O0400B1-3 and O0400C1-3. Note the total on the worksheet. If the total is less than 45 minutes, skip to STEP THREE.
2. If the total is more than 45 minutes, also count the number of therapy days from O0400A4, O0400B4 and O0400C4. Note this on the worksheet.
3. Count the number of Nursing Rehabilitation Activities from H0200C/H0500 and O0500.
 - a. Either Current toileting plan H0200C OR Bowel training program H0500 may be counted as one activity.
 - b. Each item (O0500C, E, G, H, I, J) with an entry of 6 or more days counts as one activity.
 - c. ROM (O0500A OR O0500B 6+ days) may be counted.
 - d. Bed Mobility O0500D OR Walking O0500F (6+ days) may be counted.

Record the total number of activities on the worksheet; this number will also be used in STEPS SEVEN, EIGHT and NINE.

Compare this data with the sub-categories (1 - 5) listed below. If the resident qualifies, select his RUG (Resource Utilization Group) using the RUG ADL Score. Record the RUG and CMI for each sub-category on the worksheet.

1. Low Intensity Rehabilitation Criteria:

AND 45 minutes or more of therapy per week
AND 3 days or more per week of therapy
AND 2 types or more of Nursing Rehabilitation Activities (from worksheet entry)

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
4 - 13	RLA	0.82
14 - 18	RLB	1.15

2. Medium Intensity Rehabilitation Criteria:

AND 150 minutes or more of therapy per week
AND 5 days or more per week of therapy

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
4 - 7	RMA	1.00
8 - 14	RMB	1.13
15 - 18	RMC	1.39

3. High Intensity Rehabilitation Criteria:

AND 325 minutes or more of therapy per week
AND 5 days or more per week of one type of therapy

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
4 - 7	RHA	0.90
8 - 12	RHB	1.09
13 - 18	RHC	1.22

(continued)

STEP TWO: SPECIAL REHABILITATION (continued)

4. Very High Intensity Multidisciplinary Rehabilitation:

AND 500 minutes or more of therapy per week
AND 5 days or more per week of one type of therapy

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
4 - 8	RVA	0.84
9 - 15	RVB	1.07
16 - 18	RVC	1.16

5. Ultra High Intensity Multidisciplinary Rehabilitation:

AND 720 minutes or more of therapy per week
AND 2 therapies or more provided
AND 5 days or more per week of one type of therapy
AND 3 days or more for the second therapy

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
4 - 8	RUA	0.80
9 - 15	RUB	0.99
16 - 18	RUC	1.34

Proceed to STEP THREE.

STEP THREE: EXTENSIVE SERVICES

Does the resident need one of the following treatments?
Count the treatment whether it occurred while NOT a resident or while a resident.

Parenteral/IV feeding	K0510A1, 2
Suctioning	O0100D1, 2
Tracheostomy care	O0100E1, 2
Ventilator or respirator medications	O0100F1, 2 IV O0100H1, 2

If no treatment is needed, skip to STEP FOUR.
If at least one treatment is needed, is the RUG ADL Score 7 or more?

- No. Skip to STEP FOUR.
- Yes. Begin the Extensive Services Point Count: Award one point for each of the following items. As Steps 4 – 6 are completed, return to this section to add points if the resident qualifies for those categories.

Parenteral/IV feeding	_____
IV medications	_____
Special Care classifier (STEP FOUR)	_____
Clinically Complex classifier (STEP FIVE)	_____
Impaired Cognition classifier (STEP SEVEN)	_____
TOTAL POINTS	_____

Select the final Extensive Services group using the Total Point Count. Record this RUG group and CMI on the worksheet.

<u>POINTS</u>	<u>RUG</u>	<u>CMI</u>
0 - 1	SE1	1.20
2 - 3	SE2	1.43
4 - 5	SE3	1.75

Proceed to STEP FOUR.

STEP FOUR: SPECIAL CARE

1. Does the resident meet one of the following criteria?

- Qualified for Extensive Services with ADL <7
(# NOTE: See below)
- Cerebral palsy (ADL >=10) I4400
 - Quadriplegia (ADL >=10) I5100
 - Multiple sclerosis (ADL >=10) I5200
 - Ulcers 2 or more sites M0300A, B1, C1, D1, F1, M1030 AND
 - 2 or more treatments: M1200A or B, C, D, E, G, H
 - Pressure ulcer M0300C1, D1, or F1 >0 AND
 - 2 or more treatments: M1200A or B, C, D, E, G, H
 - Radiation treatment O0100B1, 2
 - Respiratory therapy O0400D2 (7)

OR

2. Does the resident meet one of the following criteria for Fever, Feeding tube or Open lesions/Surgical wounds?

- + Fever + J1550A AND OR
- Pneumonia I2000 OR
- Vomiting J1550B OR
- Dehydration J1550C OR
- Weight loss K0300 OR
- Feeding tube * K0510B1, 2
- * (K0710A3 must = 51% or more OR K0710A3 = 26 - 50% AND K0710B3 >= 501cc)
- + Feeding tube + * K0510B1, 2 AND
- Aphasia I4300
- * (K0710A3 must = 51% or more OR K0710A3 = 26 - 50% AND K0710B3 >= 501cc)
- + Open lesions + M1040D OR
- + Surgical wounds + M1040E AND
- Surgical wound care M1200F OR
- Dressings (not to feet) M1200G OR
- Ointments (not to feet) M1200H

If the resident does not meet a criteria in 1 or 2, skip to STEP FIVE.

If the resident meets a criteria in 1 or 2 AND has qualified for the Extensive Services category, add one point for Special Care qualifier in STEP THREE. Move to STEP FIVE.

If the resident meets a criteria in 1 or 2 but does not qualify for Extensive Services, is the RUG ADL Score 7 or more?

- No. Skip to STEP FIVE. # NOTE: The resident who qualified for Extensive Services with ADL <7 is placed in SSA despite the low ADL Score.
- Yes. Select the final Special Care group using the RUG ADL Score. Record this RUG group and CMI on the worksheet.

<u>RUG ADL Score</u>	<u>RUG</u>	<u>CMI</u>
7 - 14	SSA	1.04
15 - 16	SSB	1.08
17 - 18	SSC	1.16

Proceed to STEP FIVE.

STEP FIVE: CLINICALLY COMPLEX

1. Does the resident meet one of the following criteria?

- Qualified for Special Care with ADL <7
- Pneumonia I2000
- Septicemia I2100
- Hemiplegia (ADL >=10) I4900
- Dehydration J1550C
- Internal bleeding J1550D

Feeding tube * K0510B1, 2
 * (K0710A3 must = 51% or more OR K0710A3 = 26 – 50% AND K0710B3 >= 501cc)

- Burns M1040F
- Chemotherapy O0100A1, 2
- Oxygen therapy O0100C1, 2
- Transfusions O0100I1, 2
- Dialysis O0100J1, 2

OR

2. The resident meets one of the following criteria for Coma, Diabetes, Foot infection or Physician visits/order changes:

- + Coma + B0100 AND
 - Bed mobility self-perf. G0110A1 (4 or 8) AND
 - Transfer self-perf. G0110B1 (4 or 8) AND
 - Eating self-perf. G0110H1 (4 or 8) AND
 - Toilet use self-perf. G0110I1 (4 or 8)

- + Diabetes + I2900 AND
 - Injections N0300 (7) AND
 - Physician Orders O0700 (2 or more)

- + Foot infection + M1040A OR
- + Open lesions + M1040B or C AND
 - Foot dressings M1200I

- + Physician Examinations + O0600 AND
- + Physician Orders + O0700
 - Examinations >= 1 day and Orders >= 4 days OR
 - Examinations >= 2 days and Orders >= 2 days

If the resident does not meet one of the above (1 - 2), skip to STEP SEVEN.

If the resident meets a criteria in 1 or 2 AND has qualified for the Extensive Services category, add one point for Clinically Complex qualifier in STEP THREE. Move to STEP SEVEN.

If the resident meets one of the above criteria in 1 or 2 and has not qualified for Extensive Services, move to STEP SIX to evaluate for Depression.

STEP SIX: DEPRESSION

The resident is considered to be depressed if either of the following is >=10:

- PHQ-9© Resident assessment D0300
- PHQ-9-OV© Staff assessment D0600

Record the presence or absence of Depression on the worksheet. Check the RUG ADL Score.

Select the final Clinically Complex group for which the resident qualifies. Record this RUG group and CMI on the worksheet.

STEP SIX: DEPRESSION (continued)

RUG ADL Score	Depressed?	RUG	CMI
4 – 11	No	CA1	0.77
4 – 11	Yes	CA2	0.85
12 – 16	No	CB1	0.86
12 – 16	Yes	CB2	0.94
17 – 18	No	CC1	1.01
17 – 18	Yes	CC2	1.15

Proceed to STEP SEVEN.

STEP SEVEN: IMPAIRED COGNITION

The resident is cognitively impaired if:

1. Comatose B0100 (with G0110A1, B1, H1, I1 all = 4 or 8) AND Decision making C1000 blank or '—' OR
2. BIMS Summary Score C0500 (<=9) OR
3. Severely impaired decision making C1000 (3) OR
4. CPS >=3 identified by following calculation:
 B0700, C0700, and C1000 are all assessed AND
 Two or more impairments (a – c) are present:
 a. Understood B0700 (>0)
 b. Short term memory C0700 (1)
 c. Decision making C1000 (>0) AND
 One severe impairment indicator is present:
 a. Understood B0700 (>=2) OR
 b. Decision making C1000 (>=2)

If the resident meets a criteria for Impaired Cognition and has qualified for the Extensive Services category, add one point for Impaired Cognition qualifier in STEP THREE. Total the points and identify the final Extensive Services RUG and CMI. Record them on the worksheet. This resident's classification is completed.

If the resident does not meet an Impaired Cognition requirement, move to STEP EIGHT.

If the resident meets a requirement but the RUG ADL Score is >10, move to STEP NINE.

Otherwise, if a requirement is met, using the RUG ADL Score and number of Nursing Rehabilitation Activities (STEP 2), select the final Impaired Cognition group. Record this RUG group and CMI on the worksheet.

RUG ADL Score	Nsg. Rehab.	RUG	CMI
4 - 5	0 or 1	IA1	0.54
4 - 5	2 or more	IA2	0.59
6 - 10	0 or 1	IB1	0.69
6 - 10	2 or more	IB2	0.71

Proceed to STEP EIGHT.

(continued)

STEP EIGHT: BEHAVIOR PROBLEMS

If the RUG ADL Score is 10 or less, the resident may belong in this category if there are problems with one of the following:

Hallucinations	E0100A	OR
Delusions	E0100B	OR
Physical Beh. symptoms	E0200A (2 or 3)	OR
Verbal Beh. symptoms	E0200B (2 or 3)	OR
Other Beh. symptoms	E0200C (2 or 3)	OR
Rejection of care	E0800 (2 or 3)	OR
Wandering	E0900 (2 or 3)	

If the resident does not meet one of these requirements or has a RUG ADL Score >10, move to STEP NINE.

Otherwise, using the RUG ADL Score and number of Nursing Rehabilitation Activities (STEP 2), select the final Behavior Problems group. Record this RUG group and CMI on the worksheet.

<u>RUG ADL Score</u>	<u>Nsg. Rehabs.</u>	<u>RUG</u>	<u>CMI</u>
4 - 5	0 or 1	BA1	0.49
4 - 5	2 or more	BA2	0.57
6 - 10	0 or 1	BB1	0.67
6 - 10	2 or more	BB2	0.70

Proceed to STEP NINE

STEP NINE: PHYSICAL FUNCTIONS (REDUCED)

ALL residents will qualify for one of the following groups.

Using the RUG ADL Score and the number of Nursing Rehabilitation Activities (STEP 2), select the Physical Functions (Reduced) group. Record this RUG group and CMI on the worksheet.

<u>RUG ADL Score</u>	<u>Nsg. Rehabs.</u>	<u>RUG</u>	<u>CMI</u>
4 - 5	0 or 1	PA1	0.48
4 - 5	2 or more	PA2	0.50
6 - 8	0 or 1	PB1	0.52
6 - 8	2 or more	PB2	0.53
9 - 10	0 or 1	PC1	0.66
9 - 10	2 or more	PC2	0.68
11 - 15	0 or 1	PD1	0.69
11 - 15	2 or more	PD2	0.73
16 - 18	0 or 1	PE1	0.79
16 - 18	2 or more	PE2	0.81

STEP TEN: FINAL CLASSIFICATION

Review all CMIs recorded on the worksheet. Select the highest CMI; record the associated RUG and this CMI on the worksheet as the final classification group for this resident. If the resident qualifies for both RLB and CC2, record RLB as the final classification group.

Pennsylvania Nursing-Only Normalized CMIs

(effective July 1, 2010)

RUG-III Group	CMI
RLA	0.82
RLB	1.15
RMA	1.00
RMB	1.13
RMC	1.39
RHA	0.90
RHB	1.09
RHC	1.22
RVA	0.84
RVB	1.07
RVC	1.16
RUA	0.80
RUB	0.99
RUC	1.34
SE1	1.20
SE2	1.43
SE3	1.75
SSA	1.04
SSB	1.08
SSC	1.16
CA1	.0.77
CA2	0.85
CB1	0.86
CB2	0.94
CC1	1.01
CC2	1.15
IA1	0.54
IA2	0.59
IB1	0.69
IB2	0.71
BA1	0.49
BA2	0.57
BB1	0.67
BB2	0.70
PA1	0.48
PA2	0.50
PB1	0.52
PB2	0.53
PC1	0.66
PC2	0.68
PD1	0.69
PD2	0.73
PE1	0.79
PE2	0.81

6 CMI REPORTS

CASE-MIX INDEX

The regulations at §1187.2 define a Case-Mix Index (CMI) as “A number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident.” For example, residents falling into a RUG category with a CMI of 1.15 take more than twice the nursing resources as a resident assessed in a RUG category with a CMI of 0.54. As a number, the CMI is the link between the clinical data submitted for the NF residents and the MA Case-Mix Reimbursement rate. This link is made possible by the use of the CMI Report for each Picture Date.

CMI REPORT GENERATION

The final step in completing the resident reporting requirements for each Picture Date is the correction and certification of the CMI Report by the NF. A CMI Report is “generated” by the NIS from all records submitted to the CMS MDS 3.0 Data Collection System, but only contains the list of residents the NIS determines were in the facility on a Picture Date and they have a classifiable assessment. For each of these residents, the resident’s name, Resident Internal ID, Assessment Internal ID, assessment reference date, correction # (X0800), assessment type, RUG category and appropriate CMI is listed. The CMI Report also includes, on the first page, a certifying statement to be signed by the administrator or acting administrator and CMI averages of the residents listed on the remaining page(s).

Initial CMI Report Transition

Until October 1, 2013, the first CMI Report for a NF during a Picture Date submission period was “posted” to the MA facility’s sub-directory on the CMS MDS 2.0 Data Collection System on the 20th of the Picture Date month. This report was accessed from the CMS MDS Welcome Page. To access the CMI Report, the MDS 2.0 Submissions option was selected and then the submitter clicked on Receive Validation Reports. Clicking on the CMI Report file allowed you to review your report.

As of October 1, 2013, CMS removed the MDS 2.0 Submission link from the CMS MDS Welcome Page. The MDS 2.0 Data Management

System is no longer in effect. A new link, MDS State Reports, appeared on the Welcome Page.

As of October 1, 2014, CMS disabled the state links that had been used to securely distribute the CMI Reports. A new secure file hosting server known as the Nursing Facility Report Portal (NFRP) was implemented which enables nursing facility representatives to access the CMI Reports over the Internet. A certified letter was sent to all NHAs in November 2014 outlining the new procedure and containing the initial password to allow establishment of Individual User Accounts. A complete step-by-step procedure detailing how to access and use this new system appears on the NFRP Welcome Page at <https://nfrp.panfsubmit.com>.

It is the responsibility of a facility participating in the MA program to download this CMI Report, review it carefully, and make necessary corrections before signing and uploading the Certification Page.

An example CMI Report is located in Figures 1 through 9 on pages 6-14 through 6-21.

Subsequent CMI Reports

If the initial CMI Report generated and posted for a Picture Date is not correct, the facility submits further records to the CMS MDS 3.0 Data Collection System prior to the Picture Date deadline. With each submission batch, a newer CMI Report is generated for the facility to review. Usually, the subsequent CMI Report is generated and posted within 24-hours of each submission up to the Picture Date deadline. However, the QIES ASAP system only downloads records to the state server once a day. They are transferred to the NIS and CMI Reports are generated and posted as quickly as possible. The facility repeats the submission process until a correct CMI Report is generated. The first page of this accurate report must be signed and uploaded by the Certification Page Submission Deadline.

Only the Certification Page from the final, correct CMI Report should be signed and uploaded to the NFRP. It is not necessary to certify each CMI Report that is generated. The NIS automatically produces a CMI Report after the receipt of a submission file. It is the responsibility of the facility to determine which CMI Report is correct.

