Centers for Medicare & Medicaid Services
Skilled Nursing Facilities Long-Term Care Open Door Forum
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Webinar recording:
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Jill Darling: Hi, everyone. Good morning and good afternoon. My name is Jill Darling, and I am in the Office of Communications here at CMS. Welcome to today's Skilled Nursing Facilities Long-Term Care Open Door Forum. Thank you for your patience as we were waiting for folks to join the webinar. Before we begin, I have a few announcements. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link is on the agenda. If you are a member of the press, you may listen in, but please refrain from asking questions during the webinar. If you have any questions, please email press@cms.hhs.gov. All participants are muted. For those who need closed captioning, a link was just provided and located in the chat function of the webinar. We will be taking questions at the end of the agenda today. For today's webinar, there are no slides, just the agenda slide you see on your screen. We will be using the raise hand feature at the bottom of your screen for questions, and we will call on you to ask your question and one follow-up question. We will do our best to get to all of your questions for today. And to start off, I will hand it to Kadie Derby to start off the agenda.

Kadie Derby: Great. Thanks, Jill. Good afternoon, everyone, I hope to not take up too much of your time. I just wanted to give a brief update and reminder. As most everyone knows, on September 6 of this year, CMS published a proposed rule that would establish minimum staffing standards for long-term care facilities as part of the Biden-Harris Administration's Nursing Home Reform Initiative to ensure safe and high-quality care in long-term care facilities. Given the fact that we are still in active rule making, I will not be fielding questions regarding the proposed rule on today's call. However, I did want to bring attention to some of the resources available online to promote awareness of the proposed rule and how to submit public comments.

First of all, on September 14, CMS hosted a National Nursing Home Stakeholder Call that was open to the public. The transcript, along with the slide deck presented, are available online. For the sake of not confusing anyone with a very long website, if you simply type CMS National Call page in your Google browser, the first link available will take you directly to that website. And then, if you scroll down to the middle of the page under the heading National Stakeholder Calls, it's the first one that you'll see. And then lastly, the 60-day comment period for submitting comments on this proposed rule ends November 6. We certainly are encouraging everyone to submit a formal comment through the Federal Register website. For ease of reference, the rule docket number is CMS-3442-P, as in proposed rule. That's all the updates that I had. Thanks, everyone. And I'll hand it over to you, Tammy.

Tammy Luo: Thank you, Kadie. Good afternoon, everyone. On September 29, 2023, the Centers for Medicare and Medicaid Services issued a correction notice that addressed errors related to the Fiscal Year 2024 SNF PPS Final Rule and associated materials. First, the correction notice corrects a technical error in the calculation of the final Fiscal Year 2024 SNF PPS wage indexes, specifically CMS [inaudible] in the calculation of the wage index for CBS 834 or rural North Carolina. Correcting this error required to us recalculate the wage index budget neutrality factor, which caused a very minor revision to the unadjusted SNF PPS federal per diem rates and the case mix adjusted SNF PPS rates. The wage index files on the CMS website have also been updated to reflect this correction.

Finally, the correction notice also corrected some errors in the PDPM ICD 10 Code Mappings that were made available on the CMS website. The first table in the PDPM ICD 10 Code Mappings displays a list of ICD 10 codes that are recorded in item I 0020 B of the minimum data set (MDS) assessment to determine a patient's clinical category assignment under PDPM. We are correcting typographical errors in the clinical category assignment of certain codes to properly reflect the proposals finalized in the Fiscal Year 2024 SNF PPS final rule. The second table in the Fiscal Year 2024 PDPM ICD 10 Code Mappings displays a list of ICD 10 codes associated with co-morbidities included in the speech-language pathology component under PDPM. We identified some codes that were erroneously added, noting that the addition of any ICD 10 code to the SLP co-morbidity list would amount to a change in policy that would first need to undergo notice and comment rule making. We have made the correct file available on the CMS website and would note that the preamble language of the Fiscal Year 2024 SNF PPS final rule discussing ICD 10 Mappings is unaffected by these errors. And with that, I'll turn it over to Kim.

