Office of Medicaid Policy and Planning

MDS and Case Mix Index Supportive Documentation Manual

Myers and Stauffer LC
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Contents

1 REGULATORY REQUIREMENTS

INTRODUCTION

The Office of Policy and Planning (OMPP) contracted with Myers and Stauffer LC to develop a case mix reimbursement system for Indiana's Medicaid certified nursing facilities. The case mix system was implemented beginning with rates effective October 1, 1998. Regulations at 405 IAC 1-14.7 set forth the detailed rate calculation. A portion of the rate is adjusted based on the case mix of the residents in each facility, based on the specific clinical needs of the residents.

The source of the case mix rate element is the Minimum Data Set (MDS) which is transmitted electronically to the Internet Quality Improvement and Evaluation System (iQIES). Additionally, the OMPP contracted with Myers and Stauffer LC to perform clinical reviews of the documentation that supports the responses submitted by nursing facilities on the MDS assessment. This MDS and Case Mix Index Supportive Documentation Manual describes the process in which these MDS assessments are used to develop the case mix measure used in the reimbursement rate, as well as the documentation required to validate the MDS item responses.

SCHEDULE OF CASE MIX ADJUSTMENTS

The case mix reimbursement rates are adjusted semi-annually based on the change in the resident case mix of each facility according to the following schedules:

<table>
<tr><th>Completed, transmitted and accepted MDS assessments applicable to the Rate Period:</th><th>Rate Periods:</th></tr>
<tr><td>September 1 – November 30</td><td rowspan="2">July 1 – December 31</td></tr>
<tr><td>December 1 – February 28*</td></tr>
<tr><td>March 1 – May 31</td><td rowspan="2">January 1 – June 30</td></tr>
<tr><td>June 1 – August 31</td></tr>
<tr><td colspan="2">*February 29 in leap years</td></tr>
</table>

TIME-WEIGHTED CMI RESIDENT ROSTER

A Resident Roster is a list of residents for each Medicaid certified nursing facility, displaying each resident who resided in the nursing facility during the resident roster quarter based on MDS assessments and tracking records transmitted to the iQIES System and accepted by that system. Eligible MDS assessment and tracking records active during the quarter are assigned a case mix index for the period of the quarter the assessment and tracking record apply. From this information, a day-weighted case mix index is calculated for Medicaid, All, Medicare and Other residents in the facility.

2 TIME-WEIGHTED CMI RESIDENT ROSTER ELEMENTS

PDPM CLASSIFICATION MODEL

The system for grouping a nursing facility's residents according to their clinical and functional status identified from MDS data is the Patient Driven Payment Model (PDPM) Classification Model. This classification system uses certain MDS data elements to place assessments into one of the Case-Mix groups across five components based on similar resource needs. The 5 PDPM components are Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), Nursing, and Non-Therapy Ancillary (NTA). For Indiana Case Mix reporting, only the Nursing component of the PDPM classification will be utilized. The responsibility for calculating the PDPM classification rests with OMPP or its designated contractor.

CASE MIX INDEX

The Case Mix Index (CMI) set is the standard nursing-only CMI set published by CMS for the PDPM Classification Model effective October 1, 2023. The days attributable to inactive (expired) assessments or tracking forms are categorized as BC1. The PDPM Classification Model utilizes a hierarchical classification methodology, in which assessments are classified into the highest ranked category based on the resident conditions and/or services coded.

PDPM Classification Table

The following tables list the possible PDPM classifications and CMIs that can be reflected on the Resident Rosters.

PDPM Nursing-Only Classification		CMI
Extensive Service		
ES3	Extensive Service	3.84
ES2	Extensive Service	2.90
ES1	Extensive Service	2.77
Special Care High		
HDE2	Special Care-High + Depressive Mood Symptoms	2.27
HDE1	Special Care-High	1.88
HBC2	Special Care-High + Depressive Mood Symptoms	2.12
HBC1	Special Care-High	1.76
Special Care Low		
LDE2	Special Care-Low + Depressive Mood Symptoms	1.97
LDE1	Special Care-Low	1.64
LBC2	Special Care-Low + Depressive Mood Symptoms	1.63
LBC1	Special Care-Low	1.35
Clinically Complex		
CDE2	Clinically Complex + Depressive Mood Symptoms	1.77
CDE1	Clinically Complex	1.53
CBC2	Clinically Complex + Depressive Mood Symptoms	1.47
CA2	Clinically Complex + Depressive Mood Symptoms	1.03
CBC1	Clinically Complex	1.27
CA1	Clinically Complex	0.89
Behavioral Symptoms & Cognitive Performance		
BAB2	Behavioral Symptoms & Cognitive Performance + 2 or more RN Programs	0.98
BAB1	Behavioral Symptoms & Cognitive Performance	0.94
Reduced Physical Function		
PDE2	Reduced Physical Function + 2 or more RN Programs	1.48
PDE1	Reduced Physical Function	1.39
PBC2	Reduced Physical Function + 2 or more RN Programs	1.15
PA2	Reduced Physical Function + 2 or more RN Programs	0.67
PBC1	Reduced Physical Function	1.07
PA1	Reduced Physical Function	0.62
BC1	Inactive / Expired (Delinquent)	0.59

IDENTIFICATION OF MDS ASSESSMENTS/RECORDS

The identification of the MDS assessments on the Resident Roster depends on the assessment coding at A0310A, B, and F as shown in the following tables. Only assessments or combinations of assessments listed below are considered for evaluation on the Time-weighted Resident Rosters. An assessment combined with a Part-A discharge assessment will still be evaluated on the Resident Roster, however, the response to A0310H will not be evaluated or impact the sequencing of assessments or assignment of payment source.

OBRA Assessments (A0310A)	MDS 3.0 Item Set Code (ISC)	OBRA MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Admission assessment	NC	01	99	99
Quarterly assessment	NQ	02	99	99
Annual assessment	NC	03	99	99
Significant change in status assessment	NC	04	99	99
Significant correction of prior full assessment	NC	05	99	99
Significant correction of prior quarterly assessment	NQ	06	99	99

PPS (Medicare) Scheduled Assessments (A0310B)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	Scheduled MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
5-day assessment	NP	99	01	99
Interim Payment Assessment	IPA	99	08	99

Discharge Assessments (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Discharge – return not anticipated assessment	ND	99	99	10
Discharge – return anticipated assessment	ND	99	99	11

MDS Tracking Forms (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Entry/Re-entry tracking	NT	99	99	01
Discharge – death in facility tracking	NT	99	99	12

A complete list of the Item Set Codes can be found in the RAI Manual in Chapter 2.

3 TIME-WEIGHTED CMI RESIDENT ROSTER DETAILS

DISTRIBUTION SCHEDULE

The Indiana Web Portal system (see Web Portal User Guide) is utilized to distribute Preliminary and Final Time-Weighted Resident Rosters each quarter for Medicaid certified nursing facilities. The Resident Rosters are copied to the Web Portal identified with file names indicating the resident roster quarter and the status of "Preliminary" or "Final." The following schedule is utilized.

Resident Roster Report Schedule	09/01 - 11/30	12/01 - 02/28	03/01 - 05/31	06/01 - 08/31
Preliminary Report Cutoff Date	12/01	03/01	06/01	09/01
Preliminary Report Posting Date	**12/10**	**03/10**	**06/10**	**09/10**
Final Report Cutoff Date	12/25	03/25	06/25	09/25
Final Report Posting Date	**01/15**	**04/15**	**07/15**	**10/15**

SELECTION OF RESIDENTS AND ASSESSMENTS/RECORDS

All residents that have been discharged prior to or on the first day of the resident roster quarter will not be listed on the Resident Roster. For example, if the resident is discharged prior to or on the first day of the quarter and does not return to the nursing facility before the end of the quarter, the resident will not be listed on the Resident Roster. All residents admitted during the quarter will be listed.

For each resident listed, assessment and tracking records are displayed in sequential date order. These assessment/records include the latest assessment or tracking record completed, transmitted, and accepted by the iQIES System on or prior to the beginning date of the quarter. Additionally, all eligible active assessments or tracking records completed during the quarter are displayed. The same information is listed for residents admitted during the quarter.

Note – Resident assessments and assessment corrections that have been transmitted and accepted by the iQIES system after the final report cutoff date will not be included in the Final Resident Roster.

Coordinated Universal Time (UTC) is the primary time standard globally used to regulate clocks and time. UTC is used by iQIES to determine the submission date of MDS assessments. The table below indicates the hour difference between each Indiana time zone and UTC. The equivalent time to the 11:59 PM submission cutoff is listed.

Time Zone	Hour Difference to UTC	Equivalent Time at 11:59 PM UTC
Eastern Standard Time (EST)	-5	6:59 PM EST
Eastern Daylight Time (EDT)	-4	7:59 PM EDT
Central Standard Time (CST)	-6	5:59 PM CST
Central Daylight Time (CDT)	-5	6:59 PM CDT

Myers and Stauffer is provided with the MDS assessment submission dates from iQIES based on UTC time and must use these dates in their calculations for determining whether assessments have been submitted timely on or prior to the data cut-off for a reporting period

Providers may wish to review their submission practices to ensure that MDS submissions are submitted at least one day prior to the reported data cut-off dates in the monthly roster report calendar to ensure assessments are evaluated for the roster versions in question.

