Pennsylvania MA Case-mix Reimbursement System

Resident Data Reporting Manual

Pennsylvania Department of Human Services and Myers and Stauffer LC

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Introduction

Background

The Commonwealth of Pennsylvania (Commonwealth), Department of Human Services (the Department or DHS) (formerly the Department of Public Welfare) initially published 55 Pa. Code Chapter 1187: Nursing Facility (NF) Services; Case-mix Reimbursement System on October 14, 1995, in the Pennsylvania Bulletin. These regulations set forth, among other things, resident data reporting requirements that must be met to receive payment for medical assistance (MA) NF services. This manual provides guidance for the accurate and timely satisfaction of these requirements and explains how the results are used in the NF's MA case-mix reimbursement rate.

Since March 1993, the Department has been collecting minimum data set (MDS) data electronically for use in MA case-mix reimbursement rates. There were federal regulations already in place at that time mandating that the MDS be completed for all residents residing in NFs receiving Title XVIII (Medicare) and Title XIX (Medicaid) funding. The Department then mandated the electronic submission of this data for use in MA case-mix reimbursement rates.

In late 1997, the Health Care Financing Administration (HCFA) (now the Centers for Medicare & Medicaid Services [CMS]), published regulations regarding computerization of the MDS. These regulations required NFs to encode the MDS 2.0, ensure the data passed standardized edits defined by CMS and the state and transmit the MDS in a standardized format in accordance with specifications provided by CMS. With the adoption of these regulations, the Department specified a Pennsylvania-specific MDS based on MDS 2.0 and began using MDS data submitted in accordance with these regulations in the MA case-mix reimbursement rates.

On June 24, 2006, new regulations were released modifying Chapter 1187 NF services and creating Chapter 1189 relating to county NF services to institute a new rate setting methodology for these facilities. Changes in these regulations affecting resident data reporting are incorporated into this manual. The regulation may be found on the Pennsylvania Code & Bulletin website.

In the Final Rule for the Medicare program prospective payment system (PPS) and consolidated billing for skilled nursing facilities (SNFs) for fiscal year (FY) 2010, CMS mandated that a new assessment instrument, MDS 3.0, must be used by Medicare and Medicaid participating NFs beginning October 1, 2010. To accommodate this change, the Department implemented resource utilization group (RUG)-III v.5.12 44-group classification, selection of the latest classifiable assessment for creation of the Case-mix Index (CMI) Report, and use of a new set of Pennsylvania normalized nursing only CMIs. These changes were effective for the rate setting year beginning July 1, 2010. The Pennsylvania-specific MDS is described in this manual, along with any additional submission requirements beyond those defined by the CMS.

CMS has continued to refine the MDS 3.0 instrument and the associated Resident Assessment Instrument (RAI) manual. Further revisions were put in place for October 1, 2019, with a requirement to use MDS 3.0 Version 1.17.1.

As of October 1, 2023, the federally required PPS and Omnibus Budget Reconciliation Act (OBRA) MDS assessments will no longer support the classification of assessments into RUG groupers. For the RUG-based case-mix classification system to continue in Pennsylvania, the use of the Optional State Assessment (OSA) will be required. The MDS 3.0 RAI Manual (v) 1.18.11 and MDS item set (v) 1.18.11v5 will be used in coordination with OSA manual and item set (v) 1.0v2. OSA will be required to be opened, completed, and submitted with the same assessment reference date as each federally required MDS assessment.

On October 1, 2025, CMS phased out support for the RUG reimbursement system. The State has adopted a modified version of the Patient-Driven Payment Model (PDPM), focusing exclusively on the nursing component of the model to establish Medicaid CMIs.

This version of the Resident Data Reporting Manual provides information necessary to assist Pennsylvania's MA participating NFs in understanding how MDS 3.0 is used in the Pennsylvania MA case-mix reimbursement rate setting system.

"Informed MDS User" Assumption

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

MDS Information Resources

While this manual concentrates on resident data reporting beyond that which is federally required, 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, and it is recommended that facilities view the websites periodically to determine if any updates to the listed manuals and question and answer documents have been made. In addition, local and state providers or nursing associations may be helpful in providing training and materials.

Every effort is made to ensure 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 CMS that contradicts or augments guidance provided in this manual, the more current information from CMS becomes the acceptable standard.

Websites

- **Nursing Home Quality Initiative.** This site is maintained by CMS and provides extensive information about the MDS, data submission, Medicare PPS RUG classification, etc.
- **Internet Quality Improvement and Evaluation System (iQIES) Technical Support Office.** Support is provided to each state in managing their NFs' MDS submissions and maintains a provider help desk for users of jRAVEN. This website contains information on the MDS submission process, manuals, etc.
- **Department of Health (DOH).** This site provides information about the DOH's activities in NFs.
- **DHS.** This site provides information about long-term care (LTC) and case-mix issues.

Manuals

- **RAI Manual.** This manual provides information about the completion of the MDS and is available from various publishers. Changes to this manual are released periodically by CMS — monitor the CMS site for the latest information. Procedures for correcting MDS 3.0 assessments are included in this manual.
- **MDS 3.0 Provider User's Guide.** This manual provides information about the electronic submission of MDS 3.0 from the facility to the CMS MDS 3.0 Data Collection System database and obtaining validation reports from the Certification and Survey Provider Enhanced Reporting (CASPER) reporting system. It also includes information about the error messages facilities receive on their final validation reports (FVRs).
- **CASPER Reporting User's Guide for MDS Providers.** This user's guide provides specific instructions for obtaining FVRs and generating many other MDS 3.0 analysis reports.
- **MDS 3.0 Data Submission Specifications.** This document describes item-by-item edits for each element of the MDS 3.0, as well as describing, sequencing, timing, date consistency, and record types.
- **MDS 3.0 Quality Measures User's Manual.** This manual details the calculation of the quality measures that are used in the survey and certification process and are posted on Nursing Home Compare.

Phone, Fax, and Email

- **DOH.** (717) 787-1816 (phone). This Department provides answers to questions concerning completion of the MDS and interpretation of the quality measures.

Questions may also be submitted to qa-mds@pa.gov (email).

- **Myers and Stauffer Help Desk.** (717) 541-5809 (phone), (717) 541-5802 (fax), pahelpdesk@mslc.com (email). This firm is a contractor to DHS and provides technical assistance for the submission of MDS 3.0. Refer to *Help Desk* for more information about help desk services.
- **CMSNet/Verizon Help Desk.** (888) 238-2122 (phone). This help desk provides necessary connection software and passwords to allow connectivity to the CMS MDS 3.0 Data Collection System.
- **Medicare Administrative Contractor (MAC).** (877) 235-8073 (phone) or www.novitas-solutions.com. These organizations process Medicare claims for the NF. In Pennsylvania, Novitas Solutions is the MAC. They can be contacted for questions about Medicare PPS assessments, Health Insurance Prospective Payment System (HIPPS) codes, and the UB-04 billing document.
- **Office of Long-Term Living (OLTL) Provider Supports Customer Service.** (800) 932-0939 (phone) or ra-provideroperation@pa.gov (email). The OLTL Provider Operations Help Desk provides answers to questions concerning MA case-mix reimbursement rates, MA billing.
- **Pennsylvania MDS Automation Coordinator.** (717) 214-3736 (phone). Questions may also be submitted to rbarnard@pa.gov (email).

Pennsylvania-Specific MDS

MDS Sections

CMS provides states with the ability to designate their own MDS 3.0 document as long as the document contains the minimum federally required sections. Pennsylvania has designated a document, the Pennsylvania-specific MDS, which contains Section A-Q, S, V, X, and Z of the MDS 3.0.

Rather than specific forms, MDS 3.0 designates item subset codes (ISCs) based on the responses to A0310 Type of Assessment. Data entry software should present the MDS items to be completed based on those responses. All ISCs may be found on the *Minimum Data Set (MDS 3.0) Technical Information CMS website*, and in Appendix H of the RAI Manual.