Kim Jasmin: So, I wanted to present on the jRAVEN status. The jRAVEN software CMS provides for MDS completion and submission is no longer current. It has not and will not be updated for MDS item set version 1.18.11. You may still use jRAVEN for assessments with a target date of September 30 of 2023 and earlier. This leads me into the next topic, which is the iQIES MDS user interface, which we call UI 2. IQIES is an internet facing cloud-based system and requires users to be connected to the internet to use. While the user interface is free, it is very limited in its functionality and capabilities. When using the iQIES MDS UI, or user interface, you may only code and upload one record at a time. The MDS with the response codes you complete is not saved to your computer. It is in the iQIES database in the CMS system. Think of the user interface as being similar to an online survey, one that a company might send to you as a link in an email or pops up on your screen while using a website. You complete that survey by providing responses to questions, and at the end, you may submit the survey. The information you entered is no longer on your screen. It is not on your computer anywhere. The information is in the database to which the company stored it. So, with the iQIES MDS user interface, you complete the MDS, which is a survey, by coding survey responses to the data elements, which are the survey questions. But all the info is in iQIES and not stored on your computer. The user interface doesn’t interact with any software, including EHRs (Electronic Health Records). When you submit an assessment via the user interface, if you need to modify the record, you must do so with the user interface. You cannot use vendor software to do this. In addition, when you upload an assessment in the XML layout via the vendor software, you must modify the record within the software and upload. You cannot use a user interface to modify those records. The user interface does not allow—I'm sorry—does not interact with any software, including EHRs. When you

submit an assessment via the user interface, if you need to modify the record, you must do so with the user interface. You cannot use software vendor to do this. The user interface does allow for the completion of MDS assessments for other insurance payers or purposes such as Medicare Advantage or private insurance. As you're aware, providers are not to submit those types of assessment to iQIES. The user interface is used to meet OBRA (Omnibus Budget Reconciliation Act), SNF PPS (Skilled Nursing Facility Prospective Payment System), QRP (Quality Reporting Program), and state Medicaid purposes. Consider carefully whether you want to use a user interface, especially as your only source to submit assessments. In order to submit assessments using the iQIES MDS user interface beginning October 1 of 2023, users will be required to have either the provider administrator or provider assessment coordinator user role.

The next topic is across [inaudible]. As mentioned on the August ODF call, due to the significant differences between the current MDS version 1.18.11 and the prior version, 1.17.1 the item sets are not interchangeable, and the crossover rule applies. This means that providers may not modify the target date of an assessment completed prior to October 1 to a target date on or after October 1 and vice versa. For example, if a provider submitted an MDS assessment with a target date of September 29 and determines that the target date should be October 2, you may not modify the MDS. You must code and complete a new MDS, which is in this example is version 1.18.11. We have included this information in the most recent RAI Manual, Chapter 5, which is also posted on the CMS MDS 3.0 RAI Manual webpage. Back to you, Jill.

Jill Darling: Thank you, Kim to Tammy and to Kadie. That concludes our agenda. So, we will open for Q and A. Again, reminder, please use the raise hand feature to ask your question and one follow-up question, and we will call on you. Reminder, the moderator will unmute on her end, and then please do the same on your end when you are called on. One moment, please.

Karen Mohr: Stacey Bryan, you're able to unmute and ask your question.

Stacey Bryan: Yes, ok. So, 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.

Kim Jasmin: This is Kim. 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.

Stacey Bryan: 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?

Kim Jasmin: Thank you, Stacey, for clarifying your question. I will need to reach out to our policy group to make sure that the issue you presented is what we had planned on providing to our customers. So, we'll do the research and get back to you.

Stacey Bryan: Ok. Will you email me?

Kim Jasmin: If you can send me your email address or put it in the chat, that would be great, and I can provide you an update.

Stacey Bryan: Ok. Thank you.

Jill Darling: What I can do is I will send out the SNF ODF email to everyone right now.

Stacey Bryan: Should I send my question there?

Jill Darling: Karen, we will take our next question.

Karen Mohr: Ok, Joel VanEaton, you may unmute and ask your question.

Joel VanEaton: Thank you so much for taking my question today. 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 [inaudible] 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, thank you.

John Kane: Hi Joel, this is John Kane. 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.

Joel VanEaton: 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?

John Kane: It's a good question, and I can't speak to it directly and I don't think the person that would normally be answering that kind of question is on today. But it's something, again, that we'll provide clarity in terms of the manual as well as other forms of communication.

Joel VanEaton: All right, thanks, John.