RESIDENT ROSTER FORMAT

MDS Resident Identifiers

CMS identifies residents in the iQIES system based on the identifiers listed below. The State Patient ID is assigned by the iQIES System based on first name and last name, Social Security Number, sex, date of birth of the resident and is identical to the Resident ID displayed on the facility MDS 3.0 NH Final Validation Report from CMS. Residents identified on the Roster Report, using the information coded on the MDS assessment at the record location in the following table, are uniquely identified by the State Patient ID. **Any inaccuracies of these identifiers submitted on the MDS may result in assessments being displayed incorrectly on the Roster Report.**

MDS 3.0 Location	Description
A0500A	First name
A0500C	Last name
A0600	Social Security Number
A0810	Sex
A0900	Birth Date
Assigned by iQIES System	**Resident ID on Roster (State Patient ID in iQIES)**

Resident Roster Elements

Assessments and tracking records are listed on the Resident Roster with the following information:

Record Information	Description
Resident Name	Legal name of resident as submitted on the MDS assessment (A0500).
Record Type	Determined from MDS values at A0310 A, B, F.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600).
PDPM Classification	An assessment assigned one of the PDPM Nursing classifications.
Start Date	Calculated from: ▪ a date within the record, or ▪ a date within the preceding record, or ▪ start date of the quarter.
Start Date Field	The MDS item location where the Start Date was obtained, if the date was obtained from the displayed MDS assessment.
End Date	Calculated from: ▪ a date within the record, or ▪ a date within the following record, ▪ the last date the record is active, or ▪ the end date of the quarter.
Days	Calculated as the number of days between the Start Date and End Date, if any.
Case Mix Index	A numerical score assigned to each of the PDPM Nursing classifications.
Payment Source	Determination of Payment Source; Medicare, Medicaid, or Other.

Resident Roster Summary Page

The last page of the Resident Roster includes a summary of the total number of days for each of the PDPM classifications, the calculated number of CMI points for Medicaid and All Residents and the day-weighted CMI average for Medicaid, Medicare, Other and All residents.

CALCULATION OF DAYS

The following general rules determine the days counted for each resident assessment. Transmission of appropriate assessments in expected sequential order and coded with accurate dates will result in an accurate count of days.

General Resident Roster Rules

A. Inactivated assessments (A0050 = 3) are not considered in the creation of the Resident Roster if transmitted and accepted as of the cutoff date of the Resident Roster.

B. Modified assessments (A0050 = 2) with the highest Correction Number (X0800) as of the cutoff date is considered.

C. For purposes of the Resident Roster process, the following types of assessment combinations are used only to obtain discharge dates (A2000) and/or discharge status (A2105).

MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
ND	99	99	10, 11
NT	99	99	12

D. The calculation of days includes the day of admission. The day of discharge is not included.

E. Days are counted from the entry date, if entered the facility during the quarter, the first day of the quarter until either the assessment reference date (A2300) of the next assessment, the end of the quarter or until discharged (day of discharge not included), whichever comes first, unless the maximum number of days for the assessment has been reached.

F. Days covered by temporary home visits, temporary therapeutic leave and hospital observational stays of less than 24 hours, where the hospital does not admit the resident, are included in the count of days since CMS does not require a discharge assessment to be completed.

Required Submission PDPM Item Sets

G. Providers are required to complete all MDS item set fields associated with PDPM on all OBRA nursing facility (NF) assessments. The state specifically requires (in addition to the federally required PPS admission assessment) facilities to complete the following 3 MDS items:

1. I0020: Indicate the resident's primary medical condition category
2. J2100: Recent Surgery Requiring Active SNF Care
3. O0400D: Respiratory Therapy

Failure to complete these items will result in an inaccurate nursing-only PDPM classification or will be categorized as BC1 due to the inability to classify the assessment or tracking form. This specifically includes skip pattern coding at the I0020 and I0020B items.

Inactive / Expired (Delinquent) Assessment

H. CMS requirements allow no more than 92 days between assessments. For purposes of Indiana Medicaid reimbursement only, each assessment is considered active for a maximum of 113 days, measured from the target date. An assessment that is not followed by any other assessment or Discharge assessment or Death in Facility tracking form within 113 days of the preceding record's assessment reference date will have inactive days counted for that assessment after day 113. The assessment is then considered an inactive assessment (or expired). During the inactive period following an expired assessment (beginning on day 114) until the start of the next assessment (A2300), the end of the quarter, or a discharge assessment, days are counted at the inactive PDPM classification BC1 and assigned associated CMI as detailed previously in the PDPM Classification Table.

In this example, the first Quarterly assessment was transmitted with the following:

- Assessment reference date (A2300) 10/14/2025

The subsequent Quarterly assessment was transmitted with the following:

- Assessment reference date (A2300) 02/25/2026

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/99	10/14/2025	CDE2	12/01/2025		02/03/2026	65	1.77	Medicaid
NQ/02/99/99	10/14/2025	BC1	02/04/2026		02/24/2026	21	0.59	Medicaid
NQ/02/99/99	02/25/2026	CDE2	02/25/2026	A2300	02/28/2026	4	1.77	Medicaid
					Total Days	90		

Counting 113 days from the A2300 date (10/14/2025) of the first Quarterly assessment results in 02/03/2026, meaning the active days covered by the first Quarterly assessment end on this date. From the 114th day (02/04/2026) until the day prior to the A2300 date of the next Quarterly assessment (02/25/2026), the days are counted at the inactive PDPM classification BC1. The days from the second Quarterly assessment count from the ARD (02/25/2026) until the end of the quarter.

Late Admission Assessment

I. CMS requirements allow no more than 14 days between the admission entry date (A1600 when A1700=1, Admission) and the Admission assessment reference date (A2300). For purposes of Indiana Medicaid reimbursement, when there are more than 14 days, the admission entry date is used to begin counting days for the Admission assessment up to a maximum of 14 days. Any remaining days beginning on day 15 through the day prior to the assessment reference date (A2300) of the Admission assessment will result in the inactive PDPM classification BC1.

In this example, Entry Tracking record was transmitted with the following:

- Entry date (A1600) 06/12/2025 with the A1700 = 1

The Admission assessment was transmitted with the following:

- Assessment reference date (A2300) 01/24/2026
- Entry date (A1600) on Admission assessment 06/12/2025

A Discharge assessment was transmitted with the following:

- Discharge date (A2000) 02/12/2026

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	PDPM CMI	Payment Source
NT/99/99/01	06/12/2025	BC1	12/01/2025		01/23/2026	54	0.59	Medicaid
NC/01/99/99	01/24/2026	CBC2	01/24/2026	A2300	02/11/2026	19	1.47	Medicaid
ND/99/99/11	02/12/2026		02/12/2026	A2000	02/12/2023			
					Total days	73		

Inactive days begin at the start of the quarter (12/01/2025) because the entry date (06/12/2025) is greater than 14 days prior to the assessment reference date (01/24/2026) of the Admission assessment. Days begin counting on the assessment reference date (01/24/2026) of the Admission assessment through the day prior to the discharge date (02/12/2026).

Entry Tracking Record

J. If an Entry Tracking Form is not preceded by an active assessment for a new stay in the facility and is followed by a Discharge assessment or Death in Facility Tracking Form, the PDPM classification will automatically be assigned as follows for the days starting from the entry date (A1600 when A1700=1) to the day prior to the discharge date (A2000) up to a maximum of 14 days:

- **LBC2** – when discharge status was deceased (A2105 = 13) or discharged to a hospital or inpatient rehabilitation setting (A2105 = 04, 05, 06 or 11).
- **CBC2** – when discharge status was other than death or discharge to a hospital or inpatient rehabilitation setting (A2105 = 01, 02, 03, 07, 08, 09, 10, 12 or 99).

In this example, the Entry Tracking record was transmitted with the following:

- Entry date (A1600) 12/25/2025 with A1700 = 1, Admission

The Discharge assessment was transmitted with the following:

- Discharge date (A2000) 01/07/2026
- Discharge status was deceased (A2105 = 13, deceased)

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	PDPM CMI	Payment Source
NT/99/99/01	12/25/2025	LBC2	01/01/2026		01/06/2026	6	1.63	Medicaid
NT/99/99/12	01/07/2026		01/07/2026	A2000	01/07/2026			
					Total Days	6		

When an Entry Tracking record is the first and only record for a new admission that is followed by a Discharge assessment, the PDPM classification and associated CMI (either LBC2 or CBC2) are based on the discharge status (A2105). In this example, the discharge status is deceased (13); resulting in a PDPM classification of LBC2. The Entry Tracking record must be coded A1700 = 1, Admission.

A2105 Discharge Status Key

01. Home/Community
02. Nursing Home
03. Skilled Nursing Facility / Swing Bed
04. Short-Term General Hospital
05. Long-Term Care Hospital
06. Inpatient Rehabilitation Facility
07. Inpatient Psychiatric Facility
08. Intermediate Care Facility
09. Hospice (Home/Non-Institutional)
10. Hospice (Institutional Facility)
11. Critical Access Hospital
12. Home (Home Health Care)
13. Deceased
99. Not Listed

K. Entry Tracking records are required to be submitted for each entry or reentry into the nursing facility. The entry date (A1600) indicates the exact date of entry and is used to begin the counting of days. However, the Entry Tracking record is not an assessment and therefore is unable to be classified.

In this example, a Quarterly assessment prior to the start of the quarter was followed by a Discharge assessment (return anticipated). Later, an Entry Tracking record was submitted followed by an Admission/5-day PPS assessment with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 11/15/2025

Discharge assessment:

- Discharge date (A2000) 12/06/2025

Entry Tracking record:

- Entry Date (A1600) 02/01/2026 with A1700 = 1, Admission

Admission/5-day PPS assessment:

- Assessment Reference Date (A2300) 02/13/2026 and the entry date (A1600) 02/01/2026

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	PDPM CMI	Payment Source
NQ/02/99/99	11/15/2025	LDE1	12/01/2025		12/05/2025	5	1.64	Other
ND/99/99/11	12/06/2025		12/06/2025	A2000	12/06/2025			
NT/99/99/01	02/01/2026		02/01/2026	A1600	02/01/2026			
NC/01/01/99	02/13/2026	LDE2	02/01/2026	A1600	02/28/2026	28	1.97	Medicare
					Total Days	33		

Days begin counting for the Quarterly assessment on the first day of the quarter through the day prior to the discharge date (12/06/2025). The Entry Tracking record is transmitted followed by an Admission/5-day assessment which begins counting at the entry date (02/01/2026), through the end of the quarter. The Entry Tracking record must be coded A1700 = 1, Admission. Note that no days are assigned to the Entry Tracking record but instead the entry date (02/01/2026) is assigned to the days counted for the Admission/5-day assessment as noted in the “Start Date Field” column.