If the facility continues to submit batches prior to the end of the Picture Date deadline, further CMI Reports will be generated. However, if the assessments and tracking forms submitted in these newer batches do not apply to the Picture Date period, these newer CMI Reports may be ignored by the NF.

CMI Report File Names

Each CMI Report file is named in a standard manner. The first characters are the Picture Date month and year, followed by the NF's MA PROMISe provider number, the date generated (YYYYMMDD) and ending with the time generated (HHMMSS in military time). For example, CMI-May2015-1234567890123-20150520-134421.pdf.

Picture Date Transition

For the Picture Dates of February 1, 2010 and May 1, 2010, an additional report was generated – the Latest Assessment Roster Report (LARR). This contained a list of residents identified as being in the nursing facility based on the selection of the latest assessment rather than only comprehensive assessments. MA for MA Case-Mix status was reported but no RUG or CMI was included. These were reissued in the summer of 2010 to include the RUG-III 5.12 44 Group and PA Normalized Nursing Only CMI for each resident’s assessment, and the Total Facility and MA CMI averages.

Subsequent Picture Date CMI Reports are generated using RUG-III v. 5.12 44 group classification system and the PA Normalized Nursing Only CMIs.

REVIEWING CMI REPORTS

The facility must review the CMI Report carefully for three (3) things:

- Are the correct residents appearing on the report compared to the census of the residents on the Picture Date?
- Is the resident’s MA for MA Case-Mix status correct for the Picture Date?
- Is the correct assessment for a resident appearing on the report for the Picture Date?

The remainder of this section provides the facility with a step-by-step review process for assuring accuracy of CMI Reports.

Residents

The residents appearing on the CMI Report should correspond to your facility’s census for the Picture Date. When creating a CMI Report, residency in the facility on the Picture Date is determined by the record with the effective date closest to, or on, the Picture Date. The residency status is No for the Picture Date if this record is a Discharge assessment with return not anticipated (A0310F = 10) or a Death in Facility tracking record (A0310F = 12), and the resident will not be listed on the CMI Report. If this record is a Discharge assessment with return anticipated (A0310F = 11), there are rules described below for establishing residency. If this record is any other assessment or tracking form, the residency status is Yes for the Picture Date and the resident will be listed on the CMI Report.

The effective date used to determine residency on the CMI Report varies with the assessment or tracking form:

- For an Admission record (A0310A = 01) the effective date is A1600 (Entry Date).
- For an Annual record (A0310A = 03), a Significant Change record (A0310A = 04), a Significant Correction record (A0310A = 05), a Quarterly record (A0310A = 02), a Significant Correction of Quarterly (A0310A = 06) or a Medicare PPS Only

record (A0310A = 99; A0310B=01,08) the effective date is A2300 (Assessment Reference Date).

- For a Discharge assessment/record (A0310F = 10, 11 or 12) the effective date is the Discharge Date (A2000).
- For an Entry tracking form (A0310F = 01) the effective date is the Entry Date (A1600).

If records have the same effective date, the record that was sent in the most recent batch, i.e., the highest Assessment Internal ID, is the record that is used to determine residency.

- Residents that were admitted on the Picture Date day (February 1, May 1, August 1 or November 1) should appear on the CMI Report in the MA area if they are MA for MA Case-Mix on the admission day. If not, the resident should appear in the non-MA area.
- Residents that were discharged on or before the Picture Date day (February 1, May 1, August 1 or November 1) *without* anticipated return (A0310F = 10) or Death in Facility (A0310F = 12) should not appear on the CMI Report.
- Residents that were discharged with an anticipated return (A0310F = 11) will appear in the non-MA section if they have been out of the facility 30 days or less. The submission of a Discharge assessment with an anticipated return converts an MA for MA Case-Mix resident to non-MA status.
- Residents that were discharged and do not have an Admission assessment (A0310A = 01) or Medicare PPS assessment (A0310A = 99; A0310B = 01) applicable to the new Entry date (A1600) in the CMS MDS 3.0 Data Collection System database will not appear on the CMI Report. No RUG group or CMI can be calculated from an Entry record (A0310F = 01) or a Discharge assessment/record (A0310F = 10, 11 or 12).
- MA for MA Case-Mix residents that were out of the facility on therapeutic leave on the Picture Date should appear on the MA portion of the CMI Report. An MA for MA Case-Mix resident who is out of the facility on therapeutic leave on the Picture Date but does not meet the conditions of § 1187.104(2), e.g., has exceeded the 30 days leave allowed, shall appear in the non-MA portion of the CMI Report. The NF should modify the latest NC, NQ, NP or NT ISC to record S9080A = 0 and S9080B = 31st day of therapeutic leave. When the resident returns, the NF should submit the Entry record (A0310F = 01) with S9080A = 1 and S9080B = Date of Reentry (A1700). No Discharge assessments should be completed.
- Non-MA residents that were out of the facility on therapeutic leave on the Picture Date should appear on the CMI Report in the non-MA area.
- If no classifiable resident assessment has been submitted, the resident will not appear on the CMI Report.
- If a resident was admitted on or before the Picture Date but due to the completion of Entry records (A0310F = 01) and Discharge return anticipated assessments (A0310F = 11), e.g.,

the resident returned to the hospital, the Assessment Reference Date of the Admission Assessment was the 16th of the Picture Date month or later, the resident will not appear on the CMI Report.

- If the resident was Discharged return anticipated (A0310F = 11) and has not returned after 30 days, the resident will not appear on the CMI Report.
- No resident should be listed twice.

Corrective activity: Electronically submit assessments, Discharge assessments/records or Entry Tracking records, as applicable. Electronically submit modification and inactivation records as necessary. Continue until all residents are properly listed.

Discharge – Return Anticipated

With MDS 3.0, CMS has directed that if a resident remains out of the facility more than 30 days after a Discharge-return anticipated assessment (A0310F = 11) and returns, they are to be treated as a new Admission. To coordinate with this interpretation, if the resident has been out of the facility more than 30 days on the Picture Date, the resident will not appear on the CMI Report.

If a Discharge-return anticipated assessment is the last record effective for the Picture Date and the Discharge date is 30 days or less prior to the Picture Date, the resident will appear in the non-MA section of the CMI Report. However, the nursing facility may have knowledge that the resident will not be returning to the facility. For example, this situation could occur when the resident was discharged to the hospital with an anticipated return, but the resident dies or is admitted to another nursing facility from the hospital. Without further action by the facility, the resident may incorrectly appear in the non-MA section of the CMI Report.

Corrective activity: For the Picture Dates of May 1 and August 1, 2012, the Discharge After Discharge Change Form was used. For all other Picture Dates beginning November 1, 2012, modify the Discharge Return Anticipated assessment (A0310F = 11) using S8010H1 Picture Date Reporting to have the system treat this assessment as a Discharge Return Not Anticipated in creating the CMI Report.

As an alternate approach beginning May 19, 2013, the Reasons for Assessment (A0310) may be modified as long as the Item Subset Code does not change. If A0310F = 11 (Discharge Return Anticipated), submit a modification and change A0310F to 10 (Discharge Return Not Anticipated) to remove the resident from the CMI Report. This procedure may be performed for assessments with a Discharge Date prior to May 19, 2013, as long as the assessment is submitted on or after May 19, 2013. Contact the Myers and Stauffer helpdesk for further assistance.

MA for MA Case-Mix Status

MA for MA Case-Mix status is determined for the CMI Report by the response in S9080A appearing on the latest assessment (NC, NQ, NP, or NT) with a Date of change to/from MA for MA Case-Mix (S9080B) date on or before the Picture Date. See Section 3 MA FOR MA CASE-MIX for further coding information for MA for MA Case-Mix status.

- The MA status of the residents on the CMI Report should reflect your facility's payer source records for the Picture Date day (February 1, May 1, August 1 or November 1).
- Residents who were MA Pending on the Picture Date and have not received the PA/FS 162 form on or before the Picture Date deadline should appear on the CMI Report in the non-MA section.
- Residents who were not paid for by MA on the Picture Date should appear on the CMI Report in the non-MA section.

Corrective activity: Submit a modification with S9080A denoting the correct MA status and S9080B denoting the earliest Date of Change to/from MA.

Assessments

The Assessment Reference Date (A2300) is used to determine applicability of the assessment for the Picture Date. For information concerning what records were available for use in generating the CMI Report, look for the latest batch number at the bottom of page 1 of the CMI Report. All records from that batch have been replicated to the NIS and are available for use in the CMI Report.

- The assessment listed on the CMI Report should be the most recent assessment with the Assessment Reference Date (A2300) on or before the Picture Date.
- The modification of an assessment listed on the CMI Report should be the most recent modification (X0800) of the assessment received and accepted by the CMS MDS 3.0 Data Collection System prior to generating the CMI Report. Since the automated correction policy was implemented with the system software upgrade on May 23, 2000, facilities are able to correct a record by transmitting a modification of an assessment or tracking form record to the CMS MDS 3.0 Data Collection System. When a modification is transmitted to the CMS MDS 3.0 Data Collection System, the modification becomes the active record. The record that was previously submitted is moved to a history file where it is no longer used. This will result in different modifications of the same assessment being available at different times for use in creating the CMI Reports for a Picture Date. When creating a CMI Report for a Picture Date, the most recent modification of the applicable assessment that is received and accepted prior to generating the CMI Report will be placed on the CMI Report.
- **Facilities are not able to choose the modification of an assessment to be used on a CMI Report.** The facility is not

able to request that an assessment received on an earlier date be used on a CMI Report. The most recent modification received and accepted on or before the submission deadline at the time the CMI Report is generated will always be used in creating the CMI Report. An original record is transmitted as X0800 = [blank]. However, for purposes of clarity on the CMI Report, the original record is identified as X0800 = 00.

- If a resident was admitted or readmitted to the facility within 14 days prior to the Picture Date, the NC or NQ ISC may be listed if the Assessment Reference Date (A2300) is between the Picture Date and the 15th of the Picture Date month, as long as the Assessment Reference Date is within 14 days of the Entry date (A1600).
- If a resident was admitted or readmitted to the facility within 8 days prior to the Picture Date, a Medicare PPS 5-day assessment (NP) may be listed if the Assessment Reference Date (A2300) is between the Picture Date and the 8th of the Picture Date month, as long as the Assessment Reference Date is within 8 days of the Entry date (A1600).
- Between April 1, 2011 and May 18, 2013, the MDS 3.0 Reason for Assessment (A0310) and the Target Dates (A1600 Entry Date, A2000 Discharge Date, A2300 Assessment Reference Date) could not be modified. The record had to be inactivated (A0050 = 3) and the corrected record submitted to the MDS QIES ASAP system. Beginning May 19, 2013, Reasons for Assessment and Target Dates may be modified as long as the ISC remains the same. This change is retroactive: the new rules apply to any assessment submitted on or after May 19, 2013, regardless of the Target Date. The NIS system will select the latest classifiable assessment for inclusion on the CMI Report.
- Assessments and tracking form ISCs designated as IPA, NPE, ND and NT are disregarded in generating the CMI Report. None of these records contain all the information necessary to calculate a RUG.

Corrective activity: Submit the appropriate assessment, as applicable. If the Reasons for Assessment were coded incorrectly and the ISC will not change, submit a modification with the Reasons for Assessment coded correctly.

Non-Valid Assessments

Of the residents that the NIS determines are in the facility on the Picture Date, the NIS picks the most recent valid classifiable assessment for that resident for placement on the CMI Report. “Validity” is based on the age of the assessment compared to the Picture Date. An assessment is considered valid if the Assessment Reference Date (A2300) is within four months of the Picture Date, e.g., for February 1, 2015, the ARD must be October 1, 2014 or later. If no valid assessment is present, the most recent non-valid assessment is placed on the report with a defaulted CMI according to §1187.33(b)(1). Non-valid assessments for a resident

with the status of MA for MA Case-Mix are assigned the lowest CMI for the MA CMI and the highest CMI for the Total Facility CMI rather than the CMI associated with the RUG. Non-valid assessments for a non-MA resident are assigned the highest CMI for the Total Facility CMI. In most cases, the facility should be able to submit the appropriate records in order to move the resident from the non-valid assessment area of the CMI Report to the appropriate MA for MA Case-Mix or non-MA sections of the report. These corrections should be made and the facility should wait for a new CMI Report to be generated prior to uploading the Certification Page. Any residents remaining in the non-valid assessment area of the CMI Report have a negative impact on the facility's CMI averages. An assessment may be non-valid for the following reasons:

- An Admission assessment is listed in the non-valid section of the CMI Report if there are more than 14 days between the Date of Entry (A1600) and the Assessment Reference Date (A2300). A 5-day Medicare PPS assessment will also be listed in the non-valid section of the CMI Report if there are more than 8 days between the Date of Entry (A1600) and the Assessment Reference Date (A2300). These assessments are non-valid because they were not completed in a timely manner. This only applies if the Date of Entry is on or before the Picture Date, and the Assessment Reference Date is on or after the Picture Date.
- An assessment is listed in the non-valid section of the CMI Report if the most recent assessment completed and submitted for a resident has an Assessment Reference Date earlier than four months prior to the Picture Date. This assessment is non-valid because the resident was not re-assessed in a timely manner.
- As of the May 1, 2015 Picture Date, these residents are listed first both on the Certification Page and the Resident List to encourage NFs to take corrective action.

Corrective activity: If the difference between the admission date and assessment reference date shows that the assessment was not completed on time, but it's the result of a data entry error at the facility, correct the dates in the CMS MDS 3.0 Data Collection System database by submitting a modification. Beginning May 19, 2013, only a modification is needed to correct the record.

If the dates were data entered and submitted correctly by the facility and the facility failed to complete a timely assessment, no correction may be made. To replace a non-valid older assessment with a newer assessment, submit this assessment. If no newer assessment is available, no correction may be made.

Duplicate Resident Entries

If assessments for one resident are submitted with differing identification data, e.g. Social Security Number, the CMS MDS 3.0 Data Collection System may assign two separate internal resident identification numbers (listed on the Final Validation Report as Res_Int_ID) and not recognize that the assessments are for the same resident. Depending on the assessments submitted under each resident identification number, both may have an assessment selected for inclusion on the CMI Report. In

other words, the resident is listed twice and included twice in the count of residents. This must be corrected; do not sign a Certification Page of a CMI Report that contains duplicate residents.

Corrective activity: Contact the Myers and Stauffer Helpdesk concerning the duplication. If necessary, the resident data will be merged and the single proper assessment will appear on the corrected CMI Report.

Occupancy Calculations

Effective July 1, 2010, in order to qualify for a hospital reserved bed day payment, a facility's overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to either 55 Pa. Code § 1187.104(b)(1)(ii)(B) or 55 Pa. Code § 1189.103(b)(1)(ii)(B). The nursing facility's occupancy rate for a quarter is determined according to either 55 Pa. Code § 1187.104 (b)(1)(iii) or 55 Pa. Code § 1189.103(b)(1)(ii). The occupancy rate is calculated by dividing the total number of assessments listed on the facility's CMI Report for that Picture Date by the number of the facility's certified beds. Data is used from the three most recent Picture Dates; the maximum occupancy rate of these three dates determines whether or not the NF can receive hospital reserved bed day payments for the associated rate quarter.

Beginning with the February 1, 2012 Picture Date, these occupancy rates are summarized on the Payment for Hospital Reserved Bed Days page of the CMI Report and the NF was informed whether or not they may receive these payments for the specified rate quarter. If they may not, instruction is provided concerning the proper billing procedures. See example on page 6-17.

In the past, bed size information and occupancy calculations for the latest four (4) Picture Dates were located at the end of the CMI Report. This information was provided primarily as an aid to reviewing your CMI Report and was not a required calculation. As continuing to provide this same information may be confusing when viewed with the CMI Report page described above, the old calculations were discontinued effective with the February 1, 2012 Picture Date.

Corrective activity: Establish that the number of Certified Beds on the CMI Report is accurate. The contractor receives this information from DHS and there may be some delay between a bed size change at the facility and generation of the CMI Report. If there are questions about the number of Certified Beds reported on the CMI Report, contact the Myers and Stauffer Helpdesk for further assistance.

If the occupancy rate is higher than expected for the current Picture Date, submit Discharge assessments for residents that were not in the facility on the Picture Date. If the occupancy rate is lower than expected, submit Admission or other assessments or Entry Tracking forms for residents that were in the facility on the Picture Date.

If you believe that the calculation is in error, the appeal process is detailed on the Payment for Hospital Reserved Bed Days page of the CMI Report.

