Centers for Medicare & Medicaid Services
Questions and Answers
Open Door Forum: SNF/LTC Open Door Forum
Thursday, October 12, 2023

1. Question: It's my understanding that since 10/1/23, GG discharge performance items are supposed to be on this stand-alone discharge. It's my understanding that prior to 10/1/23, these items were grayed out for a combined OBRA PPS discharge, and I've received reports from providers that they're no longer grayed out for an OBRA PPS discharge. Is that CMS's intent, or is this a software error? Because that could negatively impact their SNF QRP provider threshold with the dashes.
    a. Answer: Want to make sure you're referring to the GG items you're saying are no longer available after October 1. I just want to make sure I understand your question.
        i. Question: No, so I believe the GG items are newly required on unplanned discharges, where they weren't prior to October 1. So, prior to October 1, whenever a home combined an OBRA discharge and a PPS discharge, the GG performance items were grayed out, so it wouldn't negatively affect their QRP. For example, if they had to put dashes because it was an unplanned discharge. That's no longer occurring, and since there's been several software errors, I just need to know if that for a combined OBRA PPS discharge, is it CMS's intent that providers complete the GG discharge column performance items, or is that software problem and those items should be grayed out for the combined OBRA PPS discharge?
            1. Answer: Beginning October 1, 2023, GG0130 and GG0170 are required on an OBRA discharge combined with a PPS discharge (A0310F= 10 or 11 and A310H=1) regardless of whether it is a planned or unplanned discharge.
2. Question: I was wondering if CMS could offer some clarity a little bit—clarification—on the errata document that was published back in September, or the errata related to the final version of the RAI Manual. The third element on that indicated that the symptom frequency in DL 150 A 2 through DL 151 I 2 is blank for three or more items the interview item is deemed to not be complete and that's not new, but then it says the total severity score should be 99 and do not complete the staff assessment of mood. And so my question is that instruction in that errata for that particular situation doesn't seem to square with the remainder of the instructions in Section D of Chapter 3, where it says under health-related quality of life that [inaudible] is preferred, as it improves the detection of possible mood disorder, however a small percentage of residents are unable or unwilling to complete the PHQ-9, therefore, the staff should complete the PHQ-9 observational assessment that's the staff assessment of mood. And there are other places too on that page in particular that would indicate that we need to be completing the

observational assessment in that situation as well. So, I'm wondering if there's going to be further clarity on that or if you could offer some clarification on that for us today.

a. Answer: I appreciate you bringing it up. Obviously, we're always looking at the manual for areas where we can do refinements or improvements to ensure that the language is consistent with what we're trying to have providers achieve. We can certainly go back and take a look at some of those areas that may still carry some of that inconsistency and try to address that.
    i. Question: I guess my follow-up question would be, when would CMS indicate that the staff interview would actually be appropriate. There's a lot of residual to that instruction changing, and interestingly enough, in talking with other providers, a lot of people aren't even aware that that particular instruction changed since it's certainly not something that went into the final manual, and it's only in the errata document, but in that case, is CMS saying the only time we can do the staff interview now is if the resident is [inaudible], you know, where is the opportunity for us to assess for mood if the resident can't participate in the assessment as that is a residual then to the care area process, care area assessments, care plans, PDPM (Patient Driven Payment Model) reimbursement and so forth?
        1. Answer: It's a good question, and I can't speak to it directly on it. But it's something, again, that we'll provide clarity in terms of the manual as well as other forms of communication.