L. If the Entry Tracking record (denoted as a reentry/A1700=2) is not followed by an assessment, but is preceded by an assessment that is active, the remainder of the active days from the preceding assessment is used for the count of days starting at the entry date (A1600).

In this example, a Quarterly assessment completed prior to the quarter was followed by a Discharge assessment (return anticipated). Later, an Entry Tracking record was submitted but was not followed by an assessment. Assessments/tracking records were transmitted with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 11/30/2025

Discharge assessment:

- Discharge date (A2000) 12/06/2025

Entry Tracking record:

- Entry Date (A1600) 12/15/2025 with A1700 = 2, Reentry

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	PDPM CMI	Payment Source
NQ/02/99/99	11/30/2025	LBC2	12/01/2025		12/05/2025	5	1.63	Medicaid
ND/99/99/11	12/06/2025		12/06/2025	A2000	12/06/2025			
NT/99/99/01	12/15/2025	LBC2	12/15/2025	A1600	02/28/2026	76	1.63	Medicaid
					Total Days	81		

The Entry Tracking Form is transmitted but is not followed by an assessment. Since there is no new assessment within 14 days from the reentry date A1600 (12/15/2025), the PDPM classification is taken from the preceding active assessment and applied to the Entry Tracking Form period. The Entry Tracking form must be coded A1700 = 2, Reentry.

Missing or Expected Order of Assessments

M. When an Admission assessment is preceded by an active assessment, the days counted for the Admission assessment begin from the assessment reference date (A2300) on the Admission and not the entry date (A1600).

In this example, a Quarterly assessment was followed by an Admission assessment with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 11/15/2025

Admission/5-day Medicare assessment:

- Assessment Reference Date (A2300) 01/21/2026 including an entry date (A1600) 01/10/2026

Record Type	Target Date	PDPM Class	Start Date	Start Date Field	End Date	Days	PDPM CMI	Payment Source
NQ/02/99/99	11/15/2025	LBC1	12/01/2025		01/20/2026	51	1.35	Medicaid
NC/01/01/99	01/21/2026	HDE1	01/21/2026	A2300	02/28/2026	39	1.88	Medicare
					Total Days	90		

An Admission assessment should only be completed on admission and should not immediately follow another PDPM assessment. This is considered “Out of Expected Order of Assessments”.

DETERMINATION OF PAYMENT SOURCE

The payment source (Medicaid, Medicare or Other) identified on the Resident Roster is determined by the assessment as follows:

Medicare Payment Source Determination

- All assessments with a PPS reason for assessment in MDS item A0310B = 01 (PPS 5-day) will be assigned a Medicare payment source for the duration of the assessment. Assessments with a non-PPS reason for assessment where assessment information indicates that the Medicare stay is still active as of the target date of the record are identified as Medicare Payment source.
- All assessments with an OBRA Admission reason for assessment in MDS item A0310A = 01 (OBRA Admission) where the Medicare stay has not ended prior to the A1600 date will be assigned a Medicare Payment Source for the duration of the assessment.
- Any other assessment type where the Medicare stay has not ended prior to the ARD will be assigned a Medicare Payment Source up to the end date of the Medicare stay. Following the end of the Medicare stay, the payment source will be evaluated for the Medicaid and Other payment source criteria.

Medicaid Payment Source Determination

- All assessments with A0310A = 01 (OBRA Admission) where the Medicare stay has ended prior to the A1600 date or is not associated with a Medicare stay, or non-Admission assessments following the end of a Medicare stay and where MDS item A0700 (Medicaid Number) of the assessment is submitted with a valid recipient Medicaid number are counted as Medicaid payment source.
- A valid Medicaid recipient number is as follows:
    - a twelve (12) digit number, beginning with a ten (10) or beginning with a twelve (12) and ending with a ninety-nine (99)
    - + (plus) indicates Medicaid Pending

Other Payment Source Determination

- Any assessment(s) not identified as Medicare or Medicaid are assigned as “Other” payment source on the detail pages of the Resident Roster.

REVIEW OF PRELIMINARY RESIDENT ROSTER

The Preliminary Resident Roster is provided as a tool for use by the facility in determining whether any missing or incorrect assessments/records are noted and allows the facility a review period to evaluate assessment/records displayed on the roster. All corrections to the Preliminary Resident Roster for MDS assessments and tracking records must be made through the modification, inactivation and transmission process in accordance with the RAI manual (Chapter 5) and CMS correction policy. All corrections must be made on or before the cutoff date of the Final Resident Roster CMI report; no manual alterations of the Resident Roster are considered.

In reviewing the Preliminary Resident Roster, the following steps are suggested, but not limited to:

- Determine if all residents in the facility at any time during the quarter are listed on the Resident Roster.
- Determine if each resident is identified only once. If the same resident appears as if they were two separate residents, contact the RAI Coordinator or State Automation Coordinator to merge resident assessments and follow up with the Myers and Stauffer Help Desk.
- Review the listed assessments and tracking forms for each listed resident to determine if each assessment/tracking form is accounted for on the Resident Roster.
- Review the start date and end date for accuracy.
- Determine if each Medicaid resident is correctly identified as Medicaid for any non-PPS assessment days by reviewing MDS item A0700 Medicaid Number.
- Review any BC1 PDPM classifications and, if appropriate, submit any completed missing assessments or tracking forms or complete any modifications of previously transmitted records, when applicable, to correct the reason causing the BC1 PDPM classification assignment.
- Review the PDPM classification attributed to Entry Tracking Forms followed by a Discharge assessment for accuracy of the discharge status (A2105).
- Keep in mind, missing or corrected (if applicable) assessments that have been transmitted and accepted after the cut-off date(s) will not be reflected on the Resident Roster (both preliminary and final).
- Review for missing or corrected (if applicable) assessments that may have been transmitted and not accepted by the iQIES system. Review the CMS Validation report for errors; make corrections and retransmit, if applicable.
- Review for accuracy of dates and or reasons for assessment by following the RAI manual instructions for modifications and inactivations in Chapter 5.
- Review the type of Entry Tracking form (A1700=1, Admission or A1700=2, Reentry) to ensure that the reason fits the expected order of assessments/tracking forms displayed.

Any corrections including transmissions must be completed by the predetermined cutoff date for the quarterly Final CMI Resident Roster report.

SUMMARY RESIDENT ROSTER CMI CALCULATION

The day-weighted calculations are completed for the facility on the summary page of the Resident Roster. The CMI averages are calculated for Medicaid, Medicare, Other and All residents quarterly.

The calculated days from the detail pages of the Resident Roster for each source of payment are summed by PDPM classification. For each PDPM classification, the assigned CMI is multiplied by the total number of days to arrive at CMI points. The sum of all of the CMI points divided by the sum of all days is the day weighted average for the payment source.

The Final CMI Resident Roster report averages are used in the determination of the facility's annual normalized cost per patient day and periodic Medicaid CMI rate adjustment.

FACILITY AVERAGE ALL RESIDENT CMI CALCULATION FOR NORMALIZATION PROCESS

The annual average CMI for all residents is determined by calculating the total days and total CMI points for all residents for the resident roster report periods that align with the cost report begin and end dates. This CMI is utilized in the cost normalization process.

As defined in the table below, for a provider's cost report beginning in the month referenced in column a, the reporting quarters used for determining a facility's CMI will begin with the corresponding reporting quarter referenced in column b. The reporting quarters used in determining the facility's CMI will include reporting quarters through the provider's cost report ending in the month referenced in column c, with the corresponding reporting quarter referenced in column d.

Cost Report Begin Date	Beginning Reporting Quarter to Determine CMI		Cost Report End Date	Ending Reporting Quarter to Determine CMI
(a)	(b)		(c)	(d)
January Year 1	March – May Year 1		January Year 1	December – February Year 1
February Year 1	March – May Year 1		February Year 1	December – February Year 1
March Year 1	March – May Year 1		March Year 1	March – May Year 1
April Year 1	June – August Year 1		April Year 1	March – May Year 1
May Year 1	June – August Year 1		May Year 1	March – May Year 1
June Year 1	June – August Year 1		June Year 1	June – August Year 1
July Year 1	September – November Year 1		July Year 1	June – August Year 1
August Year 1	September – November Year 1		August Year 1	June – August Year 1
September Year 1	September – November Year 1		September Year 1	September – November Year 1
October Year 1	December – February Year 2		October Year 1	September – November Year 1
November Year 1	December – February Year 2		November Year 1	September – November Year 1
December Year 1	December – February Year 2		December Year 1	December – February Year 2

4 SUPPORTIVE DOCUMENTATION REQUIREMENTS

INTRODUCTION

Accuracy of the MDS item responses is very important. While its primary purpose as an assessment tool is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, various State Medicaid reimbursement systems, and for monitoring the quality of care provided to nursing home residents.

These Supportive Documentation Requirements apply to all Indiana Medicaid-certified nursing facilities and are applicable to all MDS assessments with an Assessment Reference Date (ARD) of June 1, 2026 and later.

SOURCE OF DOCUMENTATION REQUIREMENTS

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. Good clinical practice is an expectation of CMS. As such, 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. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes.

The information in these Requirements has been compiled in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS 3.0 form itself, and the Data Submission Specifications for MDS 3.0. Nursing facility personnel should review these resources thoroughly to accurately understand MDS coding and meet all requirements. If later guidance is released by the Centers for Medicare & Medicaid Services (CMS) that contradicts or augments guidance provided in this document, this more current information from CMS becomes the minimum acceptable standard.

MDS ITEMS FOR REVIEW

While thorough documentation and accurate coding of the MDS is essential for all MDS item responses, the Patient Driven Payment Model (PDPM) classification system uses only a subset of the MDS assessment items; those that may have an impact on your facility's rate. As such, these Requirements identify only those MDS items used in the PDPM system.