Supplemental Ventilator and Tracheostomy Care Payment (SVTCP)

In the August 24, 2013 *Pennsylvania Bulletin* (43 Pa.B. 4855), proposed rulemaking *Supplemental Ventilator Care Payment for Medical Assistance Nursing Facilities* was published. This described a new category of supplemental ventilator care payment under 55 Pa. Code § 1187.117 and § 1189.105 (c) (2). The payment was calculated on a quarterly basis and paid to NFs caring for a minimum of ten MA-recipient residents who receive medically necessary ventilator care and have at least 10% of the facility's MA-recipient resident population receiving medically necessary ventilator care. For facilities that qualified, the Supplemental Ventilator Care Payment (SVCP) per diem was calculated as (% of MA ventilator care residents x \$69 x % of MA ventilator care residents). The quarterly SVCP to qualifying facilities was calculated as the SVCP per diem times the number of paid MA facility and therapeutic leave days for the calendar quarter that contains the Picture Date used to determine the qualifying criteria

In the June 14, 2014 *Pennsylvania Bulletin* (44 Pa.B. 3565), final-form rulemaking expanded this supplemental payment to include MA residents receiving medically necessary tracheostomy care beginning July 1, 2014.

Beginning with the November 1, 2013 Picture Date, the CMI Report has included a page detailing whether the NF met the criteria for the SVCP. For the November 1, 2014 Picture Date, MA residents receiving medically necessary tracheostomy care are also included. Addenda to the CMI Reports for the February, May and August 2014 Picture Dates were posted on October 21, 2014, under the same file name as was identified on the CMI Report certified by the facility plus “- SVTCP-Addendum.htm” showing the new payment calculations including residents requiring ventilator or tracheostomy care. A resident receiving both services is counted only once. Examples of these pages are included beginning on page 6-20.

Beginning January 1, 2018, facilities located in a geographic zone where Community HealthChoices operates do not qualify for this payment.

Clinical records of residents receiving medically necessary ventilator or tracheostomy care in facilities qualifying for the SVTCP will be reviewed by the Office of Long-Term Living Nursing Facility Field Operations Representatives. Details of the appeal process are included on the CMI Report page.

Corrective activity: Establish that the numbers of MA residents and MA residents receiving medically necessary ventilator or tracheostomy care are accurate. Medically necessary tracheostomy care is identified as a positive response in either Section O0100E1 or O0100E2 of the MDS assessment identified on the CMI Report. Medically necessary ventilator care is identified as a positive response in either Section O0100F1 or O0100F2 of the MDS assessment identified on the CMI Report. If errors are found, modify the MDS assessment as necessary. If there are questions about the data reported on the CMI Report, contact the Myers and Stauffer Helpdesk for further assistance.

Reformatting of the CMI Report

With the creation of the Nursing Facility Report Portal (NFRP) now used to access CMI Reports and upload the CMI Report Certification Page, it became apparent that some changes to the CMI Report were needed. These were implemented with the May 1, 2015 Picture Date.

1. A PDF format was implemented to correct an issue with erratic page breaks. This new format assures that the pages are consistent and allows use of a larger, clearer font. The previous font size was sometimes hard to read. In addition, with the use of document scanning, the larger font assures that the document will be clear when uploaded to the nursing facility (NF) or uploaded to the NFRP.
2. The Social Security Number (SSN) was removed. This number is being removed from many documents, e.g., Medicare cards. It was not meant to be used as an identifier, and its accessibility makes potential identity theft easier. As identifiers, the Resident Internal ID and the Assessment Internal ID were added. These are available to the NF on the Final Validation Report.
3. To encourage NFs to deal with non-valid assessments that appear on the CMI Report, these assessments are now listed first both on the Certification Page and in the Resident List.
4. A reminder that this is Protected Health Information was added to the bottom of each page.
5. A reminder of the Certification Page upload process is included on the first page.

If you have any issues with the formatting, please contact the Myers and Stauffer Helpdesk for further assistance.

CERTIFICATION PAGE SUBMISSION DEADLINE

The first page of the CMI Report, the Certification Page, contains a statement certifying the accuracy of the CMI Report. This statement must be signed and dated by the Administrator or Acting Administrator. Administrators should make sure they are signing the correct Certification Report since multiple CMI Reports are generated throughout the Picture Date submission and correction period. The CMI Report file name is listed at the top of the Certification Report and in the certifying statement itself, and should match all the remaining pages of the CMI Report that has been reviewed for accuracy. If the Certification Page is signed by an employee of the facility other than the Administrator or Acting Administrator, the facility will be contacted for a replacement signature.

Only the Certification Page of the CMI Report should be uploaded to the NFRP. If the entire CMI Report is uploaded, it will be rejected. Any communication requesting changes to the CMI Report will be ignored. Changes are only possible by submitting additional MDS records to the CMS MDS 3.0 Data Collection System and obtaining a new CMI Report.

Do not sign an inaccurate CMI Report. If the CMI Report is not yet correct by the Certification Page Submission Deadline, contact the Myers and Stauffer Helpdesk for further guidance. Do not sign a CMI Report

that is “almost right” or “the best of the bunch.” Inaccurate data may affect your facility’s rate for many years and will be considered an error during Field Operations reviews.

The Certification Page must be uploaded within five business days of the Picture Date deadline. If more than one Certification Page is signed and uploaded, the Certification Page with the latest date will be deemed to be the accurate Certification Page for the Picture Date.

PICTURE DATE CALENDAR

§ 1187.33(a)(5) states “The nursing facility shall correct and verify that the information in the quarterly CMI report is accurate for the Picture Date and in accordance with paragraph (6) and shall sign and submit the CMI report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter.” This date may vary depending on the day of the week on which the 15th falls. To assist facilities in meeting Picture Date requirements, a calendar highlighting the dates for the current Fiscal Year may be found on the DHS Long Term Care Case Mix Information site (<http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm#>) and the Bulletins section of the Nursing Facility Report Portal.

Extensions of the Submission Deadline and Certification Page Submission Deadline may only be granted by the Department. An extension will only be granted upon a showing of fraud, breakdown in the Department's administrative process or an intervening natural disaster making timely compliance impossible or unsafe.

On the Picture Date, determine the total facility census, the MA status and the most recent assessment for each resident. Between the Picture Date and the Initial CMI Report posting, keep the census updated for PA/FS 162 information that is received that affects residents on the census and any assessments completed shortly after the Picture Date. This information should be used to aid in the CMI Report review process.

Shortly after the Initial CMI Report Posting Date, access the NFRP. Locate the CMI Report under the CMI Reports folder. Click on the desired report and save the report to your computer. Steps may vary depending on your browser. Open and print the report for review. Use the census document established on the Picture Date to review the report for accuracy.

Submit any additional records to the CMS MDS 3.0 Data Collection System to obtain an accurate CMI Report prior to the Last Date for Data Submission for the Picture Date. Remember that it may take up to 24 hours after a submission to receive a subsequent CMI Report. In order to have time to review the CMI Report and still have time to submit further records to correct the CMI Report, the NF should consider starting this review process as soon after the 20th of the Picture Date month as possible.

PICTURE DATE CLOSURE

Approximately two months after the Picture Date when signed Certification Pages have been received from nursing facilities participating in the MA program, the Picture Date is deemed to be closed. No changes can be made to any assessments used on the CMI Report after closure. The Picture Date CMI Averages are calculated and posted on the DHS web site. The final data is stored for use in the rate setting process.

Figure 1 – CMI Report Example – Certification Page

Commonwealth of Pennsylvania
 Department of Human Services

Page 14
 05/20/2015
 09:00:00

CMI Report for the May 2015 Picture Date

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

RETURN ONLY THIS PAGE VIA THE NFRP WEBSITE: <https://nfrp.panfsubmit.com/>

I hereby certify that the information submitted for these residents and the File: CMI-May2015-0123456789012-20150520-090000.pdf is true, accurate and correct for this Picture Date. The Medical Assistance for the MA Case-Mix status for each resident is correct for the assessment date, reentry date, or the date of change to/from MA applicable to the Picture Date. I understand that any false claims or statements, or concealment of material facts may be prosecuted under applicable Federal and State laws. Alteration of this statement is not allowed and will result in an invalid CMI Report.

Residents with Non-Valid Assessments	1
Number of Medical Assistance Residents	11
Total Number of Residents	20
CMI Average for Medical Assistance Residents	1.15
CMI Average for Total Facility	1.28

* Signature of Administrator/Acting Administrator _____

Print or Type Name: _____

Date: _____

**Sign, scan and upload only this page via the *Nursing Facility Report Portal*:
<https://nfrp.panfsubmit.com/>**

The contents of this report are based on the MDS records received up to and including batch #123456.

* Your signature and return of this statement by the deadline completes the assessment submission process for the Picture Date.

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 2– CMI Report Example – Resident Roster

Commonwealth of Pennsylvania
 Department of Human Services

05/20/2015
 09:00:00

CMI Report for the May 2015 Picture Date

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

Residents with Non-Valid Assessments

Resident Name	Resident Internal ID	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	RUG	MA CMI	Facility CMI
XXXXXXXX, XXXXXX	28859	45628859	00	11/12/2014	Quarterly	RMC	0.48	1.75

Medical Assistance Residents

Resident Name	Resident Internal ID	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	RUG	MA CMI	Facility CMI
XXXXX, XXXX X	425535	234425535	00	01/15/2015	Quarterly	SE2	1.43	1.43
XXXXXXXX, XXX	364197	34364197	00	11/05/2014	Quarterly	RMC	1.39	1.39
XXXX, XXXX X	79706	635479706	00	02/01/2015	Quarterly	PD2	0.73	0.73
XXXXX, XXXXX X	141757	345141757	00	01/23/2015	Quarterly	RMC	1.39	1.39
XXXXXXXX, XXXXX	200431	756200431	00	12/18/2014	PPS	CC2	1.15	1.15
XXXX, XXXX X	42677	5642677	00	11/04/2014	Quarterly	PA2	0.50	0.50
XXXXX, XXXXXXXX	6243664	76243664	00	01/15/2015	Quarterly	RMC	1.39	1.39
XXXXXX, XXXXX X	182376	5182376	00	11/25/2014	Comprehensive	RMC	1.39	1.39
XXXXXX, XXXXX X	308996	56308996	00	01/20/2015	Quarterly	PC1	0.66	0.66
XXXXXX, XXXX X	3222133	563222133	00	12/29/2014	PPS	SE1	1.20	1.20

Non Medical Assistance Residents

Resident Name	Resident Internal ID	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	RUG	Facility CMI
XXXX, XXXXXXX X	6267152	56267152	00	11/07/2014	Comprehensive	RHC	1.22
XXXXX, XXXXXXX	403719	45403719	00	01/29/2015	Quarterly	RMC	1.39
XXXXXXXX, XXXXXXX	7226175	7726175	00	01/14/2015	Quarterly	RMC	1.39
XXXXX, XXXXX X	64005	45664005	00	11/05/2014	Comprehensive	SE2	1.43
XXXX, XXXX X	288342	46288342	00	12/15/2014	Comprehensive	SSC	1.16
XXXX, XXXXX X	145357	87145357	00	01/28/2015	Quarterly	RMC	1.39
XXXXXXXX, XXXXX X	322709	45322709	00	11/12/2014	Quarterly	RMC	1.39
XXXXXXXXXXXX, XXXXX X	9306177	9656177	00	01/07/2015	Quarterly	CA2	0.85
XXXXXX, XXXXX	260775	45260775	01	11/07/2014	Quarterly	RMB	1.13

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 3– CMI Report Example – Resident Roster (continued) and Important Notice

Commonwealth of Pennsylvania
Department of Human Services

05/20/2015
09:00:00

CMI Report for the May 2015 Picture Date

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

Residents with Non-Valid Assessments	1
Number of Medical Assistance Residents	11
Total Number of Residents	20
CMI Average for Medical Assistance Residents	1.15
CMI Average for Total Facility	1.28

Important Notice for the May 2015 Picture Date

Updated message for 02/01/2015

Beginning with the February 1, 2015 Picture Date, signed CMI Report Certification Pages will be uploaded to the *Nursing Facility Report Portal* (<https://nfrp.panfsubmit.com>). Mailed Certification Pages will no longer be accepted. Please read the [NFRP Instruction Manual](#) available at the same website beginning on page 11 for guidance.

Please read section 6 "CMI Reports" of the [Resident Data Reporting Manual](#) (revised 11/1/2014) before signing and uploading the Certification Page. Read carefully the sections on Occupancy Calculations beginning on page 6-8 and Supplemental Ventilator and Tracheostomy Care Payment (SVTCP) beginning on page 6-9. This manual may be accessed through the Resources section of the *Nursing Facility Report Portal* (<https://nfrp.panfsubmit.com>).

Beginning with the November 1, 2006 Picture Date, the CMI Report will list both the MA for MA Case-Mix and the non-MA residents for every Picture Date as required by 55 Pa. Code § 1187.33(a)(6). For Picture Dates beginning November 1, 2012, modify the Discharge Return Anticipated assessment (A0310F = 11) using S8010H1 Picture Date Reporting, to have the system treat this assessment as a Discharge Return Not Anticipated in creating the CMI Report. Alternately, the Reasons for Assessment at A0310F may be modified to change a Discharge Return Anticipated (A0310F = 11) to a Discharge Return Not Anticipated (A0310F = 10). Contact the Myers and Stauffer Helpdesk (717-541-5809) for assistance.

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 4– CMI Report Example – Payment for Hospital Reserved Bed Days

Commonwealth of Pennsylvania
Department of Human Services

05/20/2015
09:00:00

Payment for Hospital Reserved Bed Days for the October 2015 Rate Quarter

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

In order to qualify for a hospital reserved bed day payment for the rate quarter October 1, 2015 through December 31, 2015, the facility's overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to 55 Pa. Code § 1187.104(b)(1)(ii)(B) or 55 Pa. Code § 1189.103(b)(1)(ii)(B).

The nursing facility's occupancy rate for a quarter is determined according to either 55 Pa. Code § 1187.104(b)(1)(iii) or 55 Pa. Code § 1189.103(b)(1)(ii) and uses data from three Picture Dates. All certified beds are included in the Certified Beds total regardless of any restrictions (temporary or otherwise) that may be placed on the MA certified beds or Department of Health licensed beds for the Picture Date.

Picture Date	Certified Beds	Total Assessments	Occupancy Rate
05/01/2015	23	20	87%
02/01/2015	23	22	96%
11/01/2014	23	21	91%
Maximum of latest three Picture Dates			96%

Based on the calculations above, your facility IS ELIGIBLE for hospital reserved bed day payments for dates of service October 1, 2015 through December 31, 2015.

For further information, please read *CMI Report Revision - 2/1/2012* which can be found in the Bulletins section of the *Nursing Facility Report Portal* at <https://nfrp.panfsubmit.com/>.

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Commonwealth of Pennsylvania
Department of Human Services

Page 4
05/20/2015
09:00:00

Payment for Hospital Reserved Bed Days for the October 2015 Rate Quarter

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

In order to qualify for a hospital reserved bed day payment for the rate quarter July 1, 2015 through September 30, 2015, the facility's overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to 55 Pa. Code § 1187.104(b)(1)(ii)(B) or 55 Pa. Code § 1189.103(b)(1)(ii)(B).

The nursing facility's occupancy rate for a quarter is determined according to either 55 Pa. Code § 1187.104(b)(1)(iii) or 55 Pa. Code § 1189.103(b)(1)(ii) and uses data from three Picture Dates. All certified beds are included in the Certified Beds total regardless of any restrictions (temporary or otherwise) that may be placed on the MA certified beds or Department of Health licensed beds for the Picture Date.

Picture Date	Certified Beds	Total Assessments	Occupancy Rate
05/01/2015	24	20	83%
02/01/2015	24	20	83%
11/01/2014	24	20	83%
Maximum of latest three Picture Dates			83%

Based on the calculations above, your facility IS NOT ELIGIBLE for hospital reserved bed day payments for dates of service October 1, 2015 through January 31, 2016. If you disagree with the occupancy percent calculated for your facility, you may request an appeal by filing a request for a hearing in writing with the Department of Human Services' Bureau of Hearing and Appeals and mail to:

Bureau of Hearing and Appeals (BHA)
2330 Vartan Way, Second Floor
Harrisburg, PA 17110-9721
Attn: Provider Appeal

To be considered a timely filing, your request for a hearing must be filed with BHA within thirty-three (33) days of the date of the certification page of this CMI Report. A copy of your appeal to BHA should also be sent to:

Office of Long-Term Living
Bureau of Quality and Provider Management
555 Walnut Street, 6th Floor
Harrisburg, PA 17101
Attn: Provider Operations

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 5– CMI Report Example – Payment for Hospital Reserved Bed Days (Alternate Version, Page 1)

Commonwealth of Pennsylvania
Department of Human Services

Page 5
05/20/2015
09:00:00

Payment for Hospital Reserved Bed Days for the October 2015 Rate Quarter

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

Nursing facilities that are not eligible for hospital reserved bed day payments are responsible for submitting claims with Revenue Code 185 for any resident admitted to hospitals during the relevant dates of service. The hospital admission is considered a non-covered day and should be reflected in the invoice as such. Refer to the UB-04 Billing Guide for PROMISE™ or the PA PROMISE™ PROVIDER HANDBOOK for detailed instructions. The guidelines may be found at the following websites:

Electronic billing guideline

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/form/s_001848.pdf.