Kim Jasmin: This is Kim. Joel, if you could send your question to the ODF mailbox and someone will take a look at your question and respond.

Joel VanEaton: All right. Thank you so much.

Kim Jasmin: Thank you.

Karen Mohr: Meir Waxman, you may unmute and ask your question.

Meir Waxman: Hi. Thank you for taking my question. I appreciate all your time. 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?

John Kane: Hi, this is John Kane again. 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.

Meir Waxman: 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?

John Kane: 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.

Meir Waxman: Ok. I hear what you're saying, but this is a federal problem, this is a CMS Medicare issue.

John Kane: It sounds—

Valeri Ritter: Hi, John, this is Valeri. Let me cut in really quick. If you want to send that question to the Open Door Forum, I can actually take that back and verify. I know we did have a problem last month with the iQIES, actually I think it was last week. So just send your question through the Open Door Forum. I can look into it further for you.

Meir Waxman: Ok. I mean this is. The priority of the point—I'm not one to ask questions. I just [inaudible], but this is something that all nursing homes we are using this EHR is struggling with whether it's to meet payroll, whether it's to bill correctly, this is something that we need to have clarity.

Valeri Ritter: Right, understood, and I just don't want to give you an answer off the cuff. So, if you could send that question in directly through the ODF and I will research that for you and get back to you.

Meir Waxman: Sure, and is that the email that was posted on the chat?

Valeri Ritter: That's correct.

Meir Waxman: Will do. Thank you so much.

Karen Mohr: Joel VanEaton, you may unmute and ask your question.

Joel VanEaton: Thank you so much for taking my second question. I never assumed I would get back in the queue that quickly. So I have a question and this may be one too for the email, but 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. Thank you.

Kim Jasmin: Hi, Joel, this is Kim Jasmin again. Unfortunately, we don't have the right people here on the line that can address your question. So, if you could send your specific question to the ODF email box, that would be great.

Joel VanEaton: Will do. Thank you so much.

Karen Mohr: Cindy Hudson, you may unmute and ask your question.

Cindy Hudson: Ok. Thank you so much. 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. So, if you could explain, I would appreciate it.

Kim Jasmin: Sounds like we may not have the right people on the line to address your question. Again, if you could send your questions to the ODF mailbox, please.

Cindy Hudson: Ok. Thank you.

Karen Mohr: Jane Schoof, you may unmute and ask your question.

Jane Schoof: Hello, can you hear me, ok?

Karen Mohr: Yes, we hear you.

Jane Schoof: Ok. 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.

Kim Jasmin: Hi, Jane. This is Kim again. Sorry to sound like a broken record here but of course we don't have the right people on the line to discuss the policy questions that you're addressing. So, if you could send it to the email box ODF, that would be great.

Jane Schoof: Ok. Thank you. 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?

Kim Jasmin: Jane, sorry, can you send that to the mailbox, please?

Jane Schoof: Sure. Thank you.

Karen Mohr: All right. Avery, you may unmute and ask your question.

Avery Malate: Hello, can you guys hear me?

Karen Mohr: Yes, we can.

Avery Malate: Thank you for taking my question. I have two questions. Actually. The first one is about the MDS error message user guide. Is iQIES or CMS planning to release that? Because I know that the updated version is currently, I think April of year? Hello?

Kim Jasmin: Could you repeat your question once more, please.

Avery Malate: 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?

Kim Jasmin: Yeah, sorry about that. I was trying to unmute my line. Yes, this is Kim Jasmin, 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.

Avery Malate: Got it. Thank you. 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.

Kim Jasmin: Avery, can you send your questions to the ODF mailbox so we can review and address your issue?

Avery Malate: I did. I'm still waiting for a response.

John Kane: Actually, if it's an issue related to how the grouper is calculating and I can put this into the chat, 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.

Avery Malate: All right. Thank you, John.

Karen Mohr: Katie, you may unmute and ask your question. Katie Slier, you may unmute and ask your question. You may be double muted. So, you might try to unmute your device. I will circle back to you in just a moment. Esther Olshin, you may unmute and ask your question.

Esther Olshin: Thank you for taking my call. So, 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?

John Kane: Are you talking about when you're using vendor software, or are you talking about—

Esther Olshin: Yes, 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.

Kim Jasmin: Esther, this is Kim—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.