OVERALL DOCUMENTATION INSTRUCTIONS

The Assessment Reference Date (ARD) designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time. The look-back period includes observations and events through the end of the day (midnight) of the ARD. Anything that happens after the ARD will not be captured on the MDS assessment.

All conditions or treatments must have been present or occurred within the designated observation or look-back period, which includes the full 24 hours of the Assessment Reference Date (ARD) located at MDS Section A2300. The ARD is defined in Section A of the RAI Manual as the specific end point for look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the ARD. Unless otherwise noted on the MDS form, this look-back period, also called the observation period or assessment period, is a 7-day look-back period ending on the ARD. Thus, look-back periods covering 7 days end on this date, 14 days end on this date, etc. Some assessments may have an observation period less than 7 days (such as a Medicare 5-day assessment) however; the ARD is always the end point for the observation period.

Documentation in the clinical record should consistently support the MDS item response and reflect care related to the symptom/problem. Documentation must apply to the appropriate look-back period and reflect the resident's status on all shifts. Documentation from all disciplines and all portions of the resident's clinical record within the look- back period may be used to verify an MDS item response. Conflicting documentation identified within the observation period shall be deemed as unsupported documentation.

All services provided should be necessary and appropriate for each resident as indicated in the RAI. Documentation appearing to be for reimbursement purposes only will be reported to the Office of Medicaid Policy and Planning and may not be accepted during an MDS Documentation Review.

Examples: A dementia resident may experience sundowning, exhibiting a change in cognition, behavior, and physical function over the course of the day. A dialysis resident may experience weakness or lethargy after treatment. Given the verbiage, a reviewer would consider variance in documentation as conflicting and deem the record unsupported, despite the documentation being a clear picture of the resident's status across shifts.

Signature Requirements

Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all clinical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS).

When electronic signatures are used, there must be a written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs and must include safeguards to prevent unauthorized use of electronic signatures.

Corrections

In cases of corrections, obliterations, errors or mistaken entries, the author of the original entry, at a minimum, draws a line through the incorrect information and includes the author's initials, the date the correction was made and the corrected information.

The expectation of the OMPP is that nursing facilities maintain and have readily available supporting original legal medical record documentation to include access to electronic medical records. All MDS PDPM items require supporting documentation as outlined in the Supportive Documentation Requirements User Guide.

Z0400 Requirements

Z0400 requires the **Signature, Title, Sections and Date Section Completed** by each person who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

Z0400 certification reads as follows:

"I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment for such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

Penalties may be applied for submitting false information.

Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a subset of items within a section should identify which item(s) he/she completed within that section.

5 SUPPORTIVE DOCUMENTATION REQUIREMENTS TABLE

REQUIREMENTS TABLE EXPLANATION

The Supportive Documentation Requirements table contains a header per section as well as three columns described below. Each section header also identifies that section's look-back period (7-day look-back, 14-day look- back, etc.).

MDS 3.0 Item Location and Item Description

This column identifies the MDS 3.0 item location by section letter, item number and the description of the MDS item. A notation of Cognitive Performance Scale (CPS) or the Brief Interview for Mental Status (BMIS) indicates the MDS item is associated with the BIMS severity score A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing programs in the PDPM system.

PDPM Categories Impacted

This column identifies any PDPM group(s) impacted by the MDS item. Additionally, there may be informational data in a particular area denoted by *Informational Only*.

Minimum Documentation and Review Standards Required Within the Specified Observation Period

This column provides an overview of the requirements for minimum documentation required to support the MDS responses. The column may also contain additional information that may aid the user in correctly providing supporting documentation for the MDS item.

All federal requirements must be met. In addition, state requirements may be more stringent and will supersede the federal requirements for the Resident Assessment Instrument and its components. It is the responsibility of the provider to be in compliance with both the federal and state requirements.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section B: Hearing, Speech, and Vision (7-day look back)		
B0100 Comatose (CPS)	*~Special Care High* *~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • All components of the nursing function score must = 1, 9, or 88. • Documentation of active diagnosis of coma or persistent vegetative state documented by physician, physician assistant, nurse practitioner, or clinical nurse specialist if allowable under state licensure law. ***Does NOT include:*** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's).
B0700 Makes Self Understood (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of the resident's verbal and/or non-verbal ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, gestures or a combination of these. • Consistency between interdisciplinary team notes. ***Does include:*** • Reduced voice volume. • Difficulty in producing sounds. • Difficulty in finding the right word, making sentences, writing, and/or gesturing.
Section C: Cognitive Patterns *(7-day look back)*		
C0200 Repetition of Three Words (BIMS) **C0300 A, B, C** Temporal Orientation (BIMS) **C0400 A, B, C** Recall (BIMS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Validation of completion of interview items C0200, C0300A, B, C, C0400A, B, and C at Z0400 dated on or before the ARD and within the 7-day observation period.

C0700
Short-Term Memory
(CPS)
	~Behavioral Symptoms and Cognitive Performance	***Does require:***
		• Example(s) and date(s) documenting the resident's ability to:
		  ○ Describe an event 5 minutes after it occurred if the resident's response can be validated, OR
		  ○ Follow through on a direction given 5 minutes earlier.

C1000 Cognitive Skills for Daily Decision Making (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of the resident's actual performance documenting the degree of compromised daily decision-making about everyday decisions for tasks or daily activities. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g. clocks, calendars). • Seeking information from others to plan the day. • Acknowledging the need to use appropriate assistive equipment (i.e. walker). • Awareness of strengths and limitations to regulate the day's events. ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section D: Mood (14-day look back)		
D0150A-I, Column 2 Resident Mood Interview (Symptom Frequency)	*~Special Care High ~Special Care Low ~Clinically Complex*	***Does require:*** • Validation of completion of interview items D0150A - I at Z0400 dated on or before the ARD and within the 14-day observation period.
D0500A-J, Column 2 Staff Assessment of Resident Mood (Symptom Frequency)	*~Special Care High ~Special Care Low ~Clinically Complex*	***Does require:*** • Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations, and the frequency reported for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.
Section E: Behavior (7-day look back)		
E0100A Hallucinations	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of the resident's perception of the presence of something that is not actually there, OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a detailed description of the hallucination(s), per occurrence(s). ***Does include:*** • Auditory, visual or involving smells, tastes or touch.
E0100B Delusions	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary, OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a detailed description of the delusion(s), per occurrence(s). ***Does NOT include:*** • A resident's expression of a false belief when the resident easily accepts a reasonable alternative explanation. • A belief that cannot be shown to be false or is impossible to determine if it is false.
E0200A (code 2 or 3) Physical Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of resident's physical behavioral symptoms directed toward others, OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited physical behavioral symptoms directed toward others, including a detailed description of the physical behavioral symptoms directed toward others, per occurrence(s). ***Does include:*** • Hitting, kicking, pushing, scratching, grabbing, and abusing others sexually. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior *(7-day look back)*		
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of resident's verbal behavioral symptoms directed toward others; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited verbal behavioral symptoms directed toward others, including a detailed description of the verbal behavioral symptoms directed toward others, per occurrence(s). ***Does include:*** • Threatening others, screaming at others, cursing at others. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0200C (code 2 or 3) Other Behavioral Symptoms *not directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of resident's other behavioral symptoms NOT directed toward others, OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited other behavioral symptoms not directed toward others, others including a detailed description of the other behavioral symptoms not directed toward others, per occurrence(s). ***Does include:*** • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0800 (code 2 or 3) Rejection of Care	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's values, preferences or goals, OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited rejection of care, including a detailed description of rejection of care per occurrence(s). ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care including; verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care. • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level or intensity of resources that are usually available for the provision of care. ***Does NOT include:*** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior *(7-day look back)*		
E0900 (code 2 or 3) Wandering	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) and date(s) of resident's act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident was wandering, including a detailed description of wandering per occurrence(s). ***Does NOT include:*** • Pacing (repetitive walking in a driven/pressured quality) within a constrained space). • Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section GG: Functional Abilities and Goals Look-back period for Section GG (Admission) First three days of the stay. Look-back period for OBRA/Interim ARD plus 2 previous calendar days.		
GG0130A Self-Care: Eating Tube feedings and parenteral nutrition are not considered when coding this activity. **GG0130C Self-Care: Toileting Hygiene** Managing clothing and perineal cleansing that takes place before and after the use of the toilet, commode, bedpan or urinal. **GG0170B Mobility: Sit to Lying** The ability to move from sitting on side of bed to lying flat on the bed. **GG0170C Mobility: Lying to sitting on the side of the bed** The ability to move from sitting on the side of the bed and with no back support. **GG0170D Mobility: Sit to stand** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. **GG0170E Mobility: Chair/bed to chair transfer** The ability to transfer to and from a bed to a chair (or wheelchair). **GG0170F Mobility: Toilet transfer** The ability to get on and off a toilet or commode.	*~Extensive Services* *~Special Care High* *~Special Care Low* *~Clinically Complex* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation during the observation period to accurately capture the resident's **usual** performance. • Initials and dates to authenticate the medical record entries including signatures and titles to authenticate initials per episode occurrence. • The key for coding Section GG must include all the MDS options and be equivalent to the intent and definition of the MDS key. • Key definitions must align with the definition in the RAI manual and must be available to the RN Reviewer and understood by facility staff. • Self-Care and Mobility definitions must include all tasks and components related to the specific activity. • If using narrative notes to support Section GG, each occurrence must include the specific activity. Wording must be equivalent to MDS key definitions for example "The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident". • Facilities utilizing one designated documentation collection tool should note corrections or references to additional documentation on that tool. • During the IDT meeting, facilities should determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record. • All documentation to be considered for the review must be clearly identified and presented to the reviewer in an organized manner representing how the usual performance was determined. • Documentation must be maintained as part of the permanent original legal medical record and be readily accessible during the review. • Corrections must be made in accordance with the Medical Record Correction Policy. • Entries that do not have supporting documentation will be assigned a value representing "independent". ***Does NOT include***: • Individuals hired, compensated or not, by individuals outside the facility's management and administration. • Services provided other than by staff in the facility, such as family, hospice staff, nursing/CNA students and other visitors. • Use of a dash when other coding is applicable (07, 09, 10, 88). • Policies intended to be used to validate typed names/dates and/or e-signature/time stamps within supportive documentation.