UB-04 billing guidelines

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001924.pdf.

For further information, please read *CMI Report Revision - 2/1/2012* which can be found in the Bulletins section of the *Nursing Facility Report Portal* at <https://nfrp.panfsubmit.com/>.

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 6– CMI Report Example – Payment for Hospital Reserved Bed Days (Alternate Version, Page 2)

Figure 7– CMI Report Example – SVTCP

Commonwealth of Pennsylvania
 Department of Human Services

05/20/2015
 09:00:00

Supplemental Ventilator Care and Tracheostomy Care Payment for December 2015

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

In order to qualify for a supplemental ventilator care and tracheostomy care payment authorized for December 2015, a facility must have a minimum of ten (10) MA residents who receive medically necessary ventilator care or tracheostomy care AND a minimum of 10% of their MA residents receiving medically necessary ventilator care or tracheostomy care and not be located in a geographic zone where Community HealthChoices operates. For the purposes of this report, a determination of medically necessary ventilator care or tracheostomy care is identified as a positive code in either Section O0100F1, O0100F2, O0100E1, or O0100E2 of the MDS assessment identified on this CMI Report.

Ventilator Care or Tracheostomy Care Medical Assistance Residents

Resident Name	Resident Internal ID	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	RUG	CMI
---------------	----------------------	------------------------	-------------------	-----------------	-----------------	-----	-----

No Medical Assistance residents qualify as receiving medically necessary ventilator care or tracheostomy care.

Based on these requirements and the calculations above, your facility IS NOT ELIGIBLE for a supplemental ventilator care and tracheostomy care per diem payment for December 2015 according to 55 Pa. Code § 1187.117 and § 1189.105(c). If you disagree with the number or percent of ventilator care or tracheostomy care MA residents calculated for your facility, you may request an appeal by filing a request for a hearing in writing with the Department of Human Services' Bureau of Hearing and Appeals and mail to:

Bureau of Hearing and Appeals (BHA)
 2330 Vartan Way, Second Floor
 Harrisburg, PA 17110-9721
 Attn: Provider Appeal

To be considered a timely filing, your request for a hearing must be filed with BHA within thirty-three (33) days of the date of the certification page of this CMI Report. A copy of your appeal to BHA should also be sent to:

Office of Long-Term Living
 Bureau of Quality and Provider Management
 555 Walnut Street, 6th Floor
 Harrisburg, PA 17101
 Attn: Provider Operations

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited.

Figure 8 – CMI Report Example –SVTCP (Alternate Version)

Commonwealth of Pennsylvania
Department of Human Services

Page 5
05/20/2015
09:00:00

Supplemental Ventilator Care and Tracheostomy Care Payment for December 2015

Facility Id: 000002
Provider Number: 0123456789012
Provider Name: SAMPLE NURSING FACILITY
File: CMI-May2015-0123456789012-20150520-090000.PDF

In order to qualify for a supplemental ventilator care and tracheostomy care payment authorized for September 2015, a facility must have a minimum of ten (10) MA residents who receive medically necessary ventilator care or tracheostomy care AND a minimum of 10% of their MA residents receiving medically necessary ventilator care or tracheostomy care and not be located in a geographic zone where Community HealthChoices operates. For the purposes of this report, a determination of medically necessary ventilator care or tracheostomy care is identified as a positive code in either Section O0100F1, O0100F2, O0100E1, or O0100E2 of the MDS assessment identified on this CMI Report.

Ventilator Care or Tracheostomy Care Medical Assistance Residents

Resident Name	Resident Internal Id	Assessment Internal Id	Correction Number	Assessment Date	Assessment Type	RUG	CMI
XXXXXXX, XXXXX	260775	45260775	01	11/07/2014	Quarterly	RMB	1.13
(Remaining 22 residents have been excluded from example for brevity)							

Total Number of Ventilator Care or Tracheostomy Care Medical Assistance Residents	23
Total Number of Medical Assistance Residents	250
Percent of Ventilator Care or Tracheostomy Care Medical Assistance Residents	9%

Based on these requirements and the calculations above, your facility IS NOT ELIGIBLE for a supplemental ventilator care and tracheostomy care per diem payment for December 2015 according to 55 Pa. Code § 1187.117 and § 1189.105(c). If you disagree with the number or percent of ventilator care or tracheostomy care MA residents calculated for your facility, you may request an appeal by filing a request for a hearing in writing with the Department of Human Services' Bureau of Hearing and Appeals and mail to:

Bureau of Hearing and Appeals (BHA)
2330 Vartan Way, Second Floor
Harrisburg, PA 17110-9721
Attn: Provider Appeal

To be considered a timely filing, your request for a hearing must be filed with BHA within thirty-three (33) days of the date of the certification page of this CMI Report. A copy of your appeal to BHA should also be sent to:

Office of Long-Term Living
Bureau of Quality and Provider Management
555 Walnut Street, 6th Floor
Harrisburg, PA 17101
Attn: Provider Operations

The information contained within this document is privileged and confidential and/or protected health information (PHI) and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). If the reader of this document is not the intended recipient or the employee or agent responsible for the delivery of this document to the intended recipient, you are hereby notified that any dissemination, distribution, or copying is prohibited.

7 MA CASE-MIX RATES

OVERVIEW OF MA CASE-MIX REIMBURSEMENT

What is “case-mix?” The term “case” refers to the residents; “mix” refers to differences or variety. Therefore, “case-mix” describes differences in residents within a population. Case-mix reimbursement systems measure the intensity of care and services required for each resident and translate those measures into payments. The amount of reimbursement given to the provider for care of a resident is tied to the average intensity of resource use.

The MA Case-Mix Reimbursement System is a prospective payment system: rates are set quarterly and the nursing facility is paid for the appropriate period at that rate for each day of care provided to their MA residents. There is no later settlement based on actual costs incurred by the facility, although these costs are reported on the MA-11 cost report form and affect future rates. The process used to calculate rates involves the incorporation of both resident data and cost data. A further description may be found in Chapter 1187 Subchapter G. Rate Setting.

Annually, peer group medians and prices are calculated and used in the July, October, January, and April quarterly rates. These prices are calculated for each of three (3) categories: Resident Care, Other Resident Care and Administrative. Separately, a Capital rate is also calculated. In the early stages of calculating the annual prices, the Resident Care Costs reported by the nursing facility are divided by the Total Facility CMI from the February CMI Report closest to the age of the cost reporting period that is used to calculate the price. This is called Case-Mix Neutralizing; it establishes a Resident Care Cost per case-mix point that allows comparison with other NFs in the facility’s peer group.

Once these prices are assigned to each facility and a limitation calculation is performed (see §1187.107), the Resident Care per diem is multiplied each quarter by the nursing facility’s MA CMI from the applicable Picture Date. The following example illustrates the calculation of the rates. The per diems for Resident Care, Other Resident Care, Administrative and Capital are assumed to be \$100, \$60, \$28 and \$10, respectively.

Rate Quarter	Picture Date	MA CMI	Resident Care Per Diem	Other Resd Care Per Diem	Admin Per Diem	Capital Costs	Per Diem Rate
July	February	1.20	120.00 (\$100 x 1.20)	60.00	28.00	10.00	\$218.00
October	May	1.00	100.00 (\$100 x 1.00)	60.00	28.00	10.00	\$198.00
January	August	0.80	80.00 (\$100 x 0.80)	60.00	28.00	10.00	\$178.00
April	November	0.90	90.00 (\$100 x 0.90)	60.00	28.00	10.00	\$188.00

The above table illustrates the importance to both the facility and the Department that MDS data be accurately submitted, and that the CMI Report reflect the status of the resident population on the Picture Date. After these calculations are completed, a budget adjustment factor (BAF) may be applied. The facility will receive this rate for every MA day of care billed even though that particular resident's data may not have been used in setting the rate.

COUNTY NURSING FACILITY REIMBURSEMENT

On June 24, 2006, 55 Pa Code Chapter 1189 was published creating a new methodology by which rates are set and payments made to county nursing facilities for services provided to MA residents. For the rate year 2006-2007, the per diem rate paid to a County Nursing Facility for a rate year was the facility's April 1, 2006, case-mix per diem rate as calculated under Chapter 1187, Subchapter G (relating to rate setting) multiplied by a budget adjustment factor determined in accordance with the Commonwealth's approved State Plan. Payments for each rate year beginning on or after July 1, 2007 follow a similar pattern.

County nursing facilities must continue to submit CMI Certification Pages and must also submit the initial MDS record within 7 days of completion as is required for nursing facilities beginning October 1, 2006.

8 HELPDESK

MYERS AND STAUFFER HELPDESK

Myers and Stauffer is a Department consultant, contracted to administer the NIS, the NFRP, calculate MA Case-Mix Reimbursement rates and provide technical support for the submission of records to the CMS MDS 3.0 Data Collection Systems and the correction of CMI Reports. The Myers and Stauffer Helpdesk is available for questions from vendors and providers concerning MDS 3.0 technical information and CMI Reports.

- The hours and days of operation for the helpdesk are Monday through Friday from 8:00 a.m. to 5:00 p.m.
- The PHONE number for the helpdesk is 717-541-5809. If the staff is unable to answer your call directly due to heavy call volume or during non-business hours, leave a voice mail message with your name, facility and phone number.
- The FAX number for the helpdesk is 717-541-5802. The E-MAIL address is pahelpdesk@mslc.com. Be as descriptive as possible so that the helpdesk representative may research your question prior to calling you. Include your facility name, PA identification number, the name of the facility contact person and a telephone number with area code and extension. The helpdesk will contact you as soon as possible; please do not send the same message multiple times.

Be discreet in the information you fax or e-mail. The helpdesk fax machine is located in a secure area of the helpdesk and is not used for any other business purpose. However, CMS has indicated that MDS information should not be faxed or e-mailed in an unsecure mode. Resident identification information should not be included in a fax or e-mail.

- Periodically, the helpdesk posts bulletins on the Nursing Facility Report Portal. These bulletins may be accessed at <https://nfrp.panfsubmit.com> by selecting the Bulletins link. Bulletin topics may include information on Picture Dates, copies of the RAI Spotlight, currently occurring problems and future changes that will occur in the system.

HELPDESK ASSISTANCE

The following types of problems will be supported by the Myers and Stauffer Helpdesk.

- Working with the Nursing Facility Report Portal system.
- Discerning different Record Types.
- Determining the correct sequence in which to complete and transmit assessments.
- Determining date consistency among the dates within the MDS and previous records.
- Assistance concerning the deadlines for submission of assessment information, both state and federal.
- Response to questions concerning acceptable responses for MDS items as defined in the data specifications. If it is beyond the scope of the helpdesk representative (clinical question), the caller will be instructed to call the Department of Health at 717-787-1816.
- Accessing the CMS MDS 3.0 Data Collection System submission site and navigating the site.
- Determining discrepancies in RUG/CMI calculations.
- Questions concerning Section S elements.
- Establishing the proper MA for MA Case-Mix status for a Picture Date.
- Inquiries concerning the CMI Report.
- Obtaining Final Validation Reports.
- Obtaining QM Reports.
- Identifying steps to be taken to complete necessary corrections.

Every effort will be made to answer the caller's question promptly. If the helpdesk representative is unable to answer the caller's question, the helpdesk representative will take the caller's name and phone number and research the question. The caller will be contacted when a response is determined.

PROBLEMS NOT SUPPORTED

Some problem areas will not be supported by the Myers and Stauffer Helpdesk because they are the responsibility of other entities or are outside of the resident data submission arena.

- Questions regarding vendor software, including RAVEN and jRAVEN. This includes running the vendor program, transmitting the files and any errors within the program. Technical support must be provided to the facility by the vendor.
- Support for installation of hardware devices (modems, printer, etc.).

- Support for Netscape or Internet Explorer, other than what has been developed by the CMS for public use.
- Restoration of data or complete data back-up procedures. The helpdesk will not be able to restore or recover the facility's data from the CMS MDS 3.0 Data Collection System but can provide information about the process. The CMS requires that facilities have a back-up system in place with the ability to have immediate access to the last fifteen months of assessments within their system, along with the ability to provide the assessment forms.
- Recommendation of specific software to support the backup and restoration of data. Because of the large amount of different back up devices and software available, any backup procedures will not be supported. It is the responsibility of the facility to choose any backup software and recovery procedures.
- Policy questions concerning Medicare PPS assessments, e.g., dealing with default classifications, billing questions, etc. cannot be answered. Contact your MAC for these problems.
- Interpreting QM Reports. Contact the DOH for assistance (717-787-1816).

9 FIELD OPERATIONS REVIEW

ABOUT BUREAU OF PROVIDER SUPPORT FIELD OPERATIONS REVIEWS

Field Operations Review is defined as “A review conducted by the Department’s medical and other professional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents” (55 Pa.Code §1187.2). As part of the review process, Field Operations personnel may assess the integrity of the MDS data used in the MA Case-Mix Reimbursement System.

Periodically, Field Operations teams may review MDS data both at the facility and off-site, concentrating on resident identification data and the RUG elements that are used to classify the assessment. Questions asked by the teams are:

- Are the responses that appear on the MDS in the facility the same as those that appear in the CMS MDS 3.0 DataCollection System?
- Is there sufficient documentation in the resident’s record to support the MDS response that was coded and transmitted?
- Does the CMI Report accurately reflect the resident population and MA for MA Case-Mix status on the Picture Date?

PREPARING FOR A FIELD OPERATIONS TEAM VISIT

In preparation for review of the CMI Report, the NF should have a facility Billing Census for the applicable Picture Date available. The residents appearing on the Field Operations CMI Report sample will be evaluated to assure that their MA for MA Case-Mix status was accurately reported, and that no residents were improperly included or omitted.

DOCUMENTATION GUIDANCE

Field Operations Representatives may determine if there is sufficient documentation in the resident's record to support an MDS coded response indicating that the condition or activity was present or occurred. CMS requirements for documentation are defined on page 1-7 of the MDS 3.0 RAI Manual: "While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals...it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."

Pennsylvania regulation §1187.33(a)(2) states that "The nursing facility shall ensure that the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical records maintained by the nursing facility" and further, in §1187.33(a)(2)(i), "The nursing facility's clinical records shall be current, accurate and in sufficient detail to support the reported resident data."

Documentation guidance has been developed in connection with Field Operations review procedures. Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. All supporting documentation should be found in the facility during an on-site Field Operations Review visit.

Disclaimer

Every effort is made to assure the accuracy of the information provided with regular manual updates. However, if later guidance is released by CMS that contradicts or augments guidance provided in this manual, the more current information from CMS becomes the acceptable standard.

APPEALING FIELD OPERATIONS REVIEWS

Your Field Operations Representative is always willing to discuss coding issues with you, and will share the most current information. If you have further concerns, request consultation with the Field Operations Representative's Supervisor. The list of Field Operations Offices follows.

Erie Field Operations Office
Renaissance Center, Room 815
1001 State Street
Erie, PA 16501
(814) 871-4225

Harrisburg Field Operations Office
555 Walnut Street, 6th Floor
PO Box 8025
Harrisburg, PA 17105
(717) 783-9823

Johnstown Field Operations
Office
727 Goucher Street
Johnstown, PA 15905
(814)254-0164

Norristown Field Operations Office
1965 Calamia Drive
Norristown, PA 19401
(610) 270-1907

Philadelphia Field Operations
Office
1965 Calamia Drive
Norristown, PA 19401
(610) 270-1906

Pittsburgh Field Operations Office
11 Stanwix Street, Room 330
Pittsburgh, PA 15222
(412) 770-2770

Wilkes-Barre Field Operations
Office
827 Oley Valley Road
Hickory Modular
White Haven, PA 18661
(570) 443-4124

If the problem is still unresolved, contact the Director of Field Operations
in the Division of Field Operations at (717) 772-2543.

DOCUMENTATION GUIDELINES

Column Explanations

The Documentation Guidelines table contains three columns described below.

MDS 3.0 Location, Item Description, Observation Period

This column identifies the MDS 3.0 location by section letter and item number, the description of the MDS item, the look-back period and page number(s) in the RAI Manual in which the item is described. A notation of CPS in this column indicates the MDS item affects the results of the Cognitive Performance Scale used in some of the RUG classifications. A notation of BIMS means Brief Interview for Mental Status. A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing in the RUG-III system.

NOTE: All RAI Manual page numbers and data provided in this document are current as of October 2019.

RUG-III Categories Impacted

This column identifies any RUG-III categories potentially impacted by the MDS item. A notation of *ES Count* indicates the MDS item contributes to the count of Extensive Services.

Items that do not impact any RUG-III categories are labeled as Demographic.

Documentation Guidelines Related To The Observation Period

This column provides an overview of the MDS item, any requirements for correct coding, documentation required to support the MDS coding and in some cases, items that cannot be counted in coding the item. The column may also contain any additional information that may aid the user in correctly coding the MDS item.

These Documentation Guidelines are meant only as an easy reference guide. The complete information included in the RAI Manual should also be considered in properly coding the individual items.