Section S

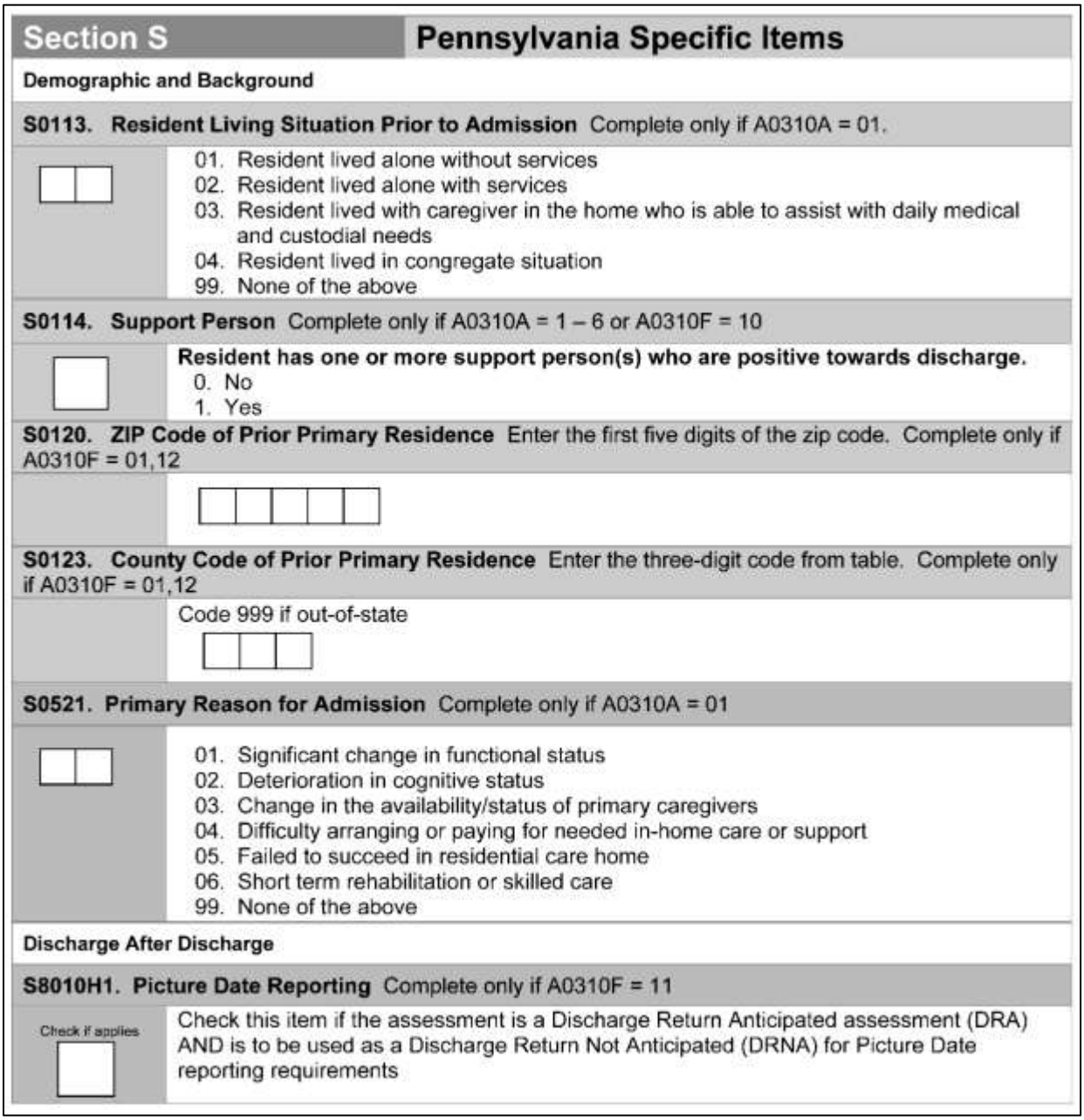
Pennsylvania has designated Section S as a state-specific section of the Pennsylvania-specific MDS. Portions of Section S are required on the comprehensive subset (NC), quarterly subset (NQ), Medicare PPS subset (NP), discharge subset (ND), and the tracking subset (NT).

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

Section S Forms

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

Figure 1. Pennsylvania MDS 3.0 Section S



Section S **Pennsylvania Specific Items**

Demographic and Background

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

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

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

☐ **Resident has one or more support person(s) who are positive towards discharge.**
0. No
1. Yes

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

☐☐☐☐☐

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

Code 999 if out-of-state

☐☐☐

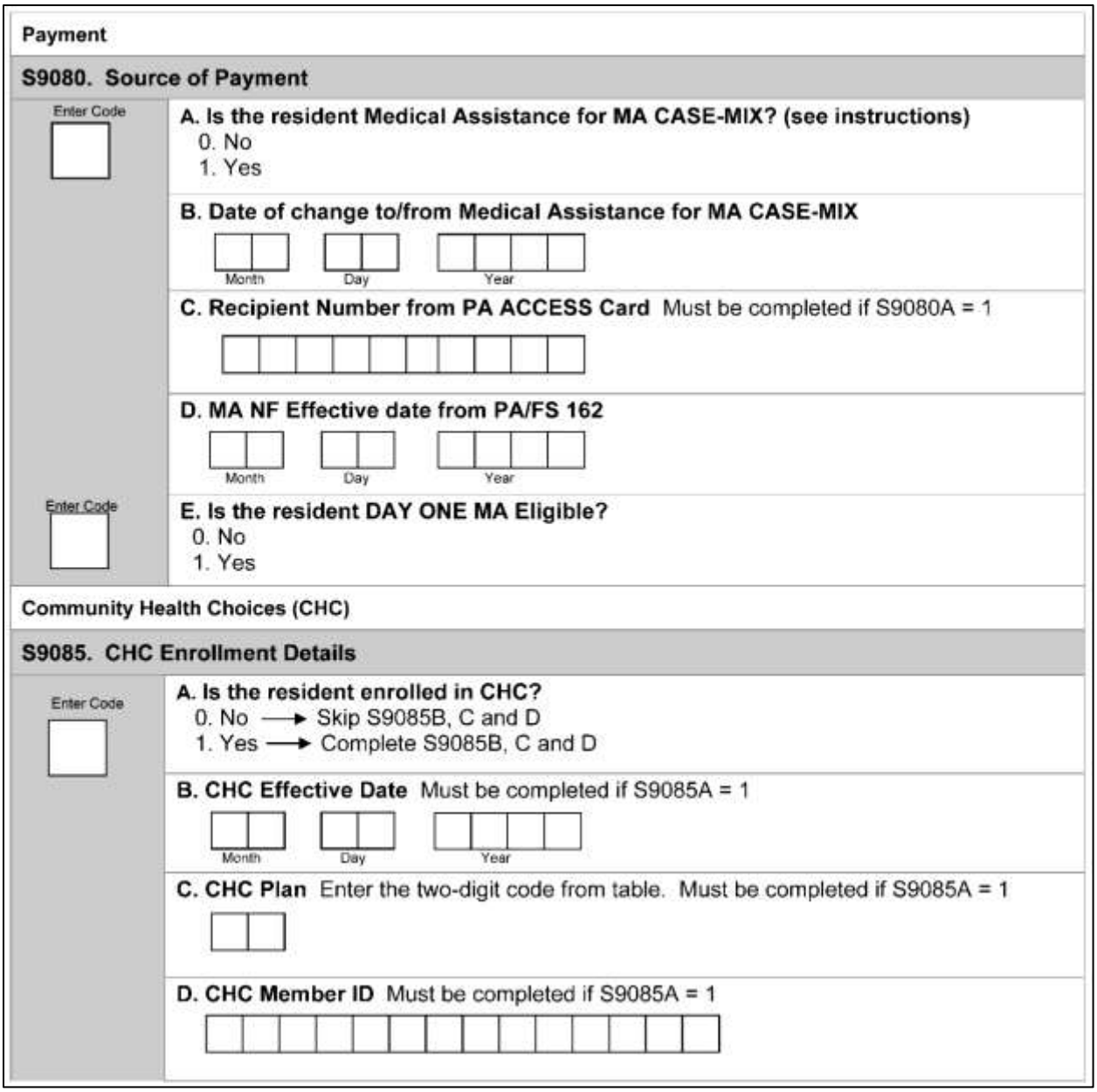
S0521. Primary Reason for Admission Complete only if A0310A = 01