3. Question: So due to the October 1 changes, there's electronic software HR is calculating incorrect HIPPS (Health Insurance Prospective Payment System) codes on assessments due to their transition on a number of items. These are reflected in incorrect HIPPS codes when mechanically altered diet is checked. At this point, there are incorrect HIPPS codes regarding when IV fluids is checked, and Section K, and is not reflected properly. Now that it is the 12th of the month and we don't have exact, we don't have a resolution, and I know many other nursing facilities are dealing with the same question, how should we go about billing when our software has incorrect codes, but when we do submit it and it is accepted to CMS, it is modified and reflected on the final validation report with the correct HIPPS code properly 3935 A showing up on the validation report says that the HIPPS code and the PDPM code does not match the value calculated by IP system can we go ahead and bill our [inaudible] based on the final validation report once that assessment is submitted and do not—and not worry about if our software is properly showing that information?
    a. Answer: With regard to any errors that are occurring within vendor software, obviously you have to take up with the provider of that software. That's not something that we can speak to. With regard to the billing questions or what should be billed anytime where you're having issues where the reported HIPPS code is being reverified through iQIES and is providing something different, one of the things I think we always encourage providers do is to reach out to their MAC (Medicare Administrative Contractor) to ensure that they're billing the

appropriate HIPPS code. The MACs are likely aware of these kinds of discrepancies already. I would encourage them to reach out to make sure that they're aware and that they are billing appropriately.

   i. Question: So just a follow-up, it is clear that CMS from the validation report understands that the assessment has a correct HIPPS code based on its recalculation. So somehow it considers let's say when there's a special care high that that is accurate. So, my question is: Why wouldn't we be able to bill based on that? Shouldn't that be the way to proceed?
      1. Answer: I'm not saying that you can't. I'm saying is that any time you have those types of discrepancies, you should reach out to your MAC to ensure that you're billing appropriately because the MAC is going to be doing the same type of verification on their side as well. I know we did have a problem last month with the iQIES, actually I think it was last week.

4. Question: A few weeks ago when the quality measure updates came out or revisions to the updates to the quality measures affected by the removal of Section G, I have some questions on those in terms of what perhaps CMS could give us some insight into the way that they developed those in particular—we talk about the particular quality measure in relationship to the percent of residents whose need for help with daily activities has increased typically dealing with the ADLs (Activities of Daily Living) prior to Section G. And as we came over into sort of the equivalent portions of Section GG for example, for toileting the only thing now that's being measured is transfer rather than toileting and hygiene. So, there's a whole piece that's missing in terms of how that equivalent took place. Same thing happened with the residents who have had mobility declines whose ability to move independently worsened. When G was part of the picture, we measured residents' movement on the unit, which included ambulation and wheelchair mobility. And when we get to the new equivalent measure for GG, it only measures walking—in fact, it's a new measure, Residents Whose Ability to Walk Independently Worsen. And I'm just curious, some of the rationale maybe you could help us with insight into why CMS chose to limit the population in terms of how these quality measures function.
   a. Answer: Thank you for your question. Both Section G and Section GG were designed to assess a range of activities and functional ability based on a unique set of data elements and response options, and both Section G and Section GG data elements have each been shown to be reliable and valid approaches to assessing function. Although both sets of data elements address daily activities and assistance needed from a helper, there are many key differences between the individual item definitions and the rating scale used to code the items in Section G and Section GG that impact the coding of the items and the way the items function psychometrically in quality measures.

      Since a one-to-one comparison cannot be made between Section G and Section GG data elements, we used a multi-step approach to identify the most appropriate

Section GG data elements to replace the Section G data elements, while maintaining, to the extent possible, the existing specifications and original concept of the measure. This multi-step process included literature review, data element validity and correlation analysis.

We conducted a comparison of the codes on similar data elements from the Section G and Section GG from MDS 3.0 used in the SNF setting. Using 3 months of data, we calculated Pearson and Spearman correlations between pairs of similar Section G and Section GG data elements. For each pair of data elements, correlations were calculated for assessments where there is a code of 01, 02, 03, 04, 05, or 06 for the GG data element and code of 0, 1, 2, 3, or 4 for the G data element. This was to limit the comparisons to residents where there are assigned a functional status rating according to the ordinal rating scale of resident performance. We also generated cross tabulations between the same pairs of similar Section G and Section GG data elements, using all the options of each data elements rating scale. We also conducted Rasch analysis using a smaller set of Section GG data. Rasch analysis uses item-level response or observation data to determine if items in a set work together to measure a single concept (or construct). The benefit of Rasch analysis is that it also provides information on the hierarchy of item difficulty (from easy to hard) that can be used to evaluate the construct validity of a set of items. We used the results of the item hierarchy from these analyses to also inform Section GG data element selection. We recognize that the functional abilities of SNF residents and long stay residents may differ but believe that the Section G data elements and Section GG data elements may be similarly related to each other in different populations.