Documentation Guidelines

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
Section A: Identification Information		
A0100B CMS Certification Number (CCN) (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> • Replaces the term “Medicare/Medicaid Provider Number” in survey, certification, and assessment-related activities • Enter the six-digit federal number which begins with 39 • Medicaid-only facilities have a Federal as well as a State number. The Medicaid Federal number has a “letter” in the third box
A0100C State Provider Number (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> • The identification number assigned to the nursing facility by the Medicaid program • Enter the thirteen-digit state MA PROMISE provider number including any leading zeroes
A0500 Legal Name of Resident (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> • Resident’s name as it appears on the Medicare card • If the resident is not enrolled in the Medicare program, use the resident’s name as it appears on a Medicaid card or other government-issued document • If resident has no middle initial, leave A0500B blank • If the resident has two or more middle names, use the initial of the first middle name • A0500A First name must not be skipped (^^^)
A0600A Social Security Number (SSN) (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> • A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes • If no SSN is available for the resident, the item may be left blank • Do not enter nine of any one number, start this number with 000 or enter 123456789 • Must not be blank if A0700 Medicaid Number contains a number
A0600B Medicare Number (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> • An identifier assigned to an individual for participation in national health insurance program • If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted • CMS has issued new Medicare Beneficiary Identifier numbers to Medicare recipients. This number should be used as soon a beneficiary receives this card. • If no Medicare number or RRB number is known or available, the item may be left blank • May only be a Medicare (HIC) number or a Railroad Retirement Board number. Do not enter an HMO number. • For a Medicare PPS assessment (A0310B = 01, 08), a Medicare number or comparable railroad insurance number (A0600B) must be present.

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
A0700 Medicaid Number (Chapter 3, Section A)	~Demographic	<ul style="list-style-type: none"> Record this number if the resident is a Medicaid recipient For a PA Medicaid recipient, enter the resident's 10-digit MA number from the PA ACCESS card Enter the out-of-state MA number for residents being served in PANFs under contract with other states' MA agencies Enter the MA number even if the resident is currently in a MC Part A stay Enter a "+" in the leftmost box if the number is pending If not applicable because the resident is not a Medicaid recipient, enter "N" in the leftmost box It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment; just include it on the next assessment
Section B: Hearing, Speech, and Vision		
B0100 Comatose (Cognitive Performance Scale [CPS]) (7-day look-back) (Chapter 3, Section B)	~Clinically Complex ~Impaired Cognition ~Extensive Services Count (ES Count)	<p>Comatose is defined as a pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The resident is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain).</p> <p>Persistent Vegetative State is defined as a resident who does not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological examination shows extensive damage to both cerebral hemispheres.</p> <p>Does require:</p> <ul style="list-style-type: none"> Diagnosis of coma or persistent vegetative state <p>Does NOT include:</p> <ul style="list-style-type: none"> Residents in advanced stages of progressive neurologic disorders
B0700 Makes Self Understood (CPS) (7-day look-back) (Chapter 3, Section B)	~Impaired Cognition ~ES Count	<ul style="list-style-type: none"> Evidence of the resident's ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination of these.
Section C: Cognitive Patterns		
C0500 BIMS summary score (Chapter 3, Section C)	~Impaired Cognition ~ES Count	<p>Brief Interview for Mental Status (BIMS) defined:</p> <p>Score range is 0-15</p> <p>Score <=9, cognitively impaired for RUG-III classification</p> <p>Score >=10, cognitively intact</p> <ul style="list-style-type: none"> Validation of completion of BIMS "on/before the ARD" in Z0400 or other forms of evidence that the interviews were completed on/before the ARD, e.g., clinical record notes, facility signature sheets, etc.
C0700 Short-Term Memory (CPS) (7-day look-back) (Chapter 3, Section C)	~Impaired Cognition ~ES Count	<ul style="list-style-type: none"> Code for the most representative level of function during the look-back period.

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
C1000 Cognitive Skills for Daily Decision Making (CPS) (7-day look-back) (Chapter 3, Section C)	~Impaired Cognition ~ES Count	<ul style="list-style-type: none"> If the resident “rarely or never” made decisions, despite being provided with opportunities and appropriate cues, code 3 severely impaired. If the resident makes decisions, although poorly, code 2 moderately impaired. <p>Does NOT include:</p> <ul style="list-style-type: none"> Resident’s decision to exercise his/her right to decline treatment or recommendations by staff
Section D: Mood		
D0300 Total Severity Score (PHQ-9©) (14-day look-back) (Chapter 3, Section D)	~Clinically Complex	<p>Total Severity Score defined:</p> <ul style="list-style-type: none"> Sum of all frequency items (D0200 Column 2) Total Severity Score range is 00-27 If Score >=10, resident is considered “Depressed” for Clinically Complex classification If Score <10, resident is not “Depressed” Validation of completion of PHQ-9© on/before the ARD (preferably the day before or day of the ARD; page D-4) in Z0400 or other forms of evidence that the interviews were completed on/before the ARD, e.g., clinical record notes, facility signature sheets, etc.
D0600 Total Severity Score (PHQ-9-OV©) (14-day look-back) (Chapter 3, Section D)	~Clinically Complex	<p>Total Severity Score defined:</p> <ul style="list-style-type: none"> Sum of all frequency items (D0500 Column 2) Total Severity Score range is 00-30 If Score >=10, resident is considered “Depressed” for Clinically Complex classification. If Score <10, resident is not “Depressed” Validation of completion of PHQ-9-OV© in Z0400 or other forms of evidence that the interviews were completed, e.g., clinical record notes, facility signature sheets, etc.
Section E: Behavior		
E0100A Hallucinations (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> Evidence of a resident’s perception of the presence of something that is not actually there Hallucinations are auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli
E0100B Delusions (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> Evidence of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary <p>Does NOT include:</p> <ul style="list-style-type: none"> A resident’s expression of a false belief when the resident easily accepts a reasonable alternative explanation
E0200A Physical behavioral symptoms <i>directed toward others</i> Presence & Frequency (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> Evidence of physical behavioral symptoms directed toward others Examples are hitting, kicking, pushing, scratching, grabbing, abusing others sexually

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
E0200B Verbal behavioral symptoms <i>directed toward others</i> Presence & Frequency (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> • Evidence of verbal behavioral symptoms directed toward others • Examples are threatening others, screaming at others, cursing at others
E0200C Other behavioral symptoms <i>not directed toward others</i> Presence & Frequency (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> • Evidence of other behavioral symptoms NOT directed toward others • Examples are hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds
E0800 Rejection of Care – Presence & Frequency (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> • Evidence of the resident’s rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident’s goals for health and well-being <p>Does include:</p> <ul style="list-style-type: none"> • Behavior that interrupts or interferes with the delivery or receipt of care which is a problem that warrants treatment to modify or eliminate the behavior would continue to be coded in this item if it occurred within the look back period. (p. E-13) <p>Does NOT include:</p> <ul style="list-style-type: none"> • Behaviors that have already been addressed and determined to be consistent with resident values, preferences or goals
E0900 Wandering – Presence & Frequency (7-day look-back) (Chapter 3, Section E)	~Behavior Problems	<ul style="list-style-type: none"> • Evidence of wandering from place to place without a specified course or known direction <p>Does NOT include:</p> <ul style="list-style-type: none"> • Pacing • Traveling via a planned course to another specific place (dining room or activity)

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
Section G: Functional Status		
<p>G0110A, 1&2 Bed Mobility G0110B, 1&2 Transfer G0110I, 1&2 Toilet Use G0110H, 1 ONLY Eating (7-day look-back) (Chapter 3, Section G)</p>	<p>~Extensive Services ~Rehabilitation ~Special Care ~Clinically Complex ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<ul style="list-style-type: none"> • Staff who actually provided the service and/or take responsibility for the service must initial documentation • Code only services provided by facility staff after admission. “Facility staff” pertains to direct employees and facility-contracted employees. • Code 0 Independent if resident completed activity with no help or oversight every time during the 7-day look-back period and the activity occurred at least three times • Code 4 Total dependence if the resident required full staff performance of the ADL activity every time the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times • Code 7 if activity occurred only once or twice • If the resident is coded Limited Assistance (2), Extensive Assistance (3) or Total Dependence (4) in Self-Performance, Support Provided must be One person physical assist (2) or Two+ person physical assist(3) • Refer to ADL Self Performance Algorithm on page G-8 (10/1/2017) for assistance in selecting the proper response when an activity does not occur 3 or more times at one level • Activity occurring off the nursing unit, e.g., in PT, may be counted • Code 8 Activity did not occur if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period • Eating would be coded 8, Activity did not occur, if resident received no nourishment by any route (oral, IV, TPN, Enteral) or if the resident was not fed by facility staff during the 7-day look-back period • Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer. (10/1/2017 p G-9) • Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support. (10/1/2017 p G-9) • How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting. (10/1/2017 p G-9) • When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use. (10/1/2017 p G-9) <p>Does NOT include:</p> <ul style="list-style-type: none"> • Eating/drinking during medication administration • General supervision in dining room • Services provided pre-admission • Services provided other than by facility staff , e.g., provided by family, hospice staff, nursing/CNA students, privately hired individuals, etc.

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
Section H: Bowel and Bladder		
<p>H0200C Current Urinary toileting program or trial Restorative Nursing (7-day look-back) (Chapter 3, Section H)</p>	<p>~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<p>Documentation in the Medical record showing that the following three requirements have been met:</p> <ol style="list-style-type: none"> 1. Evidence of implementation of an individualized resident specific toileting program that was based on an assessment of the resident's unique voiding pattern 2. Evidence that the individualized program was communicated to staff and to the resident (as appropriate) verbally and through a care plan, flow records, and a written report 3. Evidence of the resident's response to the program and subsequent evaluations as needed <ul style="list-style-type: none"> • Resident is being managed during 4 or more days of the 7-day look-back period with some type of systematic toileting program • May be counted if the resident does not want to be awakened at night but is on a toileting program by day • Field Operations will request that the facility show them the evidence that the specific approach is organized, planned, documented, monitored, and evaluated • May be bladder rehabilitation/bladder retraining, prompted voiding or habit training/scheduled voiding <p>Does NOT include:</p> <ul style="list-style-type: none"> • Less than 4 days of a systematic toileting program • Simply tracking continence status • Changing pads or wet garments • Random assistance with toileting or hygiene
<p>H0500 Bowel Toileting Program Restorative Nursing (7-day look-back) (Chapter 3, Section H)</p>	<p>~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<p>Documentation in the Medical record showing that the following three requirements have been met:</p> <ol style="list-style-type: none"> 1. Evidence of implementation of an individualized resident-specific toileting program that was based on an assessment of the resident's unique bowel pattern 2. Evidence that the individualized program was communicated to staff and to the resident (as appropriate) verbally and through a care plan, flow records, and a written report 3. Evidence of the resident's response to the program and subsequent evaluations as needed <p>Does NOT include:</p> <ul style="list-style-type: none"> • Simply tracking bowel continence status • Changing pads or soiled garments • Random assistance with toileting or hygiene
Section I: Active Diagnoses		
<p><u>Active Diagnosis look-back period</u> Diagnosis that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.</p>	<p><u>Documented Diagnosis look-back period</u> 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 that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.</p>	

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
<p><u>Step 1</u></p> <p>Identify documented diagnoses in the 60-day look-back period</p>		
<p><u>Step 2</u></p> <p>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. "Active" may be indicated by physician documentation, recent onset or acute exacerbation of the disease or condition, symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days, evidence of treatment of symptoms, and ongoing therapy with medications or other interventions. 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.</p>		
<p>I2000 Pneumonia (7-day look-back) (Chapter 3, Section I)</p>	<p>~Special Care ~Clinically Complex ~ES Count</p>	<p>Does require:</p> <ul style="list-style-type: none"> • Physician documented diagnosis • Code only active diagnosis
<p>I2100 Septicemia I2900 Diabetes Mellitus (DM) I4900 Hemiplegia/ Hemiparesis (7-day look-back) (Chapter 3, Section I)</p>	<p>~Clinically Complex ~ES Count</p>	<p>Does require:</p> <ul style="list-style-type: none"> • Physician documented diagnosis • Code only active diagnosis
<p>I4300 Aphasia I4400 Cerebral Palsy I5100 Quadriplegia I5200 Multiple Sclerosis (MS) (7-day look-back) (Chapter 3, Section I)</p>	<p>~Special Care ~ES Count</p>	<p>Does require:</p> <ul style="list-style-type: none"> • Physician documented diagnosis • Code only active diagnosis <p>Does NOT include:</p> <ul style="list-style-type: none"> • Functional quadriplegia at I5100 Quadriplegia. Code the underlying medical conditions which caused the loss of function.
Section J: Health Conditions		
<p>J1550A Fever (7-day look-back) (Chapter 3, Section J)</p>	<p>~Special Care ~ES Count</p>	<ul style="list-style-type: none"> • Fever of 2.4 degrees F. higher than baseline • A baseline temperature established prior to the ARD • A temperature of 100.4 degrees F. on admission is a fever
<p>J1550B Vomiting (7-day look-back) (Chapter 3, Section J)</p>	<p>~Special Care ~ES Count</p>	<p>Documentation of regurgitation of stomach contents.</p>

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
J1550C Dehydrated; output exceeds intake (7-day look-back) (Chapter 3, Section J)	~Special Care ~Clinically Complex ~ES Count	Evidence of 2 or more of the 3 potential dehydration indicators listed below. <ul style="list-style-type: none"> • Usually takes in less than 1500 cc of fluid daily • One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds amount of fluids taken in Does NOT require: <ul style="list-style-type: none"> • A diagnosis of dehydration
J1550D Internal Bleeding (7-day look-back) (Chapter 3, Section J)	~Clinically Complex ~ES Count	Evidence of frank or occult blood such as: <ul style="list-style-type: none"> • Black, tarry stools • Vomiting “coffee grounds” • Hematuria • Hemoptysis • Severe epistaxis (nosebleed) that requires packing Does NOT include: <ul style="list-style-type: none"> • Nosebleeds that are easily controlled • Menses • Urinalysis that shows a small amount of red blood cells
Section K: Swallowing/Nutritional Status		
K0300 Weight Loss (1 month and 6 month look-back) (Chapter 3, Section K)	~Special Care ~ES Count	Documentation in the clinical record of the resident’s weight loss of 5% or more in last month OR 10% or more in last 6 months. May be planned or unplanned. If planned, goal of weight loss or expected weight loss through use of diuretics must be documented. Calculation: <ul style="list-style-type: none"> • Identify the resident’s weight in the current observation period. • Go back 30 days from the date of this weight. Identify a weight taken within the 14-day window (+ or – 7 days of the 30th day), i.e., between 23 days before the date of this weight to 37 days before the date of the weight • Go back 180 days from the date of the weight measured in the 7-day look back period. Identify a weight taken within the 14-day window (+ or – 7 days of the 180th day), i.e., between 173 days before the date of this weight to 187 days before the date of the weight • Perform weight loss calculations as detailed in RAI Manual (p. K-6) Does require: <ul style="list-style-type: none"> • Percentage based on the actual weight • Mathematical rounding