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

Discharge After Discharge

S8010H1. Picture Date Reporting Complete only if A0310F = 11

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



Payment

S9080. Source of Payment

Enter Code ☐

A. Is the resident Medical Assistance for MA CASE-MIX? (see instructions)
0. No
1. Yes

B. Date of change to/from Medical Assistance for MA CASE-MIX
☐☐ Month ☐☐ Day ☐☐☐☐ Year

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

D. MA NF Effective date from PA/FS 162
☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

E. Is the resident DAY ONE MA Eligible?
0. No
1. Yes

Community Health Choices (CHC)

S9085. CHC Enrollment Details

Enter Code ☐

A. Is the resident enrolled in CHC?
0. No → Skip S9085B, C and D
1. Yes → Complete S9085B, C and D

B. CHC Effective Date Must be completed if S9085A = 1
☐☐ Month ☐☐ Day ☐☐☐☐ Year

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

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

MDS 3.0 Section S Manual

Section S: Pennsylvania-Specific

Items Intent

The intent of items in this section is to collect additional demographic and Pennsylvania MA case-mix payment information. Portions of Section S must be completed with all MDS 3.0 OBRA and PPS assessments (A0310A Federal OBRA Reason for Assessment = 01-06, A0310B PPS Assessment = 01-05, 07); Discharge Assessments (A0310F = 10, 11); Tracking Forms (Entry Record [A0310F = 01]; and Death in Facility Record [A0310F = 12]). S8010H1 PD reporting must be completed on any assessment when

A0310F = 11 Discharge Return Anticipated (DRA) regardless of the ISC being completed. Section S is not required with the standalone nursing home Part A PPS Discharge Assessment (A0310A = 99; A0310B = 99; A0310H = 1) unless combined with a discharge assessment.

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

Figure 2. S0113 Resident Living Situation Prior to Admission

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

☐☐

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

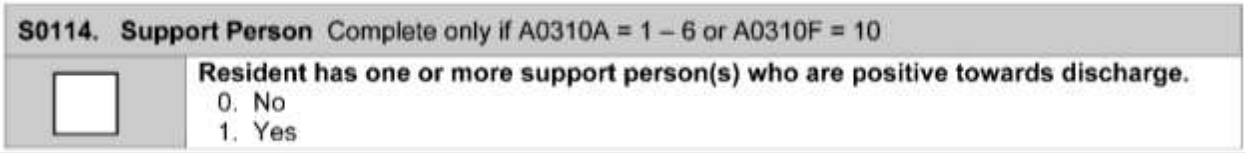
Definitions

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

Coding Instructions

- Enter the two-digit code that most closely describes the resident's previous living arrangements and availability of caregiver assistance prior to admission.
- Complete with Comprehensive Admission Assessment (ISC = NC; A0310A Federal OBRA Reason for Assessment = 01 Admission).
- This item must be completed on all admission records; it may not be skipped or dash filled.

Figure 3. S0114 Support Person(s)



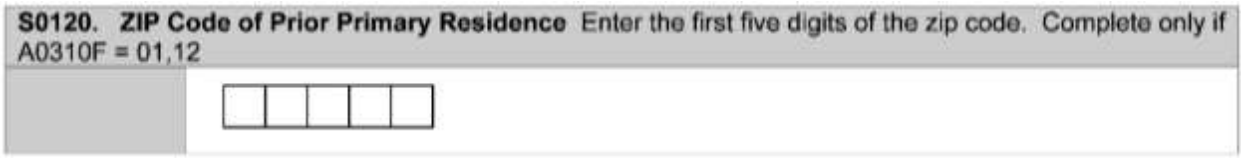
Definitions

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

Coding Instructions

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

Figure 4. S0120 ZIP Code of Prior Primary Residence



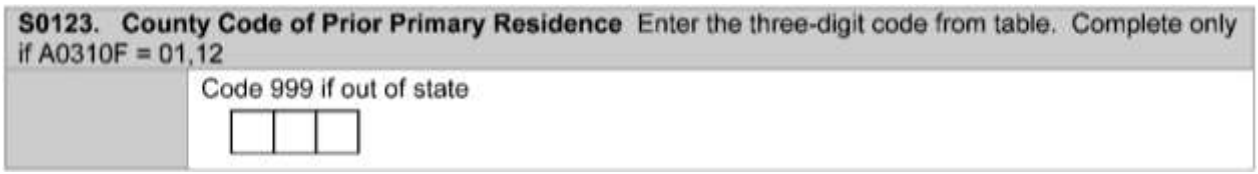
Definitions

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

Coding Instructions

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

Figure 5. S0123 County Code of Prior Primary Residence



Definitions

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

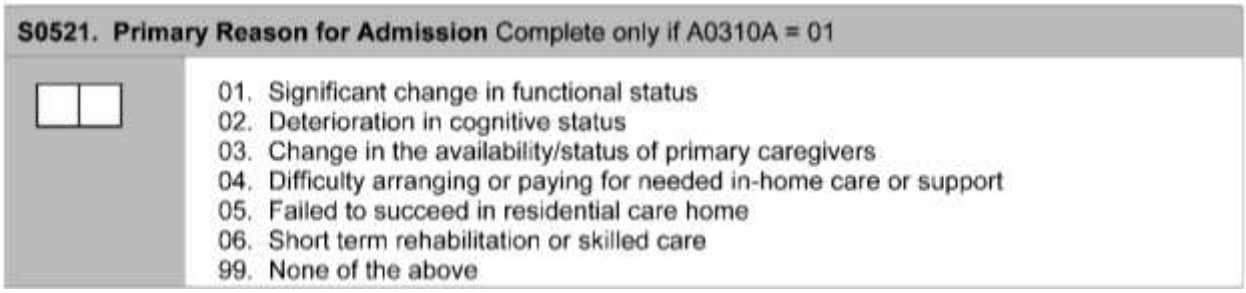
Coding Instructions

- Enter the three digits from the following table that indicate the county code of the prior primary residence.
- Enter 999 if the resident is from out of state.
- Enter dashes if the county is unknown.
- Complete with record type NT.