DEFINITION OF USUAL PERFORMANCE:

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, **record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance but rather record the resident's usual performance**.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section H: Bladder and Bowel *(7-day look back)*		
H0200C Current Urinary Toileting Program or Trial (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of a trial of an individualized, resident-centered toileting program that includes at least 3 days of toileting patterns with prompting to toilet **and recorded results to the trial toileting program in a bladder record or voiding diary.** • Following program trial and response, documentation of a current toileting program being used to manage urinary continence must include: 1) implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern; 2) documentation that the individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and 3) documentation of the resident's response to the toileting program by a licensed nurse during the observation period. ***Does include:*** • Program if only used by day (when the resident does not want awakened at night). ***Does NOT include:*** • Less than 4 days of a systematic toileting program. • Simply tracking of urinary continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.
H0500 Bowel Toileting Program (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern; • Documentation that the individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and • Documentation of resident's response to the toileting program by a licensed nurse during the observation period. ***Does NOT include:*** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses (7-day and 60-day look back)		
Active Diagnosis Definition: A physician-documented diagnosis (Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) **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. Simply listing a disease/diagnosis on the resident's medical record problem list is not sufficient for determining active or inactive status. **There are two look-back periods for this section:** 1) Diagnosis identification (Step 1) is a 60-day look back period. 2) Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for I2300 UTI, which does not use the active 7-day look-back period). ***Does require:*** • *Physician (optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) documented diagnosis in the 60-day look-back period. (Physician signed/dated diagnosis within 60-day look-back).* • *Documentation supporting active diagnosis in the 7-day look-back period.* • *Documentation related to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.* ***Does include:*** • *Functional limitations* – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis. • *Nursing monitoring* – clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.). ***Does 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; these would be considered inactive diagnoses. **NOTE:** Diagnoses should be checked off in appropriate areas in items I0100 – I7900. If a disease or condition is not specifically listed in these areas, enter the diagnosis and ICD code in I8000, Additional active diagnosis.		
I2000 Pneumonia	~*Special Care High* ~*Clinically Complex*	See Active Diagnosis Definition. ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period. • Pneumonitis.
I2100 Septicemia	~*Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Sepsis • For sepsis to be considered septicemia, there needs to **be inflammation due to sepsis and evidence of a microbial process**. If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia. If the medical record does not reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses. ***Does NOT include:*** • A hospital discharge note referencing septicemia during hospitalization without active treatment during the observation period. • Urosepsis.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses *(7-day and 60-day look back)*		
I2900 Diabetes Mellitus (DM)	*~Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Diabetic retinopathy. • Diabetic Nephropathy. • Diabetic Neuropathy.
I4400 Cerebral Palsy	*~Special Care Low*	See Active Diagnosis Definition. **Does Require:** • Nursing Function Score less than or equal to 11.
I4900 Hemiplegia/ Hemiparesis	*~Clinically Complex*	See Active Diagnosis Definition. ***Does Require:*** • Nursing Function Score less than or equal to 11. ***Does include:*** • Left or right sided paralysis. ***Does NOT include:*** • Left or right sided weakness
I5100 Quadriplegia	*~Special Care High*	See Active Diagnosis Definition. ***Does require:*** • Nursing Function Score less than or equal to 11. • Physician documentation of a spinal cord injury resulting in total paralysis of all four limbs (arms and legs) and is not the result of another condition. ***Does NOT include:*** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs. • Spastic quadriplegia, secondary to cerebral palsy should not be coded as quadriplegia.
I5200 Multiple Sclerosis (MS)	*~Special Care Low*	See Active Diagnosis Definition. **Does Require:** • Nursing Function Score less than or equal to 11.
I5300 Parkinson's Disease	*~Special Care Low*	See Active Diagnosis Definition. ***Does Require:*** • Nursing Function Score less than or equal to 11. ***Does include:*** • Paralysis agitans. • Shaking palsy. ***Does NOT include:*** • Parkinsonism and Parkinson's Syndrome.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses *(7-day and 60-day look back)*		
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	*~Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Chronic bronchitis. • Restrictive lung diseases (such as asbestosis, pulmonary fibrosis, etc.). • Emphysema. ***Does NOT include:*** • Obesity hypoventilation syndrome. • Obstructive sleep apnea
I6300 Respiratory Failure	*~Special Care Low*	See Active Diagnosis Definition. ***Does NOT include:*** • I6300 (Respiratory Failure) may not be coded at I6200.
Completion of the following 2 items is required in order to produce a full HIPPS code and thus a categorization into a nursing category. When these items are completed, the software will produce a full HIPPS code that can then be used by the facility to determine nursing category. ***Failure to complete these items will result in an inaccurate nursing-only PDPM classification or will be categorized as BC1 due to the inability to classify the assessment or tracking form.***		
I0020 / I0020B ***Indicate the residents' primary medical condition category:*** *The diagnosis recorded here should be the primary diagnosis for the resident at the time of the MDS assessment completion when completed for OBRA assessments.*		
Section J: Health Conditions *(7-day look back)*		
J1100C Shortness of Breath or Trouble Breathing When Lying Flat	*~Special Care High*	***The resident should not be placed in distress to assess this condition.*** ***Does require:*** • Documentation of the presence of or observation of shortness of breath or trouble breathing, including symptoms experienced, when lying flat during the observation period; OR • Documentation of staff interview including the date(s) staff reported resident experiencing shortness of breath or trouble breathing while lying flat and symptoms experienced; OR • Documentation indicating resident's avoidance of lying flat due to shortness of breath including interventions applied to avoid shortness of breath while lying flat during the 7-day look-back period.
J1550A Fever	*~Special Care High*	***Does require:*** • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established and documented prior to the ARD. ***Does include:*** • A temperature of 100.4 degrees F. on admission (prior to the establishment of the baseline temperature).
J1550B Vomiting	*~Special Care High*	***Does require:*** • Documentation of regurgitation of stomach contents.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional (*K0300 only; 30-day and 180-day look back)		
***K0300** (code 1 or 2) Weight Loss	*~Special Care High*	***Does require:*** • Documentation of resident's weight both 30 days and/or 180 days prior to the current weight during the observation period(s). • Documentation supporting the expressed goal for the physician-prescribed weight loss regimen in the medical record. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via physician-prescribed weight loss regimen.
Section K: Swallowing/Nutritional (7-day look back)		
K0520A2 or K0530A3 Parenteral / IV Feeding	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home, at the hospital, as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. • Consistency with physician orders (time, type, amount, rate of administration) progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • A person-centered care plan to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance and to address the underlying cause or causes of any current dehydration, as well as monitoring for potential side effects and effectiveness of Parenteral/IV feeding. • A periodic evaluation of the appropriateness of the care plan approach. • Supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need, including but not limited to: supporting lab work, clinical signs and symptoms, malnutrition, etc. • Documentation indicating reason nutrition/hydration needs are not able to be achieved and maintained by oral intake. ***Does include:*** • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV fluids running at KVO (keep vein open). • IV fluids contained in IV piggybacks. • Hypodermoclysis and sub-q ports in hydration therapy. • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition and/or hydration. • Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record. ***Does NOT include:*** • 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. Custom IV hydration and micronutrient infusions to help wounds heal, increase weight gain, prevent infections, reduce falls and hospitalizations in those at risk of dehydration which are considered experimental, clinically unproven, and in most cases medically unnecessary.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional (7-day look back)		
K0520B2 or K0520B3 Feeding Tube	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital, or as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records, and the person-centered care plan. ***Does include:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system. • Evidence in the clinical record to include time, type, amount and rate of administration.
K0710A3 Proportion of Total Calories the Resident Received Through Parenteral or Tube Feeding	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding or parenteral during the entire 7-day observation period. • Documentation of intake records to determine actual caloric intake through oral intake. *For residents receiving both oral nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided each day within observation period. 2. Calories oral feeding provided each day within observation period. 3. Percent of total calories provided by tube feeding within the observation period.
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding. Column 3-during entire 7 days	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support average fluid intake per day by tube feeding or IV during the entire 7-day observation period. *Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:* 1. Adding the total amount of fluid received each day by tube feedings or IV feedings only. 2. 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 or tube feeding on each of the 7 days.)*
Section M: Skin Conditions *(7-day look back)*		
M0300B1 Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar	*~Special Care Low*	***Does require:*** • Documentation of pressure ulcer(s)/injury within the observation period must include but is not limited to: identification of wound as a pressure ulcer, location, and description. • Documentation must include a complete history of the pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. • Documentation of a healing pressure ulcer/injury must include descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) within the 7-day observation period; or • A validated pressure ulcer healing tool may be used. ***Does NOT include:*** • Pressure ulcers/injuries that are healed during the look-back period. • A pressure ulcer/injury surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (report at L0200C). • Skin tears, tape burns, moisture associated skin damage, or excoriation.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions (7-day look back)		
M1030 Venous/Arterial Ulcers	*~Special Care Low*	***Does require:*** • Description of the venous/arterial ulcer must include but is not limited to; identification of the wound as a venous/arterial ulcer, location and description aligning with RAI requirements. ***Does NOT include:*** • Pressure ulcers/injuries. • Venous/arterial ulcers that heal during the look back period
M1040A Infection of the Foot	*~Special Care Low*	***Does require:*** • Documentation of signs and symptoms of infection of the foot. ***Does include:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded at M0300.
M1040B Diabetic Foot Ulcer	*~Special Care Low*	***Does require:*** • Description of diabetic foot ulcer must include but is not limited to identification of the wound as a diabetic foot ulcer, location and appearance. ***Does include:*** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries. • Pressure ulcers/injuries that occur on the heel of a diabetic resident.
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	*~Special Care Low*	***Does require:*** • Detailed current description of open lesion including but not limited to: location, size and appearance. • Documentation must verify that the lesion is open during the observation period. ***Does NOT include:*** • Pressure ulcers/injuries coded in M0300. • Open lesions to ankle.
M1040D Open Lesion Other Than Ulcers, Rashes, Cuts	*~Clinically Complex*	***Does require:*** • Detailed current description of open lesion including but not limited to: location, size and description. • Documentation that the lesion is open during observation period. ***Does include:*** • Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item. ***Does NOT include:*** • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, skin tears, cuts/lacerations, abrasions, or rashes.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions (7-day look back)		