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
K0510A , either 1 or 2 Parenteral / IV Feeding (7-day look-back) (Chapter 3, Section K)	~Extensive Services ~ADL Score	Includes any and all nutrition and hydration received by the resident in the last 7 days while not a resident of the facility (1) or while a resident of the facility (2), provided there is supporting documentation that they were administered for <u>nutrition</u> or <u>hydration</u> . Does include: <ul style="list-style-type: none"> • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) • TPN • IV at KVO • Hypodermoclysis and sub-Q ports in hydration therapy • IV fluids administered for the purpose of “prevention” of dehydration Does NOT include: <ul style="list-style-type: none"> • IV medications • IV fluids used to reconstitute and/or dilute meds • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • IV fluids administered in conjunction with chemotherapy or dialysis
K0510B , either 1 or 2 Feeding Tube (7-day look-back) (Chapter 3, Section K)	~Special Care ~Clinically Complex ~ES Count ~ADL Score	Presence of any type of tube that delivers food/nutritional substances/fluids/medications directly into the GI system in the last 7 days while not a resident of the facility (1) or while a resident of the facility (2) Does include: <ul style="list-style-type: none"> • NG tubes, gastrostomy tubes, J-tubes, PEG tubes Does NOT include: <ul style="list-style-type: none"> • Presence of tube with no nutrition provided • Maintenance flushes with no nutrition provided
K0710A3 Calorie Intake (7-day look-back) (Chapter 3, Section K)	~Special Care ~Clinically Complex ~(Contributes to ES count) ~ADL Score	Calculation must support the proportion of all calories <u>actually received</u> for nutrition or hydration through parenteral or tube feeding. For residents receiving P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include: <ol style="list-style-type: none"> 1) Calories tube feeding provided during observation period 2) Calories oral feeding provided during observation period 3) Percent of total calories provided by tube feeding 4) Calories by tube/total calories consumed
K0710B3 Average Fluid Intake (7-day look-back) (Chapter 3, Section K)	~Special Care ~Clinically Complex ~(Contributes to ES count) ~ADL Score	Code for the average number of cc’s of fluid the resident received per day by IV or tube feeding. Record what was actually received by the resident, not what was ordered. This is calculated by: <ul style="list-style-type: none"> • Review of the intake records • Add the total amount of fluid received each day by IV and/or tube feedings <u>only</u> • Divide the week’s total fluid intake by 7 to calculate the average of fluid intake per day • Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
Section M: Skin Conditions		
<p>M0300A Stage 1 M0300B1 Stage 2 M0300C1 Stage 3 M0300D1 Stage 4 M0300F1 Unstageable due to slough/eschar M1030 Venous/Arterial Ulcers</p> <p>Ulcers/Staging <i>(7-day look-back)</i> (Chapter 3, Section M)</p>	<p>~<i>Special Care</i> ~<i>ES Count</i></p>	<p>CMS has clarified that it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. Differentiate between scabs and eschar • Description of the ulcer including the stage for pressure ulcer • Evidence of venous/arterial ulcers in the medical record, e.g., skin sheets <p>Does NOT include:</p> <ul style="list-style-type: none"> • Reverse staging • Pressure ulcers that are healed by the ARD • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured • Mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.
<p>M1040A Infection of the foot <i>(7-day look-back)</i> (Chapter 3, Section M)</p>	<p>~<i>Clinically Complex</i> ~<i>ES Count</i></p>	<p>Evidence of signs and symptoms of infection of the foot.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Cellulitis • Purulent drainage <p>Does NOT include:</p> <ul style="list-style-type: none"> • Ankle problems • Pressure ulcers coded in M0300-M0900
<p>M1040B Diabetic foot ulcer</p> <p>M1040C Other open lesion(s) on the foot <i>(7-day look-back)</i> (Chapter 3, Section M)</p>	<p>~<i>Clinically Complex</i> ~<i>ES Count</i></p>	<p>Evidence of diabetic foot ulcers which are caused by the neuropathic and small blood vessel complications of diabetes (M1040B), or other open lesion(s) on the foot such as cuts or fissures (M1040C).</p> <p>Does require:</p> <ul style="list-style-type: none"> • Description of foot ulcer and/or open lesion such as location and appearance <p>Does NOT include:</p> <ul style="list-style-type: none"> • Pressure ulcers coded in M0300-M0900 • Pressure ulcers that occur on residents with diabetes mellitus
<p>M1040D Open lesion(s) other than ulcers, rashes, cuts <i>(7-day look-back)</i> (Chapter 3, Section M)</p>	<p>~<i>Special Care</i> ~<i>ES Count</i></p>	<p>Open skin lesions that develop as part of disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles should be coded in this item.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Description of the open lesion such as location and appearance <p>Does NOT include:</p> <ul style="list-style-type: none"> • Do not code rashes or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care. • Do not code pressure ulcers, venous or arterial ulcers, diabetic foot ulcers or skin tears here. These conditions are coded in other items on the MDS.

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
M1040E Surgical Wounds (7-day look-back) (Chapter 3, Section M)	~Special Care ~ES Count	Does include: <ul style="list-style-type: none"> • Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites • Pressure ulcers that are surgically repaired with grafts and flap procedures • Description of the surgical wound such as location and appearance Does NOT include: <ul style="list-style-type: none"> • Healed surgical sites and stomas • Lacerations that require suturing or butterfly closure • PICC sites, central line sites, peripheral IV sites • Pressure ulcers that have been surgically debrided
M1040F Burn(s) (7-day look-back) (Chapter 3, Section M)	~Clinically Complex ~ES Count	Description of the appearance of the second or third degree burns. Does include: <ul style="list-style-type: none"> • Second or third degree burns only; may be in any stage of healing • Skin and tissue injury caused by heat or chemicals Does NOT include: <ul style="list-style-type: none"> • First-degree burns (changes in skin color only)
M1200A Pressure Reducing Device/chair (7-day look-back) (Chapter 3, Section M)	~Special Care ~ES Count	Equipment aimed at reducing pressure away from areas of high risk. Does include: <ul style="list-style-type: none"> • Foam, air, water, gel, or other cushioning • Pressure relieving, reducing, redistributing devices • Must be documentation of use at least once • Must be included on care plan Does NOT include: <ul style="list-style-type: none"> • Egg crate cushions of any type • Doughnut or ring devices
M1200B Pressure Reducing Device/bed (7-day look-back) (Chapter 3, Section M)	~Special Care ~ES Count	Equipment aimed at reducing pressure away from areas of high risk. Does include: <ul style="list-style-type: none"> • Foam, air, water, gel, or other cushioning • Pressure relieving, reducing, redistributing devices • If all beds are equipped with pressure reducing mattresses, there must be a facility policy with a brochure for the mattress and inclusion in the care plan Does NOT include: <ul style="list-style-type: none"> • Egg crate cushions of any type • Doughnut or ring devices
M1200C Turning/ Repositioning Program (7-day look-back) (Chapter 3, Section M)	~Special Care ~ES Count	Documentation of a consistent <u>program</u> for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. Does require: <ul style="list-style-type: none"> • Documentation of the intervention and frequency of program • Must be specific as to the approaches for changing the resident's position and realigning the body • Documentation of monitoring and reassessing the program to determine the effectiveness of the intervention • Documentation describing an evaluation of the resident's response to the program

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
M1200D Nutrition or hydration intervention to manage skin problems <i>(7-day look-back)</i> (Chapter 3, Section M)	~ <i>Special Care</i> ~ <i>ES Count</i>	Documentation of dietary intervention(s) to prevent or treat specific skin conditions. Does require: <ul style="list-style-type: none"> • Must be individualized nutritional assessment • Supplements should only be employed when nutritional deficiencies are confirmed or suspected, and should be tailored to the individual • Description of specific skin condition Does include: <ul style="list-style-type: none"> • Vitamins and/or supplements
M1200E Pressure Ulcer Care <i>(7-day look-back)</i> (Chapter 3, Section M)	~ <i>Special Care</i> ~ <i>ES Count</i>	Documentation to include any intervention for treating pressure ulcers coded at M0300. Does include: <ul style="list-style-type: none"> • Use of topical dressings • Enzymatic, mechanical or surgical debridement • Wound irrigations • Negative pressure wound therapy (NPWT) • Hydrotherapy • Dressings for pressure ulcer on the foot (do not code at M1200I)
M1200F Surgical Wound Care <i>(7-day look-back)</i> (Chapter 3, Section M)	~ <i>Special Care</i> ~ <i>ES Count</i>	Documentation to include any intervention for treating or protecting any type of surgical wound. Does include: <ul style="list-style-type: none"> • Topical cleansing • Wound irrigation • Application of antimicrobial ointments • Application of dressings of any type • Suture/staple removal • Warm soaks or heat application Does NOT include: <ul style="list-style-type: none"> • Post-operative care following eye or oral surgery • Surgical debridement of pressure ulcer • Observation of the surgical wound
M1200G Application of Non-surgical Dressings; other than to feet <i>(7-day look-back)</i> (Chapter 3, Section M)	~ <i>Special Care</i> ~ <i>ES Count</i>	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. Does include: <ul style="list-style-type: none"> • Dressing application even once • Dry gauze dressings • Dressings moistened with saline or other solutions • Transparent dressings • Hydrogel dressings • Dressings with hydrocolloid or hydroactive particles • Compression bandages • Dressing application to the ankle Does NOT include: <ul style="list-style-type: none"> • Dressing for pressure ulcer(s) other than to feet (code at M1200E) • Band-Aids or wound closure strips • IV and Port dressings (Clarification from National RAI Panel)

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
M1200H Application of ointments/medications other than to feet <i>(7-day look-back)</i> (Chapter 3, Section M)	~Special Care ~ES Count	Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. Does include: <ul style="list-style-type: none"> • Topical creams • Powders • Liquid sealants Does NOT include: <ul style="list-style-type: none"> • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers (code at M1200E) • Ointments used to treat non-skin conditions, e.g., Nitro Paste for chest pain
M1200I Applications of Dressings to the feet <i>(7-day look-back)</i> (Chapter 3, Section M)	~Clinically Complex ~ES Count	Documentation of application of dressings to the feet (with or without topical medication) Does include: <ul style="list-style-type: none"> • Interventions to treat any foot wound or ulcer <i>other than a pressure ulcer</i> Does NOT include: <ul style="list-style-type: none"> • Application of dressings to pressure ulcers on the foot (code at M1200E) • Dressing application to the ankle
Section N: Medications		
N0300 Injections <i>(7-day look-back)</i> (Chapter 3, Section N)	~Clinically Complex ~ES Count	Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection Does include: <ul style="list-style-type: none"> • For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump • Insulin injections
Section O: Special Treatments, Procedures, and Programs		
O0100A , either 1 or 2 Chemotherapy <i>(14-day look-back)</i> (Chapter 3, Section O)	~Clinically Complex ~ES Count	Documentation to include the administration of any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment inside or outside of facility If Tamoxifen is being administered to treat the cancer, it should be coded in O0100A Chemotherapy. If it is being used to prevent the recurrence of cancer, it should not be coded in O0100A Chemotherapy. (MDS Team/RAI Coordinators Panel July 24, 2017) Does NOT include: <ul style="list-style-type: none"> • Anti-neoplastic drugs given for side effects, e.g., appetite stimulation • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer. They are not considered chemotherapy for the purpose of coding the MDS.
O0100B , either 1 or 2 Radiation <i>(14-day look-back)</i> (Chapter 3, Section O)	~Special Care ~ES Count	Documentation of procedure must include administration inside or outside of facility. Does include: <ul style="list-style-type: none"> • Intermittent radiation therapy • Radiation administered via radiation implant

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
O0100C , either 1 or 2 Oxygen Therapy (14-day look-back) (Chapter 3, Section O)	~Clinically Complex ~ES Count	Evidence of the administration of oxygen to relieve hypoxia Does include: <ul style="list-style-type: none"> • The administration of oxygen continuously or intermittently via mask, cannula, etc. • Code when used in BiPAP/CPAP • May be coded if resident places or removes his/her own oxygen mask/cannula Does NOT include: <ul style="list-style-type: none"> • Hyperbaric oxygen for wound therapy
O0100D , either 1 or 2 Suctioning (14-day look-back) (Chapter 3, Section O)	~Extensive Services	Code ONLY nasopharyngeal or tracheal suctioning. May be coded if resident performs his/her own tracheal and/or nasopharyngeal suctioning. Does NOT include: <ul style="list-style-type: none"> • Oral suctioning
O0100E , either 1 or 2 Tracheostomy Care (14-day look-back) (Chapter 3, Section O)	~Extensive Services	Documentation of tracheostomy and/or cannula cleansing. May be coded if the resident performs his/her own tracheostomy care.
O0100F , either 1 or 2 Invasive Mechanical Ventilator (ventilator or respirator) (14-day look-back) (Chapter 3, Section O)	~Extensive Services	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. Does include: <ul style="list-style-type: none"> • Any resident who has been or is in the process of being weaned off the ventilator or respirator in the last 14 days Does NOT include: <ul style="list-style-type: none"> • Ventilator/Respirator use as a substitute for CPAP or BiPAP in this field
O0100H , either 1 or 2 IV Medications (14-day look-back) (Chapter 3, Section O)	~Extensive Services	Evidence of IV medication given by intravenous push, epidural pump, or drip through a central or peripheral port. Does include: <ul style="list-style-type: none"> • Any drug or biological • Epidural, intrathecal, and baclofen pumps • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids Does NOT include: <ul style="list-style-type: none"> • Saline or heparin flush to keep a heparin lock patent • IV fluids without medication • Subcutaneous pumps • IV medications administered only during dialysis or chemotherapy • Dextrose 50% and Lactated Ringers are not considered IV medication
O0100I , either 1 or 2 Transfusions (14-day look-back) (Chapter 3, Section O)	~Clinically Complex ~ES Count	Evidence of transfusions of blood or any blood products administered directly into the bloodstream. Does NOT include: <ul style="list-style-type: none"> • Transfusions administered during dialysis or chemotherapy

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
O0100J , either 1 or 2 Dialysis (14-day look-back) (Chapter 3, Section O)	~Clinically Complex ~ES Count	Evidence of peritoneal or renal dialysis which occurred at the facility or another facility. Does include: <ul style="list-style-type: none"> • Hemofiltration • Slow Continuous Ultrafiltration (SCUF) • Continuous Arteriovenous Hemofiltration (CAVH) • Continuous Ambulatory Peritoneal Dialysis (CAPD) • IVs, IV medication and blood transfusion administered during dialysis are considered part of the dialysis procedure and should not be coded at K0500A, O0100H, or O0100I • May be coded if the resident performs his/her own dialysis

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
<p>O0400A, 1, 2 & 3 Speech O0400B, 1, 2 & 3 Occupational O0400C, 1, 2 & 3 Physical Therapy minutes (7-day look-back) (Chapter 3, Section O And Appendix A)</p>	<p>~<i>Rehabilitation</i></p>	<p>Evidence of the total number of therapy minutes provided according to type and modality.</p> <p><i>Does require:</i></p> <ul style="list-style-type: none"> • Only medically necessary therapy provided while a resident in the facility • Skilled therapy ONLY • Physician order based on qualified therapist's assessment and treatment plan • Actual therapy minutes ONLY • Documented in the resident's medical record. Time provided for each therapy must be documented separately • Care planned and periodically evaluated • For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A. <p><i>Does include:</i></p> <ul style="list-style-type: none"> • Subsequent reevaluations • Set-up time recorded under the mode for which the resident receives initial treatment • When two clinicians from different disciplines treat one resident at the same time with different treatments, both disciplines may code the treatment session in full (co-treatment) • Therapy treatment inside or outside the facility • Time required to adjust equipment or otherwise prepare for individualized therapy • Family education when the resident is present; must be documented in resident's record <p><i>Does NOT include:</i></p> <ul style="list-style-type: none"> • Therapy provided prior to admission • Time spent on documentation • Time spent on initial evaluation • Conversion of units to minutes • Rounding to the nearest 5th minute • Therapy services that are not medically reasonable and necessary, e.g., family-funded therapy • Therapy provided as restorative nursing • Services provided by aides • Services provided by a speech-language pathology assistant <p><u>Individual therapy</u> Treatment of one resident at a time</p> <p><u>Concurrent therapy</u> Treatment of 2 residents at the same time when residents are performing different activities in line-of-sight for Medicare Part A and all payers other than Medicare Part B. Residents may not be treated concurrently for Medicare Part B; instead report under Group therapy</p> <p><u>Group therapy</u> Treatment of 4 residents who are performing similar activities at the same time for Medicare Part A and all payers other than Medicare Part B. Treatment of 2 or more residents at the same time (similar or different activities) for Medicare Part B only</p>

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
O0400A4 Speech O0400B4 Occupational O0400C4 Physical Therapy days <i>(7-day look-back)</i> (Chapter 3, Section O)	~ <i>Rehabilitation</i>	Evidence of the number of days therapy services were provided during the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. <ul style="list-style-type: none"> • Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. • If the total number of minutes of therapy during the last 7 days is 0, skip this item.
O0400D2 Respiratory Therapy days <i>(7-day look-back)</i> (Chapter 3, Section O And Appendix A)	~ <i>Special Care</i> ~ <i>ES Count</i>	Evidence of the total number of respiratory therapy minutes provided. Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. <p>Does require:</p> <ul style="list-style-type: none"> • Only therapy provided while a resident in the facility • Physician order • Treatment plan • Care planned and periodically evaluated • Based on an initial evaluation performed by qualified clinician (respiratory therapist, respiratory nurse) • Services are required and provided by qualified clinician • Actual therapy minutes ONLY • Evidence of licensed nurse training. A respiratory nurse must be proficient in the modalities listed below through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and other applicable state laws. • All respiratory therapy modalities and components must be conducted by Qualified Clinicians within the State nurse practice act. There must be respiratory therapy training documentation for all clinicians performing respiratory therapy modalities, respiratory assessments and periodic review. The therapies must be documented and care planned, and ordered by Qualified Practitioner. <p>Does include:</p> <ul style="list-style-type: none"> • Coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. • Subsequent reevaluation time • Set-up time <p>Does NOT include:</p> <ul style="list-style-type: none"> • Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. • Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes. • Hand held medication dispensers • Therapy provided prior to admission • Time spent on documentation or initial evaluation • Conversion of units to minutes • Rounding to the nearest 5th minute • Therapy services that are not medically necessary

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
<p>O0500A-J Restorative Nursing Programs (7-day look-back) (Chapter 3, Section O)</p>	<p>~<i>Rehabilitation</i> ~<i>Impaired Cognition</i> ~<i>Behavior Problems</i> ~<i>Reduced Physical Functions</i></p>	<p>Documentation must include the five criteria to meet the definition of a restorative nursing program:</p> <ol style="list-style-type: none"> 1. Care plan with measurable objectives and interventions 2. Periodic evaluation by a licensed nurse. Once the purpose and objectives of treatment have been established, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program. 3. Staff trained in the proper techniques 4. Supervision by nursing 5. No more than 4 residents per supervising staff personnel <p>Program validation must include initials/ signature(s) on a daily basis to support the total days and minutes of restorative nursing programs provided.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Days for which 15 or more minutes of restorative nursing was provided within a 24 hour period • For splint or brace assistance, assessment of the resident's skin and circulation under the device, and reposition the limb in correct alignment • Time provided for each program must be documented separately • Code only services provided by facility staff after admission <p>Does NOT include:</p> <ul style="list-style-type: none"> • Requirement for Physician orders • Procedures or techniques carried out by or under the direction of qualified therapists • Movement by a resident that is incidental to care
<p>O0600 Physician Examinations (14-day look-back) (Chapter 3, Section O)</p>	<p>~<i>Clinically Complex</i> ~<i>ES Count</i></p>	<p>There must be evidence of examination of the resident by the physician or other authorized practitioners in the physician progress notes to be counted as a physician examination.</p> <p>Completion of this item is required by the Commonwealth of Pennsylvania.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Partial or full examination in the facility, in the physician's office or off-site, e.g., while undergoing dialysis • Includes telehealth visits as long as the requirements are met for physician/ practitioner type as defined below and whether it qualifies as a telehealth billable visit. Chapter 15 of the Medicare Benefit Policy Manual states that beneficiaries are eligible for telehealth services only if they are presented from an originating site located either in a rural Healthcare Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. Telehealth visits may be counted if they originate from a NF in a rural county. • Examinations performed by medical doctors, doctors of osteopathy, podiatrists, dentists, optometrists and authorized physician assistants, nurse practitioners or clinical nurse specialists working in collaboration with the physician as allowable by state law <p>Does NOT include:</p> <ul style="list-style-type: none"> • Examinations conducted prior to admission or readmission • Examinations conducted during an ER visit or hospital observationstay • Examination by a Medicine Man • Psychological therapy visits by a licensed psychologist (PhD). Record in O0400E Psychological therapy.