Figure 6. County Codes

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

Figure 7. S0521 Primary Reason for Admission



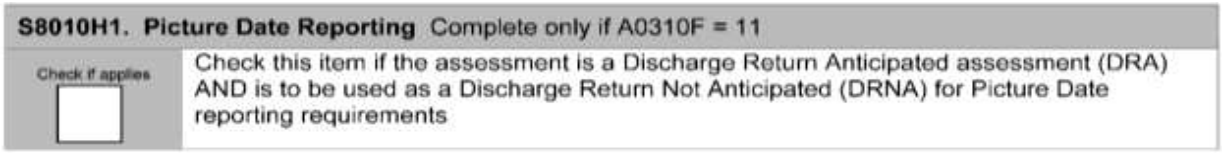
Definitions

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

Coding Instructions

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

Figure 8. S8010H1 PD Reporting



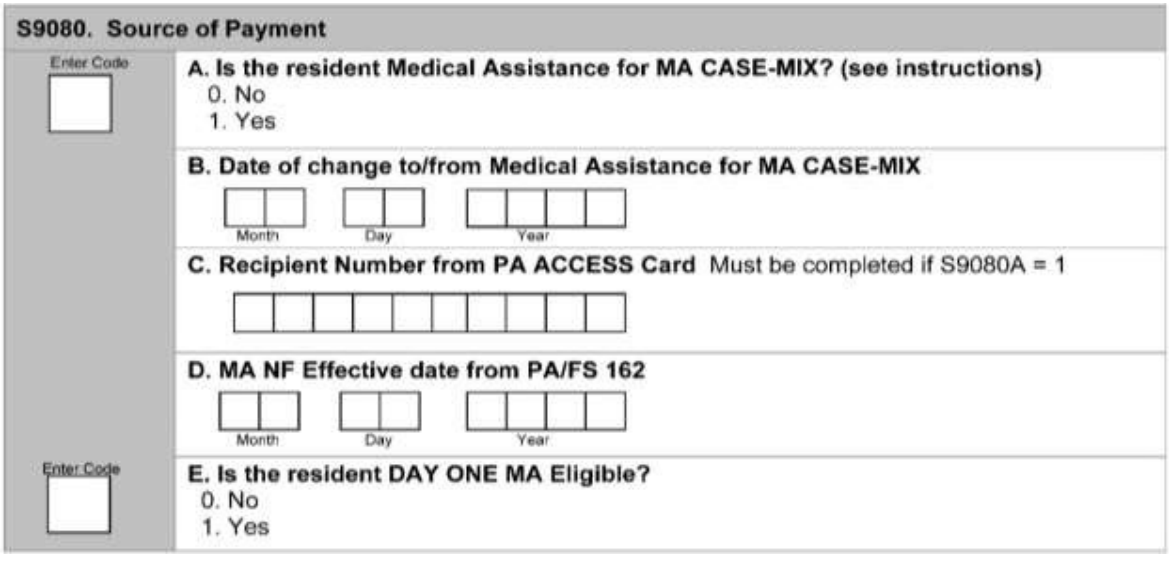
Definitions

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

Coding Instructions

- Complete only if A0310F = 11 (DRA).
- Do not check this item (submit as 0) if:
  - This is an original assessment (A0050 = 1).
  - This discharge assessment is being modified (A0050 = 2) for reasons other than using this DRA as a Discharge Return Not Anticipated (DRNA) for PD reporting requirements.
  - The ARD of the assessment is more than 30 days before the PD.
- Check this item (submit as 1) to use this DRA as a DRNA for MA PD reporting requirements. Code A0050 = 2 Modification.
- Skip this item (^) if A0310F does not = 11.
- If A0310F = 11, complete with record types NC, NQ, NP, ND.

Figure 9. S9080 Source of Payment



A. Is the resident MA for MA case-mix?

Definitions

- The resident is considered to be MA for MA case-mix if one of the following applies to

the day of care:

- The Department pays 100% of the MA rate for an MA resident.
- The Department and the resident and/or third-party pay other than Medicare Part A pay 100% of the MA rate for an MA resident.
- A managed care organization (MCO) under contract with the Department or an LTC Capitated Assistance Program (LTCCAP)/Living Independence for the Elderly (LIFE) provider (see note below) that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care.
- The resident and either an MCO under contract with the Department or LTCCAP/LIFE provider that provides managed care to an MA resident pays 100% of the negotiated rate or fee for an MA resident's care.
- The Department pays for care provided to an MA resident receiving hospice services in a NF. As long as MA is being billed for the day of care for a resident receiving hospice services, whether through MA or Medicare, the resident is MA for MA case-mix.

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

Coding Instructions

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

B. Date of change to/from MA for MA case-mix.

Definitions

- Date of change to/from MA for MA case-mix is the beginning date applicable to any change in the resident's MA for MA case-mix status.

Coding Instructions

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

C. Recipient number from Pennsylvania ACCESS card (if applicable) definitions.

- The Pennsylvania ACCESS card is a permanent plastic identification card issued to all recipients eligible for public assistance benefits. The 10-digit MA recipient number is found on this card and may be used by MA providers to verify an MA consumer's eligibility for MA services through the Eligibility Verification System.

Coding Instructions

- Enter the 10-digit MA recipient number found on the Pennsylvania ACCESS card, if available.
- If the resident does not have an MA recipient number, skip this item (enter caret [^] marks).

- Complete with record types NC, NQ, NP, NT, and ND.
- Must be completed if S9080A = 1.

D. MA NF effective date from PA/FS 162 definitions.

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

Coding Instructions

- Enter the two-digit month, two-digit day, and the four-digit year.
- If the resident does not have an applicable PA/FS 162 effective date, skip this item (enter caret [^] marks).
- Complete with record types NC, NQ, NP, NT, and ND.

E. Is the resident Day One MA eligible?

Definitions

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

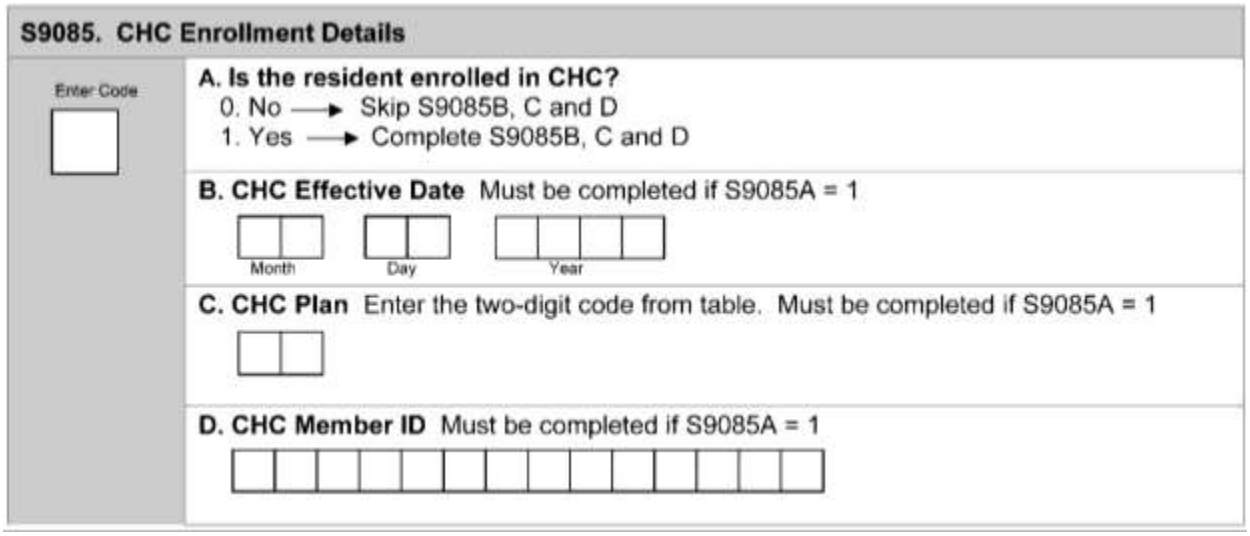
Coding Instructions

- Enter a 0 if No, 1 if Yes.
- The proper response should be identified for the first entry tracking form when the resident enters the NF. This same response should be entered each time the item must be completed until either the resident is DRNA (A0310F = 10) or the resident is DRA (A0310F = 11) and does not return within 30 days. In either of these cases, if the resident returns to the NF, the resident's

MA Day One eligibility status would be evaluated related to the new stay.

- A resident in the facility for respite care under a PDA waiver is MA Day One eligible. However, s/he is not MA for MA case-mix.
- Complete with record type NT.

Figure 10. S9085 Community HealthChoices



A. Is the resident enrolled in CHC?

Definitions

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

Coding Instructions

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

B. CHC Effective Date.

Definitions

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

Coding Instructions

- Enter the two-digit month, two-digit day, and the four-digit year.

- Complete with record types NC, NQ, NP, NT, and ND.
- This item must be completed on all listed record types if S9085A = 1. If the resident is not enrolled in a CHC plan, skip this item (enter caret [^] marks).

C. CHC plan.

Definitions

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

Coding Instructions

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

Table 1. CHC Plan Codes

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

D. CHC member ID.

Definitions

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

Coding Instructions

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

Pennsylvania-Specific MDS Specifications

Data Specifications

The partial data specifications contained in this section are taken from the CMS Data Submission Specifications and identify the record and data elements necessary to develop data encoding software for Pennsylvania NFs. For all elements, including Section S, the CMS Data Submission Specifications must

be used to develop validation and consistency checks. The specifications may be obtained from CMS' *MDS 3.0 Technical Information website*. The items included in this section are additions to the Data Submission Specifications for Section S. The items noted in the supplemental data specifications are defined as follows:

Table 2. Data Specifications

Data Specifications	
Specification Item	**Definition**
Item ID	The "Item ID" column gives the standard label for the field and a short description.
Item Values	Indicates the CMS-approved values that may be reported for the item.

Active on ISCs

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

Table 3 lists each of the Section S items, the Type of Assessment (A0310) on which the item is active (i.e., must be completed), and the associated ISC. An MDS 3.0 record is assigned an ISC by the facility software based on the coded responses to A0310 Type of Assessment and following the CMS Data Submission Specifications.