Esther Olshin: Right. Right. So currently it seems like all the vendors are having issues, no one is able to get proper HIPPS and codes, so we are going to be out of compliance. So, is there anything that we can do better or is there any guidance that CMS can give us about this? Is there any alternative?

Kim Jasmin: Yeah, the only thing I could think of, Esther, is that since it's a vendor software issue, is that you contact your software vendor directly.

Esther Olshin: Ok. Thank you.

Karen Mohr: Katie Slier, you may unmute and ask your question. I'm sorry, we're still unable to hear you at this time. We'll try to circle back, Katie.

Katie Slier: Hello, can you hear me?

Karen Mohr: We hear you, yes.

Katie Slier: Ok, I am so sorry about that. Thank you for taking my call, I appreciate it. 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?

Kim Jasmin: Katie, can you send your question to the ODF mailbox for one of us to address?

Katie Slier: Yes, absolutely. Thank you.

Kim Jasmin: Thank you.

Karen Mohr: Janet Hobbs, you may unmute and ask your question.

Janet Hobbs: Hi. Thank you for taking my call. I am just building on what Stacy had asked earlier 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?

Kim Jasmin: Yeah, that sounds like another policy question. Unfortunately, the policy folks are not on the line with us today. So, if you could send that to the ODF mailbox, that would be great.

Janet Hobbs: Thank you.

Karen Mohr: Jordan, you may unmute and ask your question.

Jordan Tjaden: Hello. Thank you for taking my question. Mine 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.

John Kane: Hi, this is John Kane. Unfortunately, we don't have anyone on the call from our Part C side that would be able to speak to anything in relation to Medicare Advantage or private plans. If you want to send it to our ODF mailbox, we can send it to one of our Part C colleagues, but unfortunately, we don't have anyone on the call to address that.

Jordan Tjaden: Understand, thank you.

Karen Mohr: Terry Raser, you may unmute and ask your question.

Terry Raser: My question’s been answered. Thank you.

Karen Mohr: Thank you. Sorah Levy, you may unmute and ask your question.

Sorah Levy: Hi. Thank you for taking my 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 [inaudible]—or something else.

Kim Jasmin: That sounds like another question that you should submit to the ODF mailbox.

Sorah Levy: Thank you. And my follow-up question based on attending some of the more recent calls, especially with the changes on behalf of many of the people that are on this call, could there be someone to answer these questions live for the next Open Door Forum, please?

John Kane: Yeah. Sorry. I was getting off mute. Yes, no, unfortunately one of the main people that we have that does the MDS policy side was sick today and wasn't able to attend today. So that's part of the reason that we're having to hedge a number of different questions that are coming in. So, typically, we try to make sure that each of the different areas of policy are represented on the call. And so, we apologize that we're not able to address some of those questions today, but we'll definitely try to make sure that we have people representing each of those areas in the future.

Sorah Levy: Thank you.

Karen Mohr: Carol Maher, you may unmute and ask your question.

Carol Maher: Yes, 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?

Christine Teague: Hi, Carol, this is Christine Teague. So, 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.

Carol Maher: So, they will have to answer the respiratory and psychological therapy question even if that's not what they were modifying. Is that what you're saying?

Christine Teague: Correct, correct.

Carol Maher: Ok, thank you.

Christine Teague: Yeah, if it was required for that assessment originally, yes.

Carol Maher: Ok. And do you have any guidance for what they should be answering to get the—is it ok to dash that little question to get the MDS to close? Because it's not accurately allowing us to answer the question.

Christine Teague: I would have to review the data specifications. So, if you could send that question in through the SNF ODS email, we can get back to you on that. I'd have to look. I don't know the specifications for each item.

Carol Maher: Ok. Thank you.

Karen Mohr: Elizabeth Gaffney, you may unmute and ask your question.

Elizabeth Gaffney: Thank you. 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.

John Kane: So, I can't speak—there's a lot of details in that, and I can't speak specifically to how this would impact a particular beneficiary. 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.

Elizabeth Gaffney: [Inaudible]. Yes, we were just looking for further guidance just because we have not been successful in working with the MAC. I mean, we've spent hours and just keep on getting the same response that the benefit's exhausting. Is there an email or somebody else I could reach out to look into this matter for us?