MDS 3.0 Location, Item Description, Observation Period	RUG-III Categories Impacted	Documentation Guidelines Related To The Observation Period
<p>O0700 Physician Orders (14-day look-back) (Chapter 3, Section O)</p>	<p>~Clinically Complex ~ES Count</p>	<p>Completion of this item is required by the Commonwealth of Pennsylvania. (October 1, 2017) Does include:</p> <ul style="list-style-type: none"> • Written, telephone, fax, or consultation orders for new or altered treatment • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes • Orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, optometrists and authorized physician assistants, nurse practitioners, clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law. • Further clarification about the use of physician extenders in resident examination and order writing may be found in Section PP of the State Operations Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf) under F388 483.40(c)(3) and 483.40(c)(4) • Orders written by attending physician delegating writing of dietary orders to dietician and therapy orders to therapist. <p>Does NOT include:</p> <ul style="list-style-type: none"> • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes • Activation of a PRN order already on file • Administration of different dosages from an established sliding scale • Monthly Medicare certification • Orders to increase the RUG classification • Orders for Restorative nursing including toileting programs • Orders written by a pharmacist • Orders for transfer of care to another physician.

10 GLOSSARY

COMMON TERMS AND ABBREVIATIONS

This manual section provides definitions of terms and abbreviations that a user may hear not only while completing the resident reporting requirements for MA Case-Mix Reimbursement purposes, but also within the larger MDS environment. Each section of this document begins with the set of glossary terms used within that section.

1101 Regulation – Medical Assistance Regulation, Chapter 1101 – General Provisions which apply to all providers, including long-term care. Among the provisions in this chapter are Recipient Eligibility, Provider Enrollment Procedures and Third Party Resources. Also referred to as 55 PA Code Chapter 1101. This regulation may be found at

www.pacode.com/secure/data/055/chapter1101/s1101.11.html.

1187 Regulation – Medical Assistance Regulation, Chapter 1187 – Nursing Facility Services; Case-Mix Reimbursement System. A specific provider regulation for nursing facility reimbursement. Also referred to as 55 PA. Code Chapter 1187. This regulation may be found at

www.pacode.com/secure/data/055/chapter1187/s1187.1.html.

1189 Regulation – Medical Assistance Regulation, Chapter 1189 – County Nursing Facility Services. A specific provider regulation for County Nursing Facility reimbursement. Also referred to as 55 PA Code Chapter 1189. This regulation may be found at www.pacode.com/secure/data/055/chapter1189/s1189.1.html.

ACCESS Card – *see* Pennsylvania ACCESS Card

Admission Date – The date the resident began this episode of care in this facility. It is found at MDS 3.0 item A1900.

Assessment Internal ID – A unique number assigned to an MDS assessment or tracking form when it is submitted to the QIES ASAP system. It can be found on the Final Validation Report.

Assessment Reference Date (ARD) – The last day of the MDS observation period. It is found at MDS 3.0 item A2300, and is the date used to identify a particular assessment on the CMI Report.

Billing Census – A monthly report accounting for each nursing facility resident's daily payer source and status, i.e., in-house, hospitalized, therapeutic leave or discharge.

Budget Adjustment Factor (BAF) – An adjustment to the calculated per diem rate based on the funding that is appropriated for nursing facility services in the General

Appropriations Act as determined in accordance with a formula specified in the Commonwealth's approved State Plan.

Care Area Assessment (CAA) – Problem-oriented frameworks for additional assessment based on problem identification items (triggered care areas). Data from the MDS is used to identify potential problem areas that need further assessment.

CAA Summary – Written documentation of the CAA findings and decision-making process.

Care Area Triggers (CATs) – Provide a “flag” for the interdisciplinary team, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions.

Case-Mix – The mix of residents being cared for in a NF at any given time.

Case-Mix Index (CMI) – A number value score that describes the relative resource use for the average resident in each of the groups under the RUG-III classification system based on the assessed needs of the resident (§1187.2). For MA, the Pennsylvania Normalized Nursing Only CMIs are used.

Case-Mix Reimbursement System – For a nursing facility, a payment system that measures the intensity of care and services required for each resident and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.

CASPER Reporting (Online Reports) – An application found on the CMS MDS Welcome Page that permits nursing facilities to obtain MDS 3.0 Final Validation Reports and other reports of interest.

Centers for Medicare and Medicaid Services, The (CMS) – The federal agency that is located in the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Certification Page – The first page generated by the NIS with every CMI Report. It contains a certifying statement as well as signature lines. The first page of the report that accurately reflects the NF population on the Picture Date must be signed and uploaded to the NFRP as the final step in the Picture Date submission process. If two signed certification pages are submitted, the one with the latest submission date will be designated as the correct page/CMI Report for the Picture Date.

Certification Page Submission Deadline – 5 business days after the 15th day of the third month of the quarter.

Classifiable Assessment – An MDS 3.0 assessment that contains all items necessary to run the RUG-III v. 5.12 44 Group system. Assessments with an ISC of NC, NQ and NP meet this standard.

CMI Report – A report generated by the Department from submitted resident assessment records and tracking forms and verified by a nursing facility each calendar quarter that identifies the total facility and MA CMI average for the Picture Date, the residents of the nursing facility on the Picture Date and the following for each identified resident:

- (i) The resident's payer status
- (ii) The resident's RUG category and CMI
- (iii) The resident assessment used to determine the resident's RUG category and CMI and the date and type of the assessment.

CMS MDS 2.0 Data Collection System – Software and hardware that was provided to each state by the CMS to collect MDS 2.0 information in a standardized method

and format. The state was then charged with administering and supporting the system. In Pennsylvania, these duties were carried out by Myers and Stauffer under contract with the Department. Beginning October 1, 2013, the system was no longer used to collect MDS 2.0 data. Beginning October 1, 2014, the system was no longer used to post CMI Reports.

CMS MDS 3.0 Data Collection System – Also known as the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system. This is a national database to which all MDS 3.0 assessments and records are submitted.

CMS MDS Welcome Page – The portal accessed by the facility using the CMSNet/Verizon connection process that allows the facility to submit data to the CMS MDS 3.0 Data Collection Systems and receive reports.

CMSNet/Verizon – The communication system used to electronically submit data to the CMS MDS 3.0 Data Collection Systems. Each person at the NF who is submitting data must have an individual password.

Community HealthChoices (CHC) – Community HealthChoices is an initiative using managed care organizations to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and Pennsylvanians who are dually eligible for Medicare and Medicaid (dual eligible).

Contractor – An entity working under contractual agreement with the Department to provide requested services, e.g., Myers and Stauffer LC is the current contractor managing the NIS, the NFRP and the MA case-mix reimbursement calculations.

Control - The first section of an MDS assessment file submitted to the CMS MDS 3.0 Data Collection System. This portion of the file contains facility, state and software vendor information for that file.

Correction Number – Taken from MDS 3.0 item X0800 Correction Number. This is the total number of correction requests following the original assessment or tracking record, including the present request.

County Assistance Office (CAO) – The local offices of the Department that administer the MA Program on the local level. They determine MA eligibility and generate the PA/FS 162s.

County Nursing Facility – A long-term care nursing facility that is licensed by the Department of Health, enrolled in the MA program as a provider of nursing facility services, and controlled by the county institution district or by county government if no county institution district exists.

Data Specifications Overview – A CMS document that describes the creation of the .xml files which are combined into a .zip file to submit MDS 3.0. Data Submission Specifications detail the requirements for each individual MDS 3.0 item.

Day-One MA Eligible – An item on the state-specific item S9080E that must be completed for every Entry and Death in facility tracking form. The response should indicate whether the facility believes the resident will be/was determined to be MA for MA Case-Mix on one or more days within the first 60 days of the resident's stay.

Department – *see* Department of Human Services.

Department of Human Services (formerly the Department of Public Welfare) (the Department) – The Department of Human Services is the Commonwealth agency designated as the single state agency responsible for the administration of the Commonwealth's Medical Assistance Program (§1187.2).

Department of Public Welfare – See Department of Human Services.

Dually Certified Facilities – Nursing facilities that participate in both the Medicare and Medical Assistance programs.

Durable Medical Equipment (DME) – Movable property that: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; and, (3) generally is not useful to an individual in the absence of illness or injury.

Entry Date – The date the resident began his/her current stay in the nursing facility. It is found at MDS 3.0 item A1600.

FAC_ID – A facility identification number assigned by the Department to each facility. This number must be placed in the Control section in each MDS 3.0 assessment file.

Federal Register – The official daily publication for Rules, Proposed Rules and notices of federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration and is available by subscription and on-line.

Field Operations Review – A review conducted by the Department's medical and other professional personnel to monitor the accuracy and appropriateness of payments to NFs and to determine the necessity for continued stay of residents.

Final Validation Report (FVR) – A report generated by the CMS MDS 3.0 Data Collection System and placed in a folder in the facility's CASPER Reporting application after a file containing MDS 3.0 assessments/tracking forms is completely processed, detailing the records processed and any errors that were identified.

Fiscal Intermediary (FI) – An organization designated by the CMS to process Medicare claims. Also known as Medicare Administrative Contractors (MACs).

Generate – A term used to indicate the production of a CMI Report and the posting of the CMI Report to the NF's directory in the NFRP so that it is available for viewing and printing by the facility. The generation of a CMI Report is either done automatically by the NIS during a Picture Date submission and correction period following a systematic queuing process based on the date of submission and when the last CMI Report was generated, or the process can be manually started by the Myers and Stauffer Helpdesk when necessary or directed by the Department.

Health Care Financing Administration (HCFA) – Federal agency located in the U.S. Department of Health and Human Services that administers Medicare and Medicaid. Currently known as The Centers for Medicare and Medicaid Services (CMS).

Health Maintenance Organization (HMO) – A managed care insurance that may be a third party payor resource for a MA resident.

HIPPS Codes – Health Insurance Prospective Payment System Assessment Indicators. Used on the UB-04 billing document when submitting payment claims to the FI for Medicare services.

Hospice – Care designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to cure-oriented treatments. Hospice staff and volunteers offer a specialized knowledge of medical care, including pain management. The goal of hospice care is to improve the quality of a patient's last days.

Hospital-Based Nursing Facility – A nursing facility that was receiving a hospital-based rate as of June 30, 1995, and is located physically within or on the immediate grounds of a hospital, operated or controlled by the hospital, and licensed or approved by the Department of Health and meets the requirements of 28 Pa. Code

§1101.31 (relating to hospital requirements) and shares support services and administrative costs of the hospital.

Hospital Reserved Bed Day – A resident receiving NF services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. A NF resident in the hospital on a Picture Date who was discharged with return anticipated (A0310F = 11), a common situation when a resident is transferred to a hospital, is considered non-MA regardless of what the MA for MA Case-Mix status was prior to the discharge. The resident properly appears in the non-MA CMI Report area. Hospital reserved bed days for a rate quarter may be billed only when the NF's Occupancy Rate was 85% or above on at least one of the three applicable Picture Dates as detailed under the Occupancy Calculations heading on page 6-17.

Import – A term used to signify the action necessary to copy MDS and tracking form records from the CMS MDS state server to the NIS. MDS 3.0 data is downloaded daily from the national database to this state server, and then imported to the NIS.

In the Facility – *see* In the Facility on the Picture Date

In the Facility on the Picture Date – Residents who are in the facility on the Picture Date will appear on the CMI Report. In some cases, the resident does not have to be physically present in the facility on the Picture Date to be considered “In the Facility.” If a resident is on therapeutic leave on the Picture Date, the resident is considered to be “In the Facility” for Picture Date purposes and will appear in the correct section based on his MA for MA Case-Mix status. If a resident has been discharged with return anticipated (A0310F = 11) and has not been out of the facility for more than 30 days, the resident is considered to be “In the Facility” for Picture Date purposes based on the rules under the Residents heading on page 6-3.

Inactivation – A type of correction allowed under the MDS Correction Policy. A NF may electronically request that an invalid record that was accepted into the database be inactivated.

Index Maximization – The term used to define the process by which “Each resident shall be included in the RUG-III category with the highest numeric CMI for which the resident qualifies” (§1187.92(b)).

Initial Federally-approved PA Specific MDS record – The MDS 3.0 Entry tracking form (A0310F = 01)(A1700=1) has been designated as the Initial MDS Record to meet the requirement at § 1187.22(18). The Entry tracking form must be completed within seven days of the Entry date (A1600) and submitted within fourteen days of the Entry date.

Internal Assessment ID – See Assessment Internal ID.

Internal Resident ID – *see* Res_Int_ID

Invalid Record – According to the MDS Correction Policy, this is a record which was accepted into the CMS MDS 2.0 or 3.0 Data Collection System databases but should not have been submitted, e.g., no such event occurred.

Item Subset Code (ISC) – A code submitted in the MDS and tracking form records used to identify certain combinations of Reasons for Assessment (A0310A-C, F, H). MDS items to be completed are determined by the responses in A0310 and the resulting ISC.

Latest Assessment – The latest MDS 3.0 assessment/tracking form with an effective date on or before the Picture Date.

Latest Classifiable Assessment – The latest MDS 3.0 assessment that has all the items necessary to classify a resident according to RUG-III v.5.12 44 Group. This

includes only assessments with ISCs of NC (Comprehensive), NQ (Quarterly) and NP (PPS).

Latest Assessment Roster Report (LARR) – An interim Picture Date report released for February 1, 2010 and May 1, 2010 detailing residents who would appear on the CMI Report when selection was based on the use of the latest MDS 2.0 assessment. Identification of MA/non-MA status was included but no RUGs or CMIs appeared on this report.

Log In ID – A number assigned by the Department and provided to each facility on the Password and Connectivity letter mailed to the NF administrator. This number is necessary to gain entry into the CMS MDS 3.0 Data Collection System. Nursing facilities will also need this ID to obtain their individual ID's.

Long Term Care (LTC) – A term denoting care provided in non-acute care settings e.g., home care, NF, etc. Most commonly, it is used to refer to care provided in a NF.

Long Term Care Capitated Assistance Program/ Living Independence for the Elderly (LTCCAP/LIFE) – The MA Long Term Care Capitated Assistance Program provided through Pennsylvania Living Independence for the Elderly (LIFE), nationally known as the PACE (Program for All-Inclusive Care for the Elderly). This is an MA financed program that is handled through a capitated payment system (one negotiated payment to be used to meet all the resident's care needs) rather than through the MA per diem payment system. The LTCCAP/LIFE provider is responsible to pay all NF bills for the duration of the resident's stay.

LTC Handbook – A handbook issued by the Department for providers of MA NF services containing all information necessary to participate in the Pennsylvania MA Program. It may be found at

<http://services.dpw.state.pa.us/oimpolicymanuals/ltc/whnjs.htm>.

Long-term Services and Supports (LTSS) – The designation for the Community HealthChoices benefit package that includes nursing facility services and Home and Community Based Services that were covered in the Aging, OBRA, Independence, COMMCare, AIDS, and Attendant Care waiver programs.