Table 3. CMS Data Submission Specifications

CMS Data Submission Specifications						
Section S	**Section S Item**	**A0310A**	**A0310B**	**A0310F**	**Type of Assessment**	**ISC Type**
S0113	Resident Living Situation Prior to Admission	01	01, 99	10, 11, 99	Comprehensive	NC
S0114	Support Person	01-06	01, 99	10, 11, 99	Comprehensive, Quarterly, Discharge	NC, NQ, ND
S0120	ZIP Code of Prior Primary Residence	99	99	01, 12	Tracking	NT
S0123	County Code of Prior Primary Residence	99	99	01, 12	Tracking	NT
S0521	Primary Reason for Admission	01	01, 99	10, 11, 99	Comprehensive	NC
S8010H1	PD Reporting	01-06, 99	01, 99	11	Comprehensive, Quarterly, PPS, Discharge	NC, NQ, NP, ND
S9080A MA for MA Case-mix?		01, 03 - 05	01, 99	10, 11, 99	Comprehensive	NC
S9080B Date of Change to/from MA		02, 06	01, 99	10, 11, 99	Quarterly	NQ
		99	01	10, 11 99	PPS	NP
S9080C Recipient Number from Pennsylvania ACCESS Card		99	99	10, 11	Discharge	ND
S9080D MA NF Effective Date from PA/FS 162		99	99	01, 12	Tracking	NT
S9080E Day One MA Eligible?		99	99	01, 12	Tracking	NT

CMS Data Submission Specifications						
Section S	Section S Item	A0310A	A0310B	A0310F	Type of Assessment	ISC Type
S9085A Is the resident enrolled in CHC?		01, 03-05	01, 99	10, 11, 99	Comprehensive	NC
S9085B CHC Effective Date S9085C CHC Product/Provider Name S9085D CHC Member ID		02, 06	01, 99	10, 11, 99	Quarterly	NQ
		99	01	10, 11, 99	PPS	NP
		99	99	10, 11	Discharge	ND
		99	99	01, 12	Tracking	NT

Section S Items Not Required

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

MA for MA Case-mix Purpose

A basic element in Pennsylvania's case-mix reimbursement system is the concept of MA for MA case-mix to determine if a resident's data is used to establish the MA CMI and Total Facility CMI or only the Total Facility CMI. The resident's MA for MA case-mix status is established on entry and is reported on all NC, NQ, NP, ND, and NT assessments/records submitted. The status will continue until the next assessment/ record confirms or changes the MA for MA case-mix status. Reporting changes in MA for MA case-mix status between assessments will be discussed in Section 3. Otherwise, only if the resident is discharged will the status be changed in the State database.

Acceptable Item Values

Table 4 indicates the CMS-defined acceptable item values for Section S.

Table 4. CMS-Defined Acceptable Item Values for Section S

CMS-Defined Acceptable Item Values for Section S	
Item ID	Item Values
S0113 Resident Living Situation Prior to Admission	01-04, 99; caret (^) mark indicating skipped when A0310A <>01
S0114 Support Person	0 No 1 Yes; caret (^) mark indicating skipped when A0310A = 99 and A0310F <>10
S0120 Residence prior to Admission: ZIP Code	5 digits; dashes indicating unknown
S0123 County code of prior residence	3 digits; dashes indicating unknown
S0521 Reason for Admission	01-06, 99; caret (^) mark indicating skipped when A0310A <> 01
S8010H1 PD Reporting	0 No 1 Yes; caret (^) marks indicating skipped
S9080A Is the resident MA for MA Case-mix?	0 No 1 Yes
S9080B Date of change to/from MA	YYYYMMDD
S9080C Recipient number from Pennsylvania ACCESS Card	10 digits; caret (^) marks indicating skipped
S9080D MA NF effective date from PA/FS 162	YYYYMMDD; caret (^) marks indicating skipped

CMS-Defined Acceptable Item Values for Section S	
Item ID	**Item Values**
S9080E Is the resident Day One MA eligible?	0 No 1 Yes; caret (^) marks indicating skipped
S9085A Resident Enrolled in CHC?	0 No 1 Yes; caret (^) marks indicating skipped
S9085B CHC Effective Date	YYYYMMDD; caret (^) mark indicating skipped when S9085A = 0
S09085C CHC Plan	01-03; caret (^) mark indicating skipped when S9085A = 0
S9085D CHC Member ID	Text with maximum length of 14; caret (^) mark indicating skipped when S9085A = 0

Transition

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

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

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

Beginning October 1, 2012, S8010H1 PD Reporting was added to Section S. If the resident was DRA (A0310F = 11) during the month before the PD and the facility has knowledge that the resident will not be returning, modify (code A0050 = 2) the DRA, checking S8010HI and submit the assessment. This directs the database to use this assessment as a DRNA for PD reporting requirements and the resident will not be included on the CMI report.

Beginning May 19, 2013, CMS reversed this policy requiring inactivation to correct target dates and reasons for assessment. These items may be changed using the modification process as long as the ISC does not change. A DRA (A0310F = 11) may be converted to a DRNA (A0310F = 10) to ensure creation of an accurate CMI report.

For the May 1 and August 1, 2012, PDs, the Discharge after Discharge Change form was used. After the August 1 PD, item S8010H1 is used.

Beginning October 1, 2016, CMS implemented a new version of the MDS — v. 1.14.1. CMS added ISC NPE, item A0310H Is this a SNF Part A PPS Discharge Assessment? and Section GG: Functional Abilities

and Goals to this version. No Section S items are required with the NPE, and the other items do not affect the calculation of any Pennsylvania MA items.

Beginning October 1, 2017, CMS implemented a new version of the MDS — v. 1.15.1. Items added in Section N: Medications and Section P: Restraints and Alarms did not affect the calculation of any Pennsylvania MA items. Pennsylvania chose to add the following items to Section S: S0133 Resident Living Situation Prior to Admission, S0114 Support Person, S0521 Primary Reason for Admission, S9085A Is the resident enrolled in CHC, S9085B CHC Effective Date, S9085C CHC Product/Provider Name, and S9085D CHC Member ID. Details about these items may be found in this chapter and in CMS Data Specifications. All previous Section S items continue to be required with no changes in specifications.

Beginning October 1, 2018, CMS implemented a new version of the MDS — V.1.16.1. Items added in Sections GG: Functional Abilities and Goals, M: Skin Conditions, I: Active Diagnosis, N: Medications, and J: Health Conditions, as well as items retired from section M: Skin Conditions, do not affect the calculation of any of the Pennsylvania MA items. CMS has also made the completion of Section K: Nutritional Status column one items optional for the following: K0510C Mechanically Altered Diet, K0510D Therapeutic Diet, K0710A Proportion of Total Calories Resident Received through Parenteral or Tube Feeding, and K0710B Average Fluid Intake per Day by IV or Tube Feeding. These Section K items do not affect the calculation of any Pennsylvania MA item and will be optional for completion in the Commonwealth. A dash is appropriate for these items.

Beginning October 1, 2019, CMS implemented a new version of the MDS — V.1.17.1. CMS has retired the RUGS IV-based payment system for PPS reimbursement and replaced it with the PDPM. With this change, CMS has also retired the scheduled PPS 14, 30, 60, and 90-day assessments, as well as the unscheduled PSS assessments end of therapy, start of therapy, and change of therapy. In lieu of these retired assessments, CMS has given each State the option to use the OSA to generate a RUG III/IV calculation for these assessments as needed for Medicaid reimbursement purposes. The Commonwealth has chosen not to use the OSA at this time, instead continuing to calculate a RUG III value based on the latest classifiable assessment. (ISC = NC, NQ, NP; A0310A = 01-06, and/or A0310B= 01). The RUG calculation is completed by the Nursing (Facility) Information System (NIS) for all classifiable assessments.

As of October 1, 2023, the federally required prospective payment system (PPS) and Omnibus OBRA assessments will no longer support the classification of these assessments into RUG groupers. As a result, Pennsylvania will require the use of the OSA to maintain the current RUG III-based case-mix classification system. An OSA will be required to be submitted with the same ARD as each federally required PPS and OBRA assessment that is completed and submitted to CMS.

Beginning October 1, 2025, CMS phased out support for the RUG reimbursement system and the OSA is no longer supported. The State has adopted a modified version of the PDPM, focusing exclusively on the

nursing component of the model to establish Medicaid CMIs. The latest classifiable OBRA or PPS assessment will be selected for inclusion on the CMI Report.

Software

Most NFs use proprietary software that performs many functions beyond basic MDS data entry and submission capabilities. In transition periods, some software may not yet be available or may not perform perfectly. CMS has the iQIES system — an internet-facing, cloud-based system — and requires users to be connected to the internet for use. Several manuals are provided for use.