M1040E Surgical Wound	*~Clinically Complex*	***Does require:*** • Description of surgical wound must include but is not limited to identification of the wound as a surgical wound, location and description aligning with RAI requirements. ***Does include:*** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. • Pressure ulcers/injury(s) that are surgically repaired with grafts and flap procedures. ***Does NOT include:*** • Healed surgical sites and healed stomas. • Lacerations that require suturing or butterfly closure. • PICC sites, central line sites, peripheral IV sites. • Pressure ulcers/injuries that have been surgically debrided.
M1040F Burn	*~Clinically Complex*	***Does require:*** • Description of the second- or third-degree burn must include but is not limited to: degree, type, cause, location and appearance. ***Does include:*** • May be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. ***Does NOT include:*** • First-degree burns (changes in skin color only).
M1200A Pressure Reducing Device/*chair* **M1200B** Pressure Reducing Device/*bed*	*~Special Care Low*	***Does require:*** • Documentation substantiating use of equipment that aims to relieve pressure away from areas of high risk during the observation period. • A facility policy identifying the use of pressure reducing/relieving/redistributing mattress on all resident bed(s) will be considered sufficient documentation for the bed device. ***Does include:*** • Foam, air, water, gel, or other cushioning, placed on chair, wheelchair or bed. • Pressure relieving, reducing, and pressure redistributing devices. ***Does NOT include:*** • Egg crate cushions of any type. • Doughnut or ring devices in chairs or wheelchairs. • A physician order for a pressure relieving device without documentation of implementation is not sufficient for supporting documentation.
M1200C Turning/ Repositioning Program	*~Special Care Low*	***Does require:*** • Documentation substantiating utilization of a program with specific approaches for changing the resident's position and realigning the body. • Documentation of specific program interventions (e.g. reposition on side, pillows between knees) and frequency. *(Program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs).* • Evaluation by the licensed nurse describing the residents' response to the program within the observation period.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1200D Nutrition or Hydration Intervention to Manage Skin Problems	*~Special Care Low*	***Does require:*** • Documentation of an individualized nutritional assessment. • Description of specific skin condition being prevented or treated. • Documentation of nutrition or hydration factors that are influencing the skin problem and/or wound healing. ***Does include:*** • Vitamins and mineral supplements when administration is an intervention for managing a skin problem.
M1200E Pressure Ulcer/Injury Care	*~Special Care Low*	***Does require:*** • Documentation of intervention(s) for treating pressure ulcers/injuries coded at M0300 B, C, D, and F. ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigation. • Negative pressure wound therapy (NPWT). • Hydrotherapy.
M1200F Surgical Wound Care	*~Clinically Complex*	***Does require:*** • Documentation of the intervention for treating or protecting any type of surgical wound identified at M1040E during the observation period. ***Does include:*** • Topical cleansing. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. • Pressure ulcers/injuries that require surgical intervention for closure (flap and/or graft coverage). ***Does NOT include:*** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer/injury. • Band-Aids. • Observation "**only**" of the surgical wound.
M1200G Application of Non-surgical Dressings Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of the application of non-surgical dressing (with or without topical medications) to the body other than to the feet. ***Does include:*** • Compression bandages. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydroactive particles. • Dressing application to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers/injuries other than to feet; use pressure ulcer/injury care (M1200E). • Band-Aids. • Wound closure strips. • Skin prep.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1200H Application of Ointments/ Medications Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. ***Does include:*** • Topical creams. • Powders. • Liquid sealants. • Cortisone. • Antifungal preparation. • Chemotherapeutic agents. ***Does NOT include:*** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers; use pressure ulcer/injury care (M1200E). • Ointments used to treat non-skin conditions (e.g. nitropaste for chest pain).
M1200I Applications of Dressings to Feet	*~Special Care Low*	***Does require:*** • Documentation of dressing changes to the feet (with or without topical medication). • Interventions to treat any foot wound or ulcer other than a pressure ulcer/injury. ***Does NOT include:*** • Dressings to pressure ulcers/injuries; use pressure ulcer/injury care (M1200E). • Dressing application to the ankle. (The ankle is not considered part of the foot.) • Skin prep.
Section N: Medications *(7-day look back)*		
N0350A Days of Insulin Injections	*~Special Care High*	***Does require:*** • Documentation must be consistent with physician orders and insulin administration records. • Documentation must include the number of days that insulin injections were received by the resident. ***Does include:*** • The number of days the resident actually required a subcutaneous injection to restart the insulin pump.
N0350B Days of Orders for Insulin	*~Special Care High*	***Does require:*** • Documentation must include the number of days that the insulin orders changed during the observation period. ***Does include:*** • Sliding scale order that is new, discontinued, or is the first sliding scale order. ***Does NOT include:*** • A sliding scale dosage schedule that is written to cover different dosages depending on lab values simply because a different dose is administered based on the current sliding scale guidelines.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0100 Special Treatments	***Informational Only***	***Does include:*** • Special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. • Items "while a resident" ONLY. ***Does NOT include:*** • Services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure, such as IV medications or ventilators. • Surgical procedures including routine pre- and post-operative procedures.
O0110A1b Chemotherapy	*~Clinically Complex*	***Does require:*** • Documentation of administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment. • Documentation must indicate that the resident actually received the chemotherapy and not just left the building (or remained in the building) with the intent to receive chemotherapy. • Cancer diagnosis. ***Does NOT include:*** • IV administered during chemotherapy. • IV medication administered during chemotherapy. • Blood transfusions administered during chemotherapy. • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer.
O0110B1b Radiation	*~Special Care Low*	***Does require:*** • Documentation of administration of radiation therapy inside or outside of facility. • Documentation must indicate that the resident actually received the radiation and not just left the facility (or remained in the building) with the intent to receive the radiation. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant.
O0110C1b Oxygen Therapy	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Supporting diagnosis. • Documentation of precipitating event for PRN usage resulting in the application of oxygen. ***Does include:*** • Resident places or removes his/her own oxygen mask, cannula. • Oxygen when used in BiPAP/CPAP. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.
O0110E1b Tracheostomy Care	*~Extensive Services*	***Does require:*** • Documentation of cleaning of tracheostomy and/or cannula cleansing during the observation period. ***Does include:*** • Changing a disposable cannula. • Resident performs his/her own tracheostomy care. • Laryngectomy tube care.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0110F1b Ventilator or Respirator	*~Extensive Services*	***Does require:*** • Documentation substantiating utilization of any type of electrically or pneumatically powered closed system mechanical ventilator support device. • The type of ventilator device and frequency used during the observation period. ***Does include:*** • Any resident being weaned off the ventilator or respirator during the observation period. • Any resident who was weaned from the respirator or ventilator in the last 14 days. ***Does NOT include:*** • Times when used as a substitute for BiPAP or CPAP.
O0110H1b IV Medications	*~Clinically Complex*	***Does require:*** • Documentation of the administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port. ***Does include:*** • Epidural, intrathecal, and baclofen pumps. • Additives such as electrolytes and insulin, which are added to the residents' TPN or IV fluids. ***Does NOT include:*** • Flushes to keep an IV port patent. • IV fluids without medication. • Subcutaneous pumps. • IV medications administered during dialysis or chemotherapy. • Dextrose 50% and/or Lactated Ringers.
O0110I1b Transfusions	*~Clinically Complex*	***Does require:*** • Documentation of the administration of blood or any blood products (e.g. platelets, synthetic blood products) directly into the bloodstream. • Documentation must indicate that the resident actually received the transfusion and not just left the building (or remained in the building) with the intent to receive a transfusion. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.
O0110J1b Dialysis	*~Special Care Low*	***Does require:*** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside facility. • Documentation must indicate that the resident actually received dialysis and not just left the building (or remained in the building) with the intent to receive dialysis. ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • Resident performing his/her own dialysis. • ***Informational:*** IV, IV medication and blood transfusion administered during dialysis are considered part of the dialysis procedure and are NOT to be coded under items K0510A (Parenteral/IV feeding), O0100H (IV medications), or O0100I (Transfusions).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0110M1b Isolation or Quarantine for Active Infectious Disease	*~Extensive Services*	***Code for "Single Room Isolation" only when all four of the following conditions are documented in the medical record:*** 1. Resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. Transmission-based precautions (contact, droplet, and/or airborne) must be in effect. **Standard Precautions Include**: • Hand hygiene compliance • Glove use • Masks • Eye protection • Gowns 3. Resident is in a room alone because of active infection and cannot have a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. Must remain in room. All services must be brought to the resident (e.g. rehabilitation, activities, dining, etc.). ***Does Require:*** • Active physician order to include: diagnosis, type of isolation, and need for a private room. • Documentation supporting infectious disease (symptomatic and have a positive test and are in the contagious stage). ***Does NOT include:*** • Standard precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(7-day look back)*		
O0400D2 Respiratory Therapy Days	*~Special Care High*	***Does require:*** • Only medically necessary therapies that occurred after admission/readmission to the facility were: 1) Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan. 2) Documented in the resident's medical record. 3) Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective. • Therapy services may occur inside or outside the facility. • Documentation of minutes that the respiratory therapist or respiratory nurse spends with the resident conducting the actual respiratory therapy treatment including the set-up and removal of treatment equipment. • A respiratory assessment pre and post treatment that includes but is not limited to the following: heart rate, respiratory rates, breath sounds, the direct care minutes, and toleration. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • Respiratory evaluation during the observation period by a respiratory therapist or a trained respiratory nurse. • A respiratory nurse must be proficient in the modalities provided either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws. ***Does include:*** • Coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc. ***Does NOT include:*** • Treatment for less than 15 direct minutes per day. • Metered-dose and/or dry powder inhalers. • Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(7-day look back)*		
O0500A-J Restorative Nursing Program Days	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each restorative program provided within a 24-hour period. • Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Time must be provided separately for each restorative program. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1) Measurable objectives and interventions must be documented in the care plan and in the medical record; and 2) Evaluation of the program by a licensed nurse. *(For the case mix review, reassess progress, goals and duration/frequency of each program **within the observation period**.)*; and 3) Staff trained in the proper techniques; and 4) Supervised by licensed nurse; and 5) No more than 4 residents per supervising helper or caregiver. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device and reposition the limb in correct alignment within the observation period. ***Does include:*** • An evaluation of the program written by a CNA and co-signed by a licensed nurse once the purpose and objectives of treatment have been established. (Contingent on state rules) ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • For both active and passive range of motion movement by a resident that is incidental to care does not count as part of a formal restorative nursing program. • Treatment for less than 15 direct minutes per day.
*******O0500A (Passive Range of Motion) and O0500B (Active Range of Motion) count as one service even if both are provided.*** *******O0500D (Bed Mobility) and O0500F (Walking) count as one service even if both are provided.***		
Section Z: Assessment Administration		
Z0400	Signature of Persons Completing the Assessment or Entry/Death Reporting	***Does require:*** • All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. • If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed. • Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a subset of items within a section should identify which item(s) they completed within that section.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