MA Case-Mix Reimbursement System – In Pennsylvania, the case-mix reimbursement system referred to in Chapter 1187 regulation for nursing facility services for MA residents.

MA CMI – The arithmetic mean CMI for MA residents in the nursing facility for whom the Department paid an MA day of care on the Picture Date.

MA Day of Care – A day of care for which one of the following applies: (1) the Department pays 100% of the MA rate for an MA resident; (2) the Department and the resident pay 100% of the MA rate for an MA resident; (3) a Managed Care Organization (MCO) under contract with the Department or a LTCCAP/LIFE provider that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care; (4) the resident and either an MCO under contract with the Department or LTCCAP/LIFE provider that provides managed care to an MA resident pays 100% of the negotiated rate or fee for an MA resident's care; (5) the Department pays for care provided to an MA resident receiving hospice services in a nursing facility (§1187.2). A hospital reserved bed day may not be counted as an MA day of care. A therapeutic leave day that satisfies the conditions of §1187.104(2) (relating to limitations on payment for reserved beds) will be counted as an MA day of care (§1187.93(2)(ii)).

MA for MA Case-Mix – A payor status used by the MA Case-Mix Reimbursement System. The resident must have a valid Recipient Number and a current MA NF effective date from the PA/FS 162 except during the first 30 days of a MA HMO

covered stay (this includes HealthChoices). Identified by a response of '1' in S9080A.

Managed Care Organization (MCO) – A network of medical care providers. Enrollees in a MCO have a Primary Care Physician (PCP) who provides most medical care and must refer the enrollee to other medical care providers or specialists in the MCO network.

MDS 3.0 File Submission Confirmation Message – This report is generated by the CMS MDS 3.0 Data Collection System when a file of MDS data is first electronically submitted and indicates whether the file was successfully received or there were file errors that must be corrected and the file resubmitted.

Medicaid (MA) – At the federal level, the Medical Assistance Program is referred to as Medicaid.

Medical Assistance (MA) – Medical services provided under a State plan approved by the United States Department of Health and Human Services under Title XIX of the Social Security Act.

Medical Assistance in Pennsylvania (MA) – Medical Assistance is a federal and state program that pays for specific kinds of medical care and treatment for low income families. Any payment made to a provider for services rendered is subject to the provisions of Title XIX of the Social Security Act and the Pennsylvania Public Welfare Code, 55 PA Code Chapter 1101. Information necessary to participate in the Pennsylvania MA program may be found in the [LTC Handbook](#).

Medicare – Medicare is a health insurance program for people 65 and over, for those who have permanent kidney failure and for certain people with disabilities administered by the CMS under provisions of Title XVIII of the Social Security Act. This insurance for the aged and disabled is funded by the federal government and individual insurance premiums paid by the insured.

Medicare Administrative Contractor (MAC) - An organization designated by the CMS to process Medicare claims. Previously known as Fiscal Intermediaries (FIs). In PA, Novitas Solutions is the MAC. They may be contacted at 1-877-235-8073 or www.novitas-solutions.com.

Medicare PPS Form (NP) – A shortened version of the full MDS form used for Medicare only assessments (A0310A = 99, A0310B = 01).

Merge – A process completed by the Myers and Stauffer Helpdesk, when necessary, to tie one set of MDS records identified as a particular Res_Int_ID with another set identified with a different Res_Int_ID. This action is necessitated when data has been submitted using different resident identifying data, causing the CMS MDS 3.0 Data Collection System to view the data as belonging to a new resident rather than as additional data for an existing resident.

Minimum Data Set (MDS) – A set of forms and process mandated by the CMS to be used to assess every NF resident. MDS 3.0 v. 1.17.1 (October 1, 2019) with the standard CMS quarterly form and the State-specific Section S is required in Pennsylvania. The Medicare PPS assessment form (NP) may also be used in PA.

Modification – A type of correction allowed under the MDS Correction Policy. A modification is requested when a valid MDS record is in the CMS MDS 3.0 Data Collection System database but the information in the record contains errors. Each modification results in an increase in the Correction Number at MDS item X0800.

Non-MA – A payer status used by the MA Case-Mix Reimbursement System to indicate that a resident does not meet the requirement for MA for MA Case-Mix status. It is also the default status if no information concerning MA for MA Case-Mix status is received from the NF.

Notice to Applicant – PA/FS 162 – A state specific form used by the CAOs to notify the applicant of eligibility for MA payment and, if appropriate, the amount the applicant is responsible for paying toward the cost of their care in a NF. It identifies the date that the applicant is eligible for NF care.

Nursing Facility (NF) – For the MA Case-Mix Reimbursement System, a long-term care nursing facility that is licensed by the Department of Health, enrolled in the MA program as a provider of nursing facility services, owned by an individual, partnership, association or corporation and operated on a profit or nonprofit basis. The term does not include intermediate care facilities for the mentally retarded, Federal or State-owned long-term care nursing facilities or Veteran’s homes.

Nursing (Facility) Information System (NIS) – The comprehensive automated database of nursing facility, resident and fiscal information needed to operate the Pennsylvania Case-Mix Reimbursement System.

Nursing Facility Report Portal (NFRP) – A secure FTP site that allows nursing facility representatives to access CMI Reports over the Internet, upload the signed Certification Page and submit cost report information. (<https://nfrp.panfsubmit.com>)

Nursing Home Administrator (NHA) – An individual licensed by the Commonwealth of Pennsylvania to administer a NF.

OBRA Assessments – A term that may be used when referring to MDS assessments completed based on the resident’s condition and clinical requirements (A0310A = 01 – 06) as required by the RAI process and manual. Other assessment reasons (A0310B, F, H) may be combined with an OBRA assessment; the only exceptions are A0310B = 8 or A0310F = 01 or 12 which may not be combined with any other assessments.

Omnibus Budget Reconciliation Act (OBRA) – A final piece of legislation passed each year by Congress that incorporates any outstanding issues that must be resolved to move into the next fiscal year.

Omnibus Budget Reconciliation Act of 1987 (OBRA – 87) Nursing Home Reform Act – In 1987, Congress enacted major nursing home reform legislation that affected all nursing facilities participating in the Medical Assistance Program as part of the Federal Budget Omnibus Reconciliation Act of 1987 (OBRA – 87). These provisions were addressed in the PA Bulletin, Volume 18, Number 52, on December 24, 1988 and MA Bulletin 1181-88-08, issued December 28, 1988.

OMRA – A resident assessment known as an Other Medicare Required Assessment created by coding MDS items A0310C = 1 – 4. This assessment reports the start and/or end of therapy or a change in therapy. They are completed as directed by federal regulation for payment requirements.

PA Number – A phrase that in dealing with MDS submissions in Pennsylvania, most commonly is synonymous with the Log In ID. For all providers, the Log In ID begins with the letter “PA”; thus, the term “PA Number.” In some cases, this number will also be the same as the Fac_ID.

PA/FS 162 – See Notice to Applicant.

Password and Connectivity Letter – A letter mailed to each new facility containing information needed for individuals to obtain passwords to submit data to the CMS MDS 3.0 Data Collection System. The letter is sent by certified mail to the NF administrator. A new letter is sent with each change in provider information such as provider number or provider name.

PDA Waiver – A Medicaid home and community-based services waiver granted under the authority of section 1915(c) of the Social Security Act to the Department.

Pennsylvania (PA) ACCESS Card – A permanent plastic identification card issued to all recipients eligible for public assistance benefits. The ten-digit MA recipient number is found on this card and may be used by MA providers to verify an MA consumer’s eligibility for MA services through the Eligibility Verification System.

Pennsylvania (PA) Bulletin – The Commonwealth’s official gazette for information and rulemaking. It is available by subscription and on-line.

Per Diem – For the MA Case-Mix Reimbursement System, a comprehensive rate of payment to a NF for covered services for a resident MA day of care.

Picture Date (PD) – The first calendar day of the second month of each calendar quarter (§ 1187.2). A “snapshot” of residents in Pennsylvania NFs participating in the MA program is taken for rate setting purposes. Assessments for both MA for MA Case-Mix and non-MA residents are listed on the CMI Report for all Picture Dates (February 1, May 1, August 1 and November 1) beginning with the November 1, 2006 Picture Date.

Picture Date Deadline – The last date that MDS and tracking form records may be submitted to automatically generate a new CMI Report for a Picture Date. Refer to the Picture Date Calendar on the DHS Long Term Care Case Mix Information site (http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_194243.pdf) and the Bulletins section of the NFRP Welcome Page.

Preventable Serious Adverse Event – An event that could have been anticipated that led to a MA resident’s death or serious injury, could have been avoided and was a result of an error or other system failure within the NF. (www.pabulletin.com/secure/data/vol44/44-37/1932.html)

Prospective Payment System (PPS) – A system by which rates are set for the future based on past costs and resident acuity. Though this system is used for both Medicare and MA systems in Pennsylvania, references to “PPS” generally are related to Medicare PPS.

Provider Number – The thirteen-digit PROMISe number assigned to the MA NF by the Department. The first nine digits are assigned by the DHS Master Provider Index for a given Federal Employer Identification Number (FEIN). The last four digits reflect the Service Location Code that is based on provider type, specialty and physical location. Providers do MA billing using the correct thirteen-digit number based on the appropriate four-digit Service Location. The number can be found in the Provider Notice received shortly after enrolling in the MA Program.

Provider Reimbursement and Operations Management Information System (PROMISe) – PROMISe is the HIPAA-compliant claims processing and management information system implemented by the Department in March 2004. PROMISe replaced MAMIS (Medical Assistance Management Information System) and incorporates claims processing and information management activities of the Department’s Offices of Medical Assistance Programs, Mental Health and Substance Abuse Services, Mental Retardation, and Social Programs.

QM Reports – The Quality Measures reports available from the CASPER Reporting option on the CMS MDS Welcome Page.

Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system. This is a national database to which all MDS 3.0 assessments and records are submitted.

QIES Technical Support Office (QTSO) – A CMS contractor that provides technical support to the state agencies housing the CMS MDS 2.0 Data Collection System. The QIES Technical Support Office function is provided by Buccaneer Computer Systems and Service.

Quality Improvement and Evaluation System (QIES) – The “umbrella” system that encompasses MDS, OASIS, ASPEN and CASPER.

RAI Manual – The Long- Term Care Facility Resident Assessment Instrument (RAI) 3.0 User’s Manual v.1.17.1 October 2019 issued by the CMS covering the Minimum Data Set, Care Area Assessments and Utilization Guidelines. (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>)

RAI Spotlight – Newsletter released quarterly by the Department of Health containing latest information from CMS, DOH and DHS.

Resident Data Reporting Manual – The Department’s Manual of instructions for submission of resident assessment records and tracking forms and verification of the CMI Report.

Recipient Number – A ten-digit number found on the Pennsylvania ACCESS Card and PA/FS 162. This is a number permanently assigned to each recipient.

Registered Nurse Assessment Coordinator (RNAC) – An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility who is responsible for coordinating and certifying completion of the resident assessment.

Replicate – A term used to signify the action necessary to copy MDS and tracking form records from the federally-provided state server to the NIS.

Res_Int_ID (Resident Internal ID) – An internal resident ID created for each individual NF resident upon the submission of their first record to the CMS MDS 3.0 Data Collection System. The Res_Int_ID is based on resident identifying information such as name, social security number, gender etc. All subsequent records for the resident are tagged with the same Res_Int_ID. The Resident Internal ID is also used to identify each resident on the CMI Report.

Resident – A person being cared for in a NF.

Resident Assessment – A standardized evaluation of each resident’s physical, mental, psychosocial and functional status.

Resident Assessment Instrument (RAI) – The designation for the complete resident assessment process mandated by the CMS, including the MDS, Care Area Assessments (CAAs) and care planning decisions.

Resident Assessment Validation and Entry Software (RAVEN) – Software available at the CMS website (<https://qtso.cms.gov>) which allows data entry and submission of MDS 2.0 data. Includes PA Section S. Comparable software for MDS 3.0 is called jRAVEN.

Resident Internal ID – See Res_Int_ID

Resource Utilization Group Version III (RUG-III) – A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs (§1187.2). The Pennsylvania MA Case-Mix Reimbursement System beginning July 1, 2010 uses version 5.12 44 group.

RUG Elements – Those items on the MDS 3.0 that are used in the RUG-III classification system.

Submission Period – The period from the Picture Date to the day before the Certification Page Upload Deadline. If data has not been submitted prior to the Picture Date, all data that affects the Picture Date must be submitted during this

period. If the period is extended, any information affecting the Picture Date received by the facility during this extended period must also be submitted, e.g., receipt of a PA/FS 162 changing the resident's MA for MA Case-Mix status.

Supplemental Ventilator Care Payment (SVCP) – A supplemental payment made based on MA residents requiring ventilator care beginning November 1, 2013. Now replaced by the Supplemental Ventilator and Tracheostomy Care Payment (q.v.).

Supplemental Ventilator and Tracheostomy Care Payment (SVTCP) – A supplemental payment made to nursing facilities based on the number and percentage of MA residents requiring medically necessary ventilator or tracheostomy care on the Picture Date beginning July 1, 2014.

The Department – *see* Department of Human Services.

Therapeutic Leave Days – A resident receiving NF services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the NF if the leave is included in the resident's plan of care and is ordered by the attending physician. The Department will pay a NF the NF's current per diem rate on file with the Department for a therapeutic leave day (55 Pa.Code §1187.104(2)). No MDS Discharge Tracking form is completed for a resident on therapeutic leave. An MA resident on therapeutic leave on the Picture Date is still considered to be MA for MA Case-Mix and should properly appear on the CMI Report in the MA area. An MA resident on therapeutic leave on the Picture Date who does not meet the conditions of 55 Pa.Code §1187.104(2) should appear in the non-MA area.

Title XVIII – Designation for the federal Medicare statute.

Title XIX – Designation for the federal Medicaid statute.

Total Facility CMI – The arithmetic mean CMI of all residents regardless of the residents' sources of funding.

Valid Record – According to the MDS Correction Policy, this is a record which was accepted into the CMS MDS 3.0 Data Collection System database and met the following criteria: it was not a test record, the event had occurred, the correct resident was identified, the correct reason for assessment was indicated and the record was required to be submitted.

11 ACRONYMS

COMMON ACRONYMS

This manual section provides definitions of acronyms that a user may hear not only while completing the resident reporting requirements for MA Case-Mix Reimbursement purposes, but also within the larger MDS environment. Each section of this document begins with the set of acronyms used within that section.

ADL – Activities of Daily Living

ARD – Assessment Reference Date

BAF – Budget Adjustment Factor

CAA – Care Area Assessment

CAO – County Assistance Office

CAT – Care Area Trigger

CHC – Community HealthChoices

CMI – Case-Mix Index

CMS – Centers for Medicare and Medicaid Services, The

COLA – Cost of Living Adjustment

DHS – Department of Human Services (formerly DPW)

DLTCPS – Division of Long Term Care Provider Services

DME – Durable Medical Equipment

DOH – Department of Health, Division of Nursing Care Facilities

DPW – Department of Public Welfare (currently DHS)

FI – Fiscal Intermediary

FVR – Final Validation Report

HCFA – Health Care Financing Administration (currently CMS)

HMO – Health Maintenance Organization

IPA – Interim Payment Assessment

ISC – Item Subset Code

jRAVEN – Resident Assessment Validation and Entry Software for MDS 3.0

LARR – Latest Assessment Resident Roster

LIFE – Living Independence for the Elderly

LTC – Long Term Care

LTCCAP/LIFE – Long Term Care Capitated Assistance Program/Living Independence for the Elderly

LTSS – Long-Term Services and Supports

MA – Medical Assistance, Medicaid

MAC – Medicare Administrative Contractor

MCO – Managed Care Organization

MDS – Minimum Data Set

MPAF – Medicare PPS Assessment Form

NF – Nursing Facility

NFRP – Nursing Facility Report Portal

NHA – Nursing Home Administrator

NIS – Nursing (Facility) Information System

OBRA – Omnibus Budget Reconciliation Act

OLTL – Office of Long Term Living

OSA – Optional State Assessment

PA – Pennsylvania

PA/FS 162 – Notice to Applicant

PD – Picture Date

PDPM – Patient Driven Payment Model

PPS – Prospective Payment System

PROMISe – Provider Reimbursement and Operations Management Information System

PSAE – Preventable Serious Adverse Event

QIES – Quality Improvement and Evaluation System

QIES ASAP - Quality Improvement and Evaluation System Assessment Submission and Processing [system]

QM Reports – Quality Measures Reports

QTSO – QIES Technical Support Office

RAI – Resident Assessment Instrument

RAVEN – Resident Assessment Validation and Entry Software for MDS 2.0

RDRM – Resident Data Reporting Manual

RNAC – Registered Nurse Assessment Coordinator

RUG-III – Resource Utilization Group Version III

SNF – Skilled Nursing Facility

SVCP – Supplemental Ventilator Care Payment

SVTCP – Supplemental Ventilator and Tracheostomy Care Payment