As always, CMS will continue to monitor the data and determine the need to refine these measures as part of the measure life cycle.

5. Question: I'm also curious as to the rationale behind the change with Section O, where the minutes for therapy minutes, they're only going to be reported for the first reference period. I'm curious as to the rationale with that when we're also looking at grouping concurrent and a lot of other things hinge on the minutes.
    a. Answer: As of November 1st, providers will have to report this data. Please see the MDS Errata V3.01.3 posted September 21. It is issue 23.
6. Question: I have two questions. The first question does have to do with MDS coding. We're struggling with the race ethnicity interview as interviews are to be asked you know, within on the ARD (Assessment Reference Date) or within the look back. And we're asked for race and ethnicity interviews to be done on death and facility, and unplanned discharges. And I just wanted to verify, are we truly expected, obviously we can't interview the patient, it would be technically after the ARD potentially if we didn't get the interview with the family member on the day they passed, are we really expected

to be calling the family when their loved one passed to ask a race ethnicity question? Or when a patient's being wheeled out with EMS on an unplanned discharge? I just want to make sure we're doing—because I hate to dash these questions, and I know the third step is to go to the medical record, but to verify that all this is done on the date of death or on the date of patient's emergently being taken out of the facility.

a. Answer: For the race and ethnicity questions, in the event of a death in facility, the facility would use the documentation in the medical record. As noted in the MDS RAI Manual on 2-38 bullet 2, the Death in Facility Tracking record must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days). For an unplanned discharge, if the resident and/or family member responded to the SDOH items previously, and the responses are in the medical record, the RAI Manual indicates to use medical record documentation when the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item. As noted in the MDS RAI Manual on 2-39, the OBRA Discharge Assessment must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
    i. Question: And my second question has more to do with iQIES and the transition of CASPER reports. And I was just curious as to whether or not more of the CASPER reports are going to be moved into iQIES. Some of those were very helpful reports. And are there plans for more to come over, or what's in iQIES, is that all we're going to have going forward for CASPERs?
        1. Answer: There was an initial set of MDS 3.0 and SNF QRP reports that were identified to be most important for the migration of MDS data submission and reporting into iQIES and this set did not encompass all the reports that had been available in the CASPER Reporting application. CMS will continue to evaluate and iteratively add other reports to iQIES as deemed necessary. Requests for any new or additional reports may be submitted to the IQIES Idea Portal. A link to access the Portal can be found here: https://cmsqualitysupport.servicenowservices.com/ccsq_support_central. In addition, a user manual that describes how to access the portal and submit a suggestion can be accessed on the iQIES References and Manuals page on the QIES Technical Support Office (QTSO) website: https://qtso.cms.gov/software/iqies/reference-manuals.

7. Question: My question is about the MDS error message user guide. I was wondering if iQIES or CMS is planning to release a new version relative to the transition?
    a. Answer: We do plan to provide an update version of MDS error message guides, and that should be coming out shortly. I'd say within the next week or two.

i. Question: And my second question is about the—it's actually a follow-up question on the gentleman's question about the iQIES and recalculation of the HIPPS. So, I know that CMS just released through iQIES the FVR, the addendum to the Final Validation Report where you have the Excel spreadsheet. So, we did peruse those documents and did our own due diligence, and we found out that some of the recalculation from iQIES is actually the incorrect recalculation. So, this is on the errors green line 35A and 3535B. We're in the HIPPS value or HIPPS codes calculated by our software is actually the correct codes, and we would send that out to CMS to iQIES, and it's giving us a recalculated HIPPS measure which is inaccurate.
    1. Answer: there's a better email address to send it to will be grouperbetatesting@cms.hhs.gov. They are the ones tasked with ensuring that the grouper is operating properly So again, I'll put that into the chat, but that will be the appropriate email box for any grouper-related issues.