Level Of Care (LOC) and PASRR		
LOC	Nursing facility admission must meet the level of care criteria as defined in 405 IAC 1-3-1 (skilled level of care) and/or 405 IAC 1-3- 2 (intermediate level of care).	***Does require:*** • The MDS to determine the resident continues to meet level of care criteria. ***Resident records may be reviewed to determine continued NF care needs in accordance with State LOC criteria.***
Level I	A screening used to identify individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), mental illness/intellectual disability/developmental disability (MI/ID/DD), or related condition (RC). A Level I is required regardless of payer source prior to admission to a Medicaid certified nursing facility.	***Does require:*** • Level I forms to be in the resident's medical record or readily available for all residents admitted to a Medicaid-certified nursing facility. • Level I screenings to be updated to reflect the resident's current condition if there has been a significant change in condition. • Level I when a continued NF stay beyond the approval end date of a categorical determination or exemption, along with a LOC screen, in order to initiate the required onsite Level II (regardless of the resident's pay source). • Level I when admitted from out-of-state. • Level I due to a change in medication, diagnoses, etc. • Level I be updated when the Level I screen is no longer accurate even when the screen may not be associated with a Level II condition. ***Resident records may be reviewed to ensure Level I forms are completed and updated to reflect the residents' current condition.***
Level II	An assessment involving an in- depth clinical evaluation by a trained mental health professional to verify whether or not an individual has a serious mental illness and determines appropriateness of nursing facility placement.	***Does require:*** • Level II forms to be in the resident's medical record or readily available as applicable: o Community Mental Health Center Level II forms (all pages). o Bureau for Developmental Disabilities Services (BDDS) Level II Evaluation forms. o Inappropriate Referral form(s). o Ascend Summary of Findings Form for residents with a diagnosis of MI/IDD or IDD (effective 1/3/2017). ▪ Long Term Approval ▪ Time Limited Approval ▪ Denial o Level II recommendation documentation. o Yearly resident review (if required). ***Resident records will be reviewed to ensure that all residents requiring a Level II PASRR have been appropriately referred, including a significant change in mental status.***

SUPPORTIVE DOCUMENTATION REQUIREMENTS

Office of Medicaid Policy and Planning Case Mix Review Policies and Procedures Posted at https://myersandstauffer.com/client-portal/indiana/indiana-case-mix/ Click on "State Review Policies" located under the "Resources" section It is the responsibility of the facility to read and understand the complete policies		
Medical Record Correction for the Case Mix Review	*Effective July 1, 2015* *Revised July 1, 2021*	a) If an error is discovered in the medical record supporting documentation within 14 days of the MDS assessment reference date (ARD), but no later than the completion date of the MDS and before submission to the Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing (ASAP) system, the documentation may be corrected using standard editing procedures. b) Any corrections made including but not limited to, the Functional Scoring documentation must have an associated note of explanation per correction. c) If a significant error is discovered in a record after submission to the iQIES ASAP system, modification or inactivation procedures must be followed as directed in Chapter 5 of the RAI manual. d) A quarterly or summary note will not substitute for an occurrence correction for the Case Mix Review unless there is date(s) specificity within the summary. e) Improper or illegible corrections will not be accepted for the Case Mix Review. f) All documentation, including corrections, must be part of the original legal medical record. g) Any and all MDS coding and interpretation questions shall be referred to the State RAI Coordinator.
Electronic Health Records Review Policy	*Effective July 1, 2015* *Revised July 1, 2021*	a) The facility must: • Designate a liaison who will access the system, AND • Retrieve electronic health record information as requested. b) Undue delays in the production of original and/or EHR medical records are unacceptable and could result in an additional review, and/or unsupported assessments. Please refer to the Excessive Wait Time for Medical Records Policy. c) The provider is solely responsible for ensuring that all necessary back up of data and security measures are in place.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

Office of Medicaid Policy and Planning Case Mix Review Policies and Procedures Posted at https://myersandstauffer.com/client-portal/indiana/indiana-case-mix/ Click on "State Review Policies" located under the "Resources" section It is the responsibility of the facility to read and understand the complete policies		
Facility Request for Cancellation of Review	*Effective July 1, 2015* *Revised July 1, 2021*	a) The facility Administrator or designee must submit the request for cancellation in writing to Myers and Stauffer. b) Request may be emailed, AND c) Request must be signed by either facility Administrator or designee, AND d) Request must include reason for cancellation, AND e) If request is due to State Surveyors in the facility, the name and contact number of Survey Team Lead must be included in the request. f) After receiving the request, Myers and Stauffer will make a decision as to grant or deny the request for cancelation of the review and will notify the facility in writing by email. The reasons that a facility request for cancelation may be approved include but are not limited to: g) State surveyors are in the facility prior to or in advance of the scheduled review, h) Inclement weather/weather emergency, i) State declared emergency. **Note:** This list is not all inclusive; there may be additional circumstances that will be evaluated on a case-by-case basis. In the event of a second consecutive request for cancellation, Myers and Stauffer will make a determination based on the circumstances surrounding the request and OMPP may be notified. OMPP may provide additional instruction as deemed necessary.

6 CASE MIX (MDS) REVIEW PROTOCOL

POLICY DECISIONS FOR CASE MIX REVIEWS

- Delinquent MDS assessment definition
  - Any assessment with an assessment reference date (ARD) greater than 113 days from the previous ARD will be deemed delinquent and assigned a PDPM code of BC1 and associated case mix index of 0.59
- Case mix review Supporting Documentation Requirements (SDR)
  - Documentation requirements that define the supporting documentation necessary to verify an MDS PDPM item(s)
- Unsupported MDS assessment definition
  - When the case mix review results in a different PDPM classification
- Frequency of case mix reviews
  - As determined by OMPP
- Sample payer source selection
  - 90% Medicaid
  - 10% Other
- Primary sample size is the greater of:
  - 30% of the residents listed on the Review Roster Report or 25 assessments
- Expanded sample size (required if primary sample review results exceed the unsupported threshold) is the greater of:
  - 20% of the remaining residents listed on the Review Roster Report or 10 assessments
- Threshold defines when expanded review is required
  - Greater than 20% unsupported
- Validation improvement plan (VIP) is required when a facility review exceeds the threshold
- Follow-up case mix review process
  - Required when a facility exceeds the threshold at the close of the review
  - Notification for follow-up case mix reviews is not provided

PRE-CASE MIX REVIEW PROTOCOL

- Facility notification will occur up to 72 hours prior to the scheduled on-site review
  - Notification by telephone
  - Confirmation sent by email
    - Email will include (at a minimum) a Notification Form, Facility Statistical Information Form, and an Entrance Conference Form.
  - Facility will receive the resident listing including the ARD and PDPM classification for each resident for review by close of business the day of the notification call.
  - Facilities should begin uploading documentation (if this is the method chosen to provide the residents' legal medical record supportive documentation) immediately after receipt of the resident listing.
  - Facilities will have until the close of business the day of the entrance conference to finalize the uploaded documentation or 24 hours from the closing of the entrance conference to provide electronic health record access.
- Online meeting
  - The RN Reviewer will schedule the review entrance meeting through an online application.
    - Facility staff will receive an email invitation.
    - Invitation will identify the day and time of the review entrance conference.
    - On the day of the scheduled entrance conference the facility should click on the "join meeting" button within the email invitation.