Vendor Testing

CMS provides a software product for NFs to assist vendors in testing their products. The Validation Utility Tool is a software utility that can be used to validate MDS 3.0 submission files in the iQIES Submission System.

MA For MA Case-mix

MA For MA Case-mix Status

The MA or non-MA status of a resident at any point during the resident's stay is important to determine a correct case-mix reimbursement rate for a facility. The concept was developed to identify and designate those residents for whom the facility provided an "MA Day of Care." Chapter 1187.2 was amended so that effective January 1, 2004, an "MA Day of Care" is defined as one of the following: (1) the Department pays 100% of the MA rate for an MA resident; (2) the Department and the resident pay 100% of the MA rate for an MA resident; (3) an MA MCO or an LTCCAP provider that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care; (4) the resident and either an MA MCO or LTCCAP provider that provides managed care to an MA resident, pays 100% of the negotiated rate or fee for an MA resident's care; or (5) the Department pays for care provided to an MA resident receiving hospice services in a NF. To qualify for a hospital reserved beds days payment for rate year 2011 and thereafter, the facilities' overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to § 1187.104(b)(1)(iii)(b). A hospital reserved bed day may not be counted as an MA day of care. A therapeutic leave day will be counted as an MA day of care. However, if the MA resident on therapeutic leave no longer meets the conditions of § 1187.104(2) (e.g., has exceeded the 30 days allowed leave), the resident will be included in the census of the NF as a non-MA resident.

The resident's MA for MA case-mix status is reported in Section S at S9080A and completed on NC, NQ, NP, ND, and NT. If the resident's status changes, the most recent assessment before the PD should be modified to reflect the new MA for MA case-mix status. Consider the scenario where a resident reaches the end of his Medicare Part A benefits and starts coverage under a private insurance policy. The facility would not complete a modification in this scenario because the response to S9080A did not change, even though the source of payment did change.

Transition

Reporting a change in MA for MA case-mix status may now be done only with the use of the modification process. Use of MA change tracking forms is no longer appropriate since MDS 3.0 ISCs do not include an MA change tracking form. The modification process will be used to report changes in MA for MA case-mix status in items S9080A – B. In Chapter 5 of the MDS 3.0 RAI Manual, modifications are discussed, including demographic errors. While technically a change to the Section S Source of Payment information is not a correction, CMS has approved the modification of Pennsylvania's Section S to indicate a change to or from MA for MA case-mix. First, identify the latest assessment prior to the PD. Create a modification by coding A0050 as 2 Modification, complete the assessment, and then complete the items in Section X so the prior submitted assessment can be found in the national database. Change S9080A to reflect the MA for MA case-mix status and the date of the change in S9080B. The change in the MA for MA case-mix status for a modification is accurate on the date coded in S9080B Date of

Change to/from MA for MA case-mix. The modified assessment, which includes the updated Section S information, is then submitted as usual.

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

Beginning January 2018, DHS implemented the CHC program. This is an initiative to enable elderly and disabled Pennsylvanians to remain in the community. MCOs coordinate physical health care and long-term services and supports for older people with physical disabilities and people who are eligible for both Medicare and MA. If a resident served by a CHC-MCO in this program requires NF care, they are considered to be MA for MA case-mix.

Evaluating MA for MA Case-mix Status

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

- What standards must be met to consider a resident MA for MA case-mix?
    - The resident must be a resident of an MA facility.
    - The resident must have a valid Recipient Number (S9080C). A resident who is MA pending is not considered to be MA for MA case-mix purposes.
    - The Department pays 100% of the MA rate for an MA resident.
    - The resident must be physically in the facility or on therapeutic leave.
    - The resident must have a NF eligibility date from the PA/FS 162 – Notice to Applicant. However, this standard does not have to be met for the first 30 days in a NF by residents served by an MA managed care organization (MCO). See the bullet below.
    - Residents served by a physical health MCO (PH-MCO) (either mandatory or voluntary) are considered MA for MA case-mix during their first 30 days in the NF even though they do not have a PA/FS 162 with a NF effective date. They become MA pending on Day 31 and are no longer MA for MA case-mix if a PA/FS 162 has not been received.
    - Residents participating in CHC are considered MA for MA case-mix.
    - The PH-MCOs are responsible for nursing facility coverage through the first 30 days and any additional days up to and including the day a beneficiary is determined eligible for MA long-term services and supports. Enrollment in a CHC-MCO is effective the day after the eligibility determination and is indicated by a CHC-MCO start date in EVS. Providers are reminded to access EVS to ensure claims are submitted to the appropriate entity. If a beneficiary is determined ineligible for CHC, the beneficiary will remain in their PH-MCO and

the PH-MCO will remain responsible for physical health services, excluding the nursing facility payment, for day 31 and ongoing. The resident is considered non-MA for MA case-mix starting with day 31.

- An MA resident funded through the LTCCAP/LIFE program is MA for MA case-mix. This is an MA-financed program that is handled through a capitated payment system (one negotiated payment to be used to meet all the resident's care needs) rather than through the MA per diem payment system. The LTCCAP/LIFE provider is responsible for paying all NF bills for the duration of the resident's stay. If the MA resident is funded through an LTCCAP/LIFE provider, s/he is MA for MA case-mix. The LTCCAP/LIFE provider is responsible for providing the facility with a copy of the resident's PA/FS 162.
- **NOTE:** Some LTCCAP/LIFE providers also serve clients funded through private pay or other insurance. If a client does not have an ACCESS card or a PA/FS 162, she is not MA for MA case-mix even though covered by the LTCCAP/LIFE program.
- A resident participating in MA hospice is considered MA for MA case-mix.
- A resident receiving some services from a Medicare hospice, but the facility is billing MA for the day of care, is considered MA for MA case-mix.
- MA must be paying 100% of the resident's day of care, or the day of care is paid partially by MA combined with resident pay and/or third-party pay other than Medicare Part A to equal 100%.

Non-MA Status

Some situations disqualify a resident from being considered MA for MA case-mix:

- An MA pending resident is not MA for MA case-mix. MA pending is the resident's status while the application for MA benefits is in process. The resident may be in the NF for an extended period before the PA/FS 162 – Notice to Applicant is issued by the CAO. Until the PA/FS 162 is received from the CAO, the MA pending resident is not MA for MA case-mix.
- A resident funded by an out-of-state MA program is not MA for MA case-mix.
- A resident in the facility for respite care under a PDA waiver is MA Day One eligible. However, s/he is not MA for MA case-mix.
- A resident receiving any payment from Medicare Part A (Medicare per diem) is not MA for MA case-mix. This includes residents participating in Medicare Part A hospice where Medicare is paying for the day of care. However, payments may be received from Medicare Part B (ancillaries).
- A resident for whom a provider is not receiving any funds from MA is not MA for MA case-mix. Some part of the day of care must be paid by MA. There are infrequent situations where, though the resident has an MA number and MA NF effective date, other sources are paying the total facility bill. If the facility is not billing MA for any part

of the day of care, the resident is not MA for MA case-mix.

- A resident who has been discharged (A0310F = 10, 11, 12) is not MA for MA case-mix. However, when completing S9080A on a discharge assessment, the resident's MA for MA case-mix status should be reported at S9080A as if that discharge day was a billable day. When a discharge assessment is submitted, the resident's status is converted to non-MA in the NIS as of the discharge date (A2000). The NF will report the correct status on the entry tracking form when the resident returns.
- An MA resident who is out of the facility on therapeutic leave but has exceeded the 30 days leave allowed in § 1187.104(2) is not MA for MA case-mix.
- An MA resident who has been identified as sustaining a *Preventable Serious Adverse Event (PSAE)* on the PD is not MA for MA case-mix.
- A resident whose assessment does not contain a response for S9080A or S9080B is completed with dashes (--) or blank (^) is not MA for MA case-mix.

Further guidance on determining MA for MA case-mix status may be found in the Section S instructions included in this manual.

Coding For MA for MA Case-mix Status

MA for MA case-mix status is completed on the NC, NQ, NP, ND, or NT by placing a "1" for MA for MA case-mix in S9080A or "0" for non-MA. The date that applies to the MA for MA case-mix status coded in S9080A is coded in S9080B. If either S9080A or S9080B is left blank (^) or filled with a dash, the resident is assumed to be non-MA when generating the CMI report.