8. Question: What's CMS guidance for providers if the MDS software isn't calculating proper regs and other issues that are preventing us to be able to close the MDS? This is going to cause us to be out of guidelines with the completion and submission requirements, but we're unable to close it and lock it with proper information. What are we to do? Across the board the vendor softwares have not been programmed properly and so we can't transmit an inaccurate MDS, and in some cases we can't even lock it.
    a. Answer: if it's a vendor software issue, I would suggest reaching back out to the vendor who provided the software product to you. If it's other than issues that you're having with the vendor software, I would suggest contacting the iQIES help desk.
9. Question: I had a question with regards to the guidance in the final manual about the inability to code an AO310 and AO310B, an assessment for Medicare Advantage plans. Can we—is there any clarification as far as can we still complete a five-day assessment but not transmit? Or should we not even be completing these assessments at all and somehow generating another assessment?
    a. Answer: At this time, when using a software vendor, you have flexibility in how you code data items for assessments that are not OBRA or PPS required assessments or not the OSA, as long as you do not transmit these assessments to iQIES, and you document that the assessment is not for OBRA/PPS/OSA purposes. The iQIES MDS User Interface tool does NOT support non-OBRA/PPS/OSA uses of MDS assessments, and you MUST not deviate from the RAI manual. CMS encourages vendors to utilize Z0300 as intended with the implementation of MDS 3.0 (in October 2010) and to support the needs of their customers, which are often greater than CMS requirements related to MDS assessments, such as reports/feedback, and EHR and claims integration.

10. Question: On Section GG, for an unplanned discharge, what is the expectation for documentation supporting that? Because typically you use the ARD plus the two previous days when—and that can be done when you have a planned discharge. But if somebody is acutely discharged to the hospital, we don't have that same kind of like time to have an interdisciplinary team meeting and so on and so forth. And on the other hand, we do not want to dash it because of the effect on QRP compliance. So, what guidance can you give us about what we need to do for that?
    a. Answer: Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual,
    states that the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that:
    (1) the assessment accurately reflects the resident's status
    (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
    (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

    Nursing homes are left to determine:
    (1) who should participate in the assessment process
    (2) how the assessment process is completed
    (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this 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. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements

    GG items for which the interdisciplinary team has no information should be dashed in the event of an unplanned discharge. We understand the concern regarding the potential negative affect on the QRP compliance threshold and CMS will analyze the QRP data involved as it becomes available.

11. Question: My question is related to the managed care organizations who are still cutting beneficiaries off prior to that 20th day although they could continue to make progress. I understand that they manage care groups are under investigation and just want to see what CMS's thoughts were, or if there was any update on lack of better term cracking down on a managed care organization that is only permitting two or three days for a patient when their Medicare benefit qualifies them for 20 days of skilled care without co-pays.
    a. Answer: Given the complexity of the subject, CMS will respond directly to the inquirer.
12. Question: Would we be able to get some more detailed guidance or clarification for determining the primary diagnosis category in I0020B for the long-term care residents? Even with the updated little paragraph in Section I it still appears very focused on a new admission that is coming for a skilled stay, and we're looking for some guidance on if it is the original reason they were admitted to the facility even if it's many years ago or if it's the reason they're stuck in the nursing home and not able to live in a less restrictive environment or if it's the diagnosis using most resources or something else.
    a. Answer: Thank you for your question. We recommend that you reach out to your state RAI coordinator to help address this question and provide the appropriate guidance. While CMS can provide direction on coding items on the MDS, this guidance relates to the use of these items on federally required assessments for federal purposes. If an item is being utilized for state-based purposes (e.g., Medicaid case-mix determinations), then your state or the state RAI coordinator would need to provide this type of guidance.
13. Question: I understand that there's an MDS submission file update that's going to be applied in November that will help us with the respiratory therapy that's not—those questions are not going through the edits correctly. And it says it will be retroactive to October 1. So, my question is: Does that mean when we do a question now and we, a lot of people, are just having to dash it to get it to be able to close the MDS, will we be able to modify an MDS after November's files are updated? And then will it then be able to fix this issue for these October MDSs about respiratory therapy and psychological therapy that can affect state case mixes that are using the PDPM components?
    a. Answer: After the errata fix goes into effect on November 1, you will be able to go back to assessments that did not have those items active. You will be able to go back and do corrections if you choose to. CMS is not requiring you to do that. However, if you need to do that, you can go back and correct it. Also, with the retroactive onset, what will happen is if a provider goes back to correct an assessment completed between October 1 and 30, they will have to complete those items to close that MDS.
14. Question: We have a billing issue that we've been trying to resolve that's related to the waiver, the Public Health Emergency waiver that ended. We had a resident that exhausted the original hundred days back on March 30 and did qualify for the waiver. So, we waived the 60-day wellness period, so the first day was March 31. Discharged to the