- Entrance conference
  - Facility Administrator or designee, MDS coordinator, Medical Records and any other staff of facility choice are encouraged to attend
  - Facility designee to complete Facility Statistical Information Form
  - Review process is explained
  - Facility Administrator or designee and all other staff in attendance sign the entrance conference form
  - Time allowed for questions

CASE MIX (MDS) REVIEW PROTOCOL

- Review process
  - Facility liaison will access/provide RN reviewer access to medical records for resident list as directed by the RN reviewer
  - Facility liaison must be available to assist/navigate facility electronic records
  - Facility has two options for providing supporting documentation:
    - Direct network access to facility software (read-only mode)
      - Providers expected to provide direct electronic health record access to RN Reviewer within 24 hours after the close of the entrance conference.
      - Network access must remain effective through the end of the review process.
      - RN Reviewer will complete the MDS review not later than close of business 7 business-days from the date all requested documentation is received.
    - Facility to upload documentation to the Myers and Stauffer web portal
      - Providers are required to upload only relevant documentation by close of business the day of the entrance conference.
      - Facility liaison will be contacted if additional assistance is required to locate medical record documentation via the preferred communication route of the facility and an additional request list will be posted to the web portal. – This is the facility's "2nd Request"
  - Facility must provide supporting documentation within two business days after notification.
    - Example: Monday notification = documentation due by close of business (5:00 pm EST) Wednesday
    - Friday notification = documentation due by close of business (5:00 pm EST) Tuesday
  - Suspected intentional alteration of or creation of clinical documentation after MDS assessments have been completed and transmitted or during the case mix review will be reported to OMPP and may be referred to the Medicaid Fraud Control Unit of the Indiana Attorney General's Office for investigation of possible fraud and could result in felony or misdemeanor criminal conviction. In addition, the state may exercise the right to complete an additional review.
- Expanded Reviews
  - If the facility fails to achieve the pass threshold of 20% or less unsupported after the primary sample of assessments has been completed, an expanded review will be required.
    - The expanded sample size is the greater of 20% of the remaining residents on the Review Roster or 10 assessments.
    - Expansion list is posted to the web portal and facility notified.
    - Facility must provide supporting documentation within two business days after notification (if uploading documentation to the web portal).
  - Examples:
    - Tuesday notification = documentation due by close of business (5:00 pm EST) Thursday
    - Thursday notification = documentation due by close of business (5:00 pm EST) Monday
  - If the RN Reviewer is unable to locate all documentation provided via the web portal upload or in the electronic health record, an additional 2nd Request will be made, and the facility will be required to provide the supporting documentation via upload to web portal within 2 business days.
- Exit conference
  - At the close of the review the RN Reviewer will schedule the exit conference date with the facility.
  - The RN Reviewer will complete the Exit Conference Form, send it to the facility and discuss all items checked on the Exit Conference Form.
  - Facility Administrator or designee may invite any staff deemed appropriate to attend the exit conference
  - Preliminary findings will be reported including the number of assessments reviewed and percent unsupported
  - Facility Administrator or designee and all other staff in attendance sign the exit conference form

POST- CASE MIX (MDS) REVIEW PROTOCOL

- ❑ Case Mix Review Findings Letter is posted to the web portal no later than 10-business days following the final exit conference date
- ❑ Informal Reconsideration Process
  - o Facility has 15-business days from the date of the posting of the case mix review findings letter to request an informal reconsideration
  - o Myers & Stauffer response to the informal reconsideration no later than 10-business days following receipt of the request for an informal reconsideration
  - o Facility has 45 days after release of the Indiana Health Coverage Program (IHCP) rate by the rate-setting contractor to request a formal rate reconsideration

CORRECTIVE REMEDY

- ❑ At the close of the review all unsupported assessments will be reclassified into the PDPM classification based on review findings
- ❑ The direct care rate component will be recalculated
- ❑ Myers & Stauffer will notify facility of any prospective rate adjustment
- ❑ Adjustment will impact all quarters within the bi-annual reporting period where the assessment is displayed
- ❑ Adjustment will impact the administrative component by penalty of 7.5% for one quarter (for reviews over the threshold) and increases when consecutive reviews are over the threshold

WEB PORTAL

- ❑ Facility Rosters are posted to the web portal located at: https://incasemixreports.mslc.com/
  - o Once logged in, the system presents the opening page which displays which facility rosters are available to access, view and download
  - o The headers are listed below:
    - Rosters
    - Change Password
    - Log Out
    - Clicking on these headers allows the user to toggle between each screen.
  - o Refer to the Web Portal User Guide

WEB SITE

- ❑ Current information is always available under *Resources* at: *https://myersandstauffer.com/client-portal/indiana/indiana-case-mix/*
  - o Case Mix in Indiana Newsletter
  - o Supportive Documentation Requirements
  - o State Review Policies
  - o Report and Portal Reference Materials
  - o Time Weighted
  - o Calendar
  - o MDS 3.0
  - o Web Portal
  - o FAQs

7 RESOURCES

The Indiana Medicaid facility's Time-Weighted CMI Resident Roster is linked to the federal requirements for completion and submission of the MDS. The following list of resources may be beneficial to aid in the correct completion and submission of the MDS 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.

Every effort is made to ensure 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

(Click on a title below to access the corresponding website)

- **QIES Technical Support Office (QTSO)** - This website provides technical guidance, containing references & manuals, software tools and training materials for providers.
- **Myers and Stauffer - Indiana** - This website is maintained by Myers and Stauffer and allows provider access to information that is useful for their businesses, such as provider resource documents and training information.

HELP DESK

(Click on a title below to access the corresponding help desk email)

- **Myers and Stauffer Help Desk** – Myers and Stauffer is a contractor to the Office of Medicaid Policy and Planning and provide the Resident Rosters as well as technical assistance. Contact the Myers and Stauffer Help Desk at *inhelpdesk@mslc.com* or by phone at 317-816-4122. **DO NOT EMAIL PHI (Including patient names or patient identification numbers).**
- **QTSO Help Desk** - Contact the QTSO Help Desk at *iqies@cms.hhs.gov* or by phone at 800-339-9313 for assistance with MDS/CASPER login ID/password or for assistance with iQIES submission software.

GLOSSARY

COMMON TERMS AND ABBREVIATIONS

This user guide section provides definitions of terms and abbreviations that a user may hear not only while reviewing the Roster Report, but also within the larger MDS environment.

Term/Abbreviation	Definition
Admission Entry Date	The date the resident began his/her current stay; denoted at MDS item A1600, Entry date and A1700 = 1 (Admission).
Assessment Reference Date (ARD)	The last day of the MDS observation period; denoted at MDS item A2300.
Assessment Submission and Processing System (ASAP)	The CMS system that receives submissions of MDS 3.0 data files, validates records for accuracy and appropriateness, and stores validated records in the CMS database.
Case Mix	The mix of residents being cared for in a nursing facility at any given time.
Case Mix Index (CMI)	A weight or numeric score assigned to each PDPM classification based on their specific, clinical, and data-driven needs rather than the volume of services provided
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.
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.
CMSNet	The communication system used to electronically submit data to the iQIES system. Each staff member at the NF who is submitting data must have an individual password.
Discharge Date	The date a resident is discharged from the facility; denoted at MDS item A2000.
Discharge	The act of leaving a facility, regardless of intent to return.
Inactivation	A type of correction allowed under the MDS Correction Policy (Chapter 5 of the RAI manual). A NF may electronically request that an invalid record that was accepted into the database be inactivated.
Inactive period	For Indiana Medicaid purposes only, the period following an expired assessment beginning with Day 114 until the start of the next assessment (A2300 or A1600 date) or the end of the Resident Roster quarter. OR the period greater than 14 days between the Admission date and the Admission assessment reference date beginning Day 15.

Term/Abbreviation	Definition
Item Set Code (ISC)	A code based upon combinations of reasons for assessment (A0310 items A, B, and F) that determines which items are active on a particular type of MDS assessment or tracking record.
Medicaid Average CMI	The average of all calculated Medicaid CMI Points (Days x CMI assigned to an assessment assigned a Medicaid payment source) divided by calculated Medicaid days (Sum of days assigned to an assessment assigned a Medicaid payment source).
Minimum Data Set (MDS)	A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid.
Modification	A type of assessment correction allowed under the MDS Correction Policy (Chapter 5 of RAI Manual). A modification is requested when an accepted MDS assessment is in the iQIES system database but the information in the assessment contains errors. Each modification results in an increase in the Correction Number at MDS item X0800.
OBRA Assessments	A term used when referring to federally required MDS assessments based on the resident's condition and clinical requirements (A0310A = 01–06) as required by the RAI manual.
Omnibus Budget Reconciliation Act (OBRA '87)	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
Patient Driven Payment Model (PDPM)	A Medicare payment model that improves payment accuracy and appropriateness by focusing on the patient/resident, rather than the volume of services provided. Effective 10/1/2019.
PDPM Element	Those items on the MDS that are used in the PDPM classification system.
Prospective Payment System (PPS)	A payment system, developed for Medicare skilled nursing facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categories residents by the type and intensity of resources used.
PPS Assessment	A term used when referring to MDS assessments completed for Medicare PPS requirements/reimbursement (A0310B = 01).
iQIES Technical Support Office (QTSO)	A CMS contractor that provides technical support to the state agencies housing the iQIES system. The iQIES Technical Support Office function is provided by GDIT.
Internet Quality Improvement and Evaluation System (iQIES)	The "umbrella" system that encompasses MDS, OASIS, ASPEN and OSCAR.
RAI Manual	The Long-Term Care Facility Resident Assessment Instrument User's Manual, issued by the CMS covering the Minimum Data Set and Care Area Assessments.
Reentry Date	The date the resident returns to the facility and continues his/her current episode; denoted at MDS item A1600, Entry date and A1700 = 2 (Reentry).

Term/Abbreviation	Definition
Resident	A person being cared for in a Nursing Facility.
Resident Internal ID/ State Patient ID	A unique internal resident ID created for each individual nursing facility resident upon the submission of their first assessment/tracking form to the iQIES system. The Resident Internal ID is based on resident identifying information that includes resident name (first and last), social security number, gender, date of birth. All subsequent records for the resident are identified with the same unique Resident Internal ID.
Resident Assessment	A standardized evaluation of each resident's physical, mental, psychosocial and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status, quarterly and on an annual basis.
Resident Assessment Instrument (RAI)	The designation for the complete resident assessment process mandated by the CMS, including the MDS, Care Areas Assessments (CAAs) and care planning decisions.
Roster Quarter	Quarter 1 = 12/01/Current Year to 02/28/Subsequent Year (02/29 for leap year) Quarter 2 = 03/01/Current Year to 05/31/Current Year Quarter 3 = 06/01/Current Year to 08/31/Current Year Quarter 4 = 09/01/Current Year to 11/30/Current Year
Stay	A set of contiguous days in the facility.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600).
Total CMI	The average of all calculated CMI Points (Days x CMI assigned to an assessment for all payment sources) divided by calculated days (Sum of days assigned to an assessment for all payment sources).
Unsupported MDS Resident Assessment	When the case mix (MDS) review of an MDS resident assessment results in a different PDPM classification.