MA Status Continuum

The MA status of the resident is reported by the facility on five ISCs creating the ability to determine the status on a particular day of care. At S9080B, the NF reports the date of change to/from MA. MA for MA case-mix status is established at these various points during the resident's NF stay. It carries forward from that point until there is submission of a record to iQIES of a change and the applicable date of that change falls after the date of the last MA status change.

MA Pending

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

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

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

MA Pending Examples

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

Assumptions:
Date of Entry (A1600) – January 1

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

PA/FS 162 received – March 12

- An MA pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the PA/FS 162, the facility should modify the latest assessment (NC, NQ, NP, NT) before the PD to report this status change with S9080A = 1, and S9080B = January 1 and S9080D = January 1.
- An MA pending resident was admitted to the facility from the hospital. Medicare Part A is still covering his/her NF stay on March 12 when the PA/FS 162 form is received. From January 1 through March 12, the resident is non-MA due to receipt of Medicare Part A benefits and the MA pending status. On March 13, the resident continues to be non-MA because of the continued Medicare Part A benefits. No modification should be completed until the Part A stay ends because the response to S9080A has not changed. When the Part A stay ends, modify the latest assessment (NC, NQ, NP, or NT) before the PD with S9080A = 1 Yes, S9080B = the day after Medicare Part A stopped, and S9080D = January 1.
- An MA pending resident was admitted to the facility from the hospital. Medicare Part A covered his stay through January 15. From January 1 through January 15, the resident is non-MA due to

receipt of Medicare Part A benefits and the MA pending status. On January 16, the resident remains non-MA due to the MA pending status. After receipt of the PA/FS 162, the facility should modify the latest assessment (NC, NQ, NP, or NT) before the PD with S9080A = 1 Yes, S9080B = January 16 and S9080D = January 1.

- An MA pending resident was admitted to the facility from the hospital. Medicare Part A covered his stay through January 15. He died February 10. A modification of the latest NC, NQ, NP, or NT with an ARD on or before the PD should be submitted even though the PA/FS 162 was received several weeks after the discharge with S9080A = 1, S9080B = January 16, and S9080D = January 1. A new CMI report will be generated including him in the proper MA section.

- An LTCCAP/LIFE resident was admitted to the facility from the community with no prior hospital stay. The LTCCAP/LIFE provider provides a PA/FS 162 dated two years previously. Due to the LTCCAP/LIFE status, the resident is MA for MA case-mix immediately upon entry and the resident's entry tracking form should be completed with S9080A = Yes, S9080B = January 1, and S9080D = effective date on PA/FS 162 received from the LTCCAP/LIFE provider.

- An MA MCO resident was admitted to the facility with no prior hospital stay. Due to the MA MCO status, the resident is MA for MA case-mix immediately upon entry for 30 days. The resident's entry tracking form should be completed with S9080A = 1, S9080B = January 1, and S9080D = blank (^). No PA/FS 162 is necessary on admission. However, if the PA/FS 162 is not received by Day 30, the resident becomes MA pending on January 31 (Day 31). A modification of the latest assessment (NC, NQ, NP, or NT) before the PD should be completed with S9080A = 0, S9080B = January 31, and S9080D = blank (^).

- An MA pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the PA/FS 162, the facility should complete a modification of the latest assessment (NC, NQ, NP, or NT) prior to the PD with S9080A = 1, S9080B = January 1, and S9080D = January 1. The resident starts to receive Medicare hospice services, such as medications and counseling on April 1, but the facility is billing MA for the day of care. No modification should be completed because the response to S9080A has not changed. The resident is still MA for MA case-mix even though s/he is receiving Medicare Part A hospice services.

- An MA pending resident was admitted to the facility from the community with no prior hospital stay. After receipt of the PA/FS 162, the facility should complete a modification of the latest assessment (NC, NQ, NP, or NT) before the PD with S9080A = 1, S9080B = January 1, and S9080D = January 1. The resident starts to receive MA hospice services on April 1. No modification should be completed because the response to S9080A has not changed. The resident is still MA for MA case-mix since s/he is receiving MA hospice services.

- A resident who is eligible for both MA and Medicare enters the facility under Medicare Part A hospice. The resident is receiving "ancillary" services, such as medications and counseling from

Medicare Part A and Medicare Part A is also paying for the day of care. The entry tracking form should be completed with S9080A = 0 and S09080B = January 1.

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

If the PA/FS 162 had not been received before the PD deadline, the resident would properly appear in the non-MA section for the February PD. The facility did not have knowledge that s/he was MA for MA case-mix during the February PD submission and correction period. If the correction period had been extended by the Department, the facility would be responsible for seeing that the modifications were submitted, a new CMI report generated, and a new Certification Page signed and submitted.

Day One MA Eligible

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

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

Data Submission

Getting Started

To be eligible to participate in the Pennsylvania MA program, providers shall be currently licensed by the Pennsylvania DOH and enrolled as a provider with the Department. An online provider enrollment application must be completed at https://provider.enrollment.dhs.pa.gov/. After a new NF is enrolled in the MA program, the Department mails an enrollment letter to the facility and sends a copy of the letter to Myers and Stauffer, the Department's case-mix contractor. This letter is usually mailed to the facility within three or four months of the date of the facility's certification; however, the process may take longer for some facilities.

The new facility must register for an account in the iQIES to submit MDS assessments to CMS. The registration process involves two main steps: creating an account in the HCQIS Access, Roles, and Profile (HARP) system and then requesting a user role in iQIES.

The first step is to create a CMS identity and login through the HARP system. Go to the HARP registration page at https://harp.cms.gov/register. After creating a HARP account, the user must log in to iQIES to request a user role. Navigate to https://iqies.cms.gov/ and sign in with your new HARP credentials to request a user role.

The new facility must also obtain MDS 3.0 data entry software. This software may be developed internally or purchased from a software vendor. When the facility has obtained software, the new facility is now ready to submit records to iQIES. All assessments that have been completed since the facility's certification date must be submitted. Since there is usually a time lag of several months between the certification date and the receipt of the password and connectivity letter, there will initially be a large number of assessment records to submit.

For PDs that occur during the time lag between the effective date of the facility's certification and the receipt of the password and connectivity letter, the statewide average MA CMI for a PD will be used in a facility's MA case-mix reimbursement rate calculation. If the facility receives their password and connectivity letter prior to a PD, the facility is expected to complete the submission and CMI report requirements for the PD that are detailed in the *CMI Reports* section of this manual and §1187.33 "Resident Data and Picture Date Reporting Requirements."

Change of Provider Information

When a facility changes its information, such as facility name or address, or undergoes a change of ownership, the facility must notify the Department of the change in writing on facility letterhead. Once the Department has processed the information change, it mails an update letter to the facility and sends a copy of the letter to the contractor. This letter is usually mailed to the facility within three or four

months of the date of the information change; however, the process may take longer for some facilities.

The facility may continue to submit data using the old Provider Reimbursement and Operations Management Information System (PROMISe) provider number and other information until the new password and connectivity letter is received. For change of ownership situations, there is no need for the facility to resubmit records created and/or submitted with the old PROMISe provider number after receiving notification of their new number. The NIS and iQIES connect these records to the new account.

Submission Process

The MDS 3.0 assessments and tracking forms must be submitted to CMS' iQIES. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA or SNF PPS reasons are not to be submitted to iQIES. Examples include, but are not limited to, private insurance and Medicare Advantage Plans (i.e., Medicare Part C). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 website at: https://www.cms.gov/medicare/quality/nursing-home-improvement/minimum-data-set-technical-information.

When the transmission file is received by iQIES, the system performs a series of validation edits to evaluate whether data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order regarding records that were previously accepted by iQIES for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a FVR. All error and warning messages are detailed and explained in the iQIES MDS Error Message Reference Guide available at: https://qtso.cms.gov/reference-and-manuals/iqies-mds-error-message-reference-guide, a CMS national database using the CMS instructions found in the Provider User's Guide. The data submitted by Pennsylvania NFs is transferred via a secure server and then transferred into the Pennsylvania Nursing Facility Information System. This national database is referred to in this manual as iQIES. Chapter 1187.33(a)(1) "Resident Data and Picture Date Reporting Requirements" also requires data to be submitted electronically. The Department has designated that these submission requirements mirror the federal requirements for submission. Thus, all records submitted by MA facilities to fulfill the resident data reporting requirements are submitted to iQIES.