John Kane: So, you can email it to me if you'd like, and we can take a look at it. But again, it's difficult for us to adjudicate a specific case as it relates to a particular beneficiary as opposed to being able to speak just globally to the manner in which the PHE ended and how the policies were impacted.

Elizabeth Gaffney: Ok. Thank you.

Karen Mohr: Yasa Unger, you may unmute and ask your question. We're unable to hear you at the moment. We'll circle back around. Susan Battaglia, you may unmute and ask your question. Ok. Susan Battaglia, you may unmute. For those asking questions, make sure your device is unmuted and then make sure that Zoom is unmuted. I'll circle back around to see if we can catch your question in a moment. Yasa Unger, you may unmute and ask your question. All right. Continuing on, we'll go to Thomas Kress. You may unmute and ask your question.

Thomas Kress: Good afternoon. Apologies, my hand raise was a mistake. Thank you.

Karen Mohr: Thank you for that. Joe, you may unmute and ask your questions.

Joe Pioppi: Hi, 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?

John Kane: Yes, the ones that are on the website currently are representative of the correct values.

Joe Pioppi: All right. Thank you.

Karen Mohr: Holly Arnold, you may unmute and ask your question.

Holly Arnold: Yes, I see that Jill had posted that the Q and As, because I believe all of us need answers to those, where would that actually be posted?

Jill Darling: It will be posted on the CMS podcast and transcript webpage. You can Google it. And it will be listed under the Skilled Nursing Facilities Long-Term Care Open Door Forum heading. You just have to scroll down, and it will be posted. You got to give us like more than a week, maybe two weeks so we can get these answered along with getting the transcript edited as well.

Holly Arnold: Ok. Thank you very much.

Jill Darling: You're welcome.

Karen Mohr: Eleisha Wilkes, you may unmute and ask your question.

Eleisha Wilkes: Thank you. 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? Thank you.

John Kane: I'm sorry. Is it the HIPPS calculation for what type of patient?

Eleisha Wilkes: So, for example, the Medicare Advantage, Medicare Part C, where they request the PDPM HIPPS, obviously, we know that those cannot be submitted.

John Kane: Right. So, 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.

Eleisha Wilkes: Understood. Thank you.

John Kane: Karen, just before we get to the next question, I just wanted to take a moment because I was thinking back over some of the questions that came up earlier with regard to discrepancies with what is provided on the Final Validation Report versus what is being calculated by vendor software and I was having trouble remembering the exact reference, and I was able to find it. I'd refer everyone to Chapter 6 of the Claims Processing Manual, specifically Section 30.1, where it states the following: “SNFs that submit claims that have not completed this process will not be paid. It is important to remember that the record will be accepted into the State RAI database, even if the calculated RUG (Resource Utilization Group) code differs from the submitted values. The error will be flagged on the Final Validation Report by issuing a warning message and listing the correct RUG code. When such discrepancies occur, the RUG code reported on the Final Validation Report shall be used for billing purposes.” I hope that this helps to address some of those earlier questions in regard to when there is a discrepancy between what the vendor software is calculating versus what is being provided on the Final Validation Report. Our Claims Processing Manual states clearly that the code that is provided on the Final Validation Report is the one that ought to be used. So, hopefully, that helps a little bit.

Karen Mohr: Ok. We have time for just a couple more questions. [Inaudible], you may unmute and ask your question.

Jill Darling: Karen, this will be our last question.

Karen Mohr: Thank you. [Inaudible], you may unmute and ask your question. All right. Do you want to move on to the next?

Jill Darling: Yes.

Karen Mohr: Ok. Thank you. Last question. Genice you may unmute and ask your question.

Genice Hornberger: Hi, 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. Thank you.

Kim Jasmin: Hi, this is Kim Jasmin. 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.

Genice Hornberger: And I guess just a follow-up to that is certainly any update would be ideal if you would repost it. I know that probably is you know, a challenge to do, but more frequent communications would be better. Thank you.

Kim Jasmin: Thank you.

Jill Darling: All right. Well, thank you, everyone, for joining us today. We know there was some lag in some answers to questions, but we will get them. Like we mentioned in the chat, I will be putting together a Q and A document about questions asked today. Like I said, we need some time to get answers for those questions and also editing the transcript. So that will be posted on our CMS podcast and transcript web page. Again, thank you for joining us. And have a wonderful day. And this concludes today's webinar. Thank you.