hospital on May 4, only using 34 days of that new benefit period. The gentleman did have a three-day qualifying hospital stay returned. We have not been able to get this claim paid because the MAC keeps telling us that everything exhausted on May 11. We're just looking for guidance on how to get this corrected.

a. Answer: I'll speak very globally about sort of what we had said previously about when the waiver ends and how it affected things like benefit periods. So, if you had a beneficiary that had a benefit period that had, you know, a hundred days and it started, you know, sometime prior to May 11, the fact that May 11 came, and the PHE ended did not in any way impact—or should not have impacted the number of days that were available to a beneficiary within that benefit period. So, it could have impacted in terms of how the—if a beneficiary required a qualifying hospital stay, and things like that, but you know, a benefit period is a benefit period. So as long as there were days remaining within that benefit period, and this is obviously assuming that the beneficiary meets all of the other skilled criteria, you know, daily skilled need and QHS (Qualifying Hospital Stay) and all those other you know, all the other things that we have in our manuals about what's required for a stay, so assuming that they met all of those various criteria, then yes, as long as the person has been benefit days remaining, the PHE ending would not have affected that. So, again, that's from a very global standpoint. I can't speak to the specific aspects of any particular beneficiary's case, and for that, you would need to work through the MAC and the appropriate channels to adjudicate a specific case on that.

15. Question: I was just hoping that you could explain when the wage index correction and the PDPM ICD 10 category corrections were updated. Were those the September 18 postings, or is that posting yet to come?
    a. Answer: Yes, the ones that are on the website currently are representative of the correct values.
16. Question: I have a question about the iQIES user interface. I have assisted several swing beds and MDS processes and many of them utilized jRAVEN to complete but not transmit PPS assessments for Medicare Part C. It's my understanding that their only option moving forward would be to look into a different type of software or potentially complete those Part C requested assessments on paper, which would then require them to manually calculate the PDPM HIPPS code. So, I just want to first make sure that my understanding is correct, and if so, is there any plan to provide some type of tool to assist with the HIPPS calculation similar to when I believe I remember seeing when PDPM was first initiated there was some type of group or tool. So, am I correct? And is there any assistance available for the HIPPS calculation?
    a. Answer: we can only speak to the PDPM HIPPS code as it relates to Medicare Part A patients. To the extent that a Part C plan is requiring you to follow the same guidance as you would for a Medicare Part A patient, then you could utilize the same basic grouping software as what's available for Part A patients. If there are discrepancies between what is being utilized by a Part C plan, which I know

that sometimes they do, then that's something that you have to speak directly with the plan sponsor. Again, that's a private arrangement that we can't really speak to.

17. Question: I was wondering the last data specification was posted on 9/21, but as providers have started to submit to iQIES, there's been some errors that have come back or fatal rejections where we had to get clarification on those data specifications, and iQIES has provided clarity and further guidance on you know, what that should be. I guess my question is: Are you expecting to release an updated data technical specification, and if so, when would that be? I guess I'm just wondering how many other possible issues are out there that maybe we haven't identified yet in trying to make sure that the MDSes are getting submitted successfully.
    a. Answer: Yes, if we find that there's quite a bit of issues that haven't been resolved based on the reported issues to the service desk then yes, we'll be providing an errata document and posting that as soon as possible. So, make sure you're checking the website regularly.