Submission Deadlines

The deadline for submitting MDS and tracking form records for resident reporting requirements follows the federal guidelines of within 14 days of completion for most records. A newly admitted resident's initial MDS record must be submitted within seven calendar days of the date the record is completed (§ 1187.22(18)). After reviewing the MDS 3.0 record types and federal requirements for completion and submission, the Department has decided that timely completion and submission of the entry tracking

form (A0310F = 01) will meet this requirement.

Table 5. Submission Deadlines

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

The deadline for submitting any assessment or other tracking form that would affect the accuracy of a CMI report is the lesser of 14 days of completion of the form or the end of the PD submission and correction period. See PD Submission and Correction Deadlines in Chapter 5 of the MDS 3.0 RAI Manual.

Resident Identification Information

Each record for a specific resident should be submitted with identical identification information — name, birth date, death date, gender, race/ethnicity, current facility internal ID, social security number (SSN), Medicare number, and Medicaid number. Variations in resident identification information will lead to a Warning (-1031) on the FVR alerting the facility that basic information has been submitted differently on this record. The resident table in the database has been updated with this new information.

If any of the above patient identifiers are changed in a subsequently submitted MDS assessment, CMS will create a new resident identification number and assumes this is a "new" resident. The facility usually becomes aware of this problem due to the receipt of an unexpected sequencing error on the FVR (inconsistent record sequence -1018) and a notice that a new resident has been created (-1027).

Appropriate corrective action must be taken. Corrective action may include contacting the Pennsylvania MDS Automation Coordinator and requesting that the data be merged.

At times, identification information changes are expected. A resident's Medicaid number is received so the entry at A0700 changes from the + (pending) of previous records to a 10-digit number, or a resident dies and the date of death is inserted into the death date field which was previously blank.

Records with the Same Effective Date

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

For example, if a resident returned to the facility from the hospital on January 20, an entry tracking form (A0310F = 01, A1700 = 2) would be completed with an entry date in item A1600 of January 20. If the resident left the facility later that same day and return was not anticipated, a discharge assessment

(A0310F = 10) would be completed with a discharge date in item A2000 of January 20. If these two records are submitted to iQIES in the same batch, the record that is processed last will determine the residency status for the PD. If the entry tracking form is processed last, the resident will be deemed to be a resident of the facility for the February PD, which is incorrect.

To prevent this situation from occurring, the facility should submit any resident's records that have the same effective date in separate batches. The records should be submitted in the order the facility wishes them to be saved in iQIES. To continue the previous example, the entry tracking form with an entry date in item A1600 of January 20 should be submitted first and the discharge assessment with a discharge date in item A2000 of January 20 should be submitted later in a separate batch. This would ensure the residency status of the resident would be correctly reported on the CMI report.

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

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

Picture Date Submissions

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

Picture Date Submission and Correction Deadlines

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

requirements will also meet Chapter 1187 PD deadline requirements.

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

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

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

A calendar containing important PD milestones is posted on the *DHS Long-Term Care Case-mix Information site* and the Bulletins section of the NF Report Portal (NFRP).

PDPM Classification

PDPM

To translate clinical information submitted for MA facility residents into MA case-mix reimbursement rates, a PDPM group is calculated by the NIS for each MDS assessment that can be classified (ISC = NC, NQ, NP; A0310A = 01-06 and/or A0310B = 01) using a subset of the elements submitted on these assessments.

PDPM classification is used for the MA case-mix reimbursement system for PDs that affect January 1, 2026 rates and beyond. For each PDPM group, a CMI is assigned. A CMI is a numerical score that describes the relative resource use for the average resident in each PDPM group. The MA case-mix reimbursement system uses state-specific CMIs that are based on the CMS nursing-only PDPM component.

The MA case-mix reimbursement system incorporates the hierarchy index for CMIs. If a resident's assessment qualifies for more than one PDPM classification, the assessment is assigned to the PDPM category that is higher (or comes first) in the hierarchy.

Effective October 1, 2023, Pennsylvania has required a concurrent OSA be completed with the same ARD on each federally required assessment submitted for all Medicaid certified NFs. The OSA completed with same ARD as the federally required assessments noted in this manual will be used to support the RUG classification case-mix system that is currently used. The OSA is required for all residents in the facility regardless of payor source. With the implementation of PDPM in Pennsylvania the OSA is no longer required to be submitted.

Eligible Assessments

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

PDPM Classification

PDPM classification involves assessing an SNF patient's characteristics via the MDS to determine their placement into separate case-mix groups for five components: physical therapy, occupational therapy, speech-language pathology, nursing, and non-therapy ancillary. These classifications, derived from patient data, drive the CMI used to calculate the per diem payment, with adjustments for factors like functional status, cognitive impairment, clinical conditions, and comorbidities. Software and official CMS documentation provide detailed logic and tools for calculating and encoding the final *Health Insurance*

Prospective Payment System (HIPPS) code, which represents the patient's PDPM classification.

Introduction to the PDPM Calculation Worksheet for SNFs

The following pages were extracted from the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, chapter 6. This worksheet will aid the NF in understanding the factors that contribute to the placement of an assessment in a specific PDPM category. Please note that the Department has chosen to only use the nursing component to determine a resident PDPM classification for MA reimbursement. Only the pages related to the nursing component have been included here. The full version of the worksheet can be obtained from the CMS website.

This educational tool was developed to assist providers with understanding the PDPM Group logic when used with MDS 3.0 Version 1.20.1. This tool should not be used for software development. Additional information is available on CMS' *MDS 3.0 Technical Information* page in the PDPM Grouper package.

On the worksheet, work through all steps in the instructions and use these responses to arrive at the final classification for this resident. Record information on the worksheet as directed.

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

- When MDS data is submitted electronically, for a section with instructions to "Check all that apply," the blank boxes are submitted as "0," the checked boxes are submitted as "1."
- "AND" and "OR" are very powerful words typed in capitals to draw attention to the special classification requirements.

6.6 PDPM Calculation Worksheet for SNFs

In the PDPM, there are five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each resident is to be classified into one and only one group for each of the five case-mix adjusted components. In other words, each resident is classified into a PT group, an OT group, an SLP group, an NTA group, and a nursing group. For each of the case-mix adjusted components, there are a number of groups to which a resident may be assigned, based on the relevant MDS 3.0 data for that component. There are 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups.

PDPM classifies residents into a separate group for each of the case-mix adjusted components, each of which has its own associated case-mix indexes and base rates. Additionally, PDPM applies variable per diem payment adjustments to three components, PT, OT, and NTA, to account for changes in resource use over a stay. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP and nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.

Calculation of PDPM Cognitive Level

The PDPM cognitive level is utilized in the SLP payment component of PDPM. One of four PDPM cognitive performance levels is assigned based on the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status for the PDPM cognitive level. If neither the BIMS nor the staff assessment for the PDPM cognitive level is complete, then the resident will be classified as if the resident is cognitively intact.

STEP #1

Determine the resident's BIMS Summary Score on the MDS 3.0 based on the resident interview. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS involves the following items:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score that ranges from 00 to 15. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Calculate the resident's PDPM cognitive level using the following mapping:

Table 6: Calculation of PDPM Level from BIMS

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13-15
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

PDPM Cognitive Level: _____

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), then proceed to Step #2 to use the Staff Assessment for Mental Status for the PDPM cognitive level.

STEP #2

If the resident's Summary Score is 99 or the Summary Score is blank or has a dash value, then determine the resident's cognitive status based on the Staff Assessment for Mental Status for the PDPM cognitive level using the following steps:

A) The resident classifies as severely impaired if one of the following conditions exists:

a. Comatose (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88). It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

b. Severely impaired cognitive skills for daily decision making (C1000 = 3).

B) If the resident is not severely impaired based on Step A, then determine the resident's Basic Impairment Count and Severe Impairment Count.

For each of the conditions below that applies, add one to the Basic Impairment Count.

a. In Cognitive Skills for Daily Decision Making, the resident has modified independence or is moderately impaired (C1000 = 1 or 2).

b. In Makes Self Understood, the resident is usually understood, sometimes understood, or rarely/never understood (B0700 = 1, 2, or 3).

c. Based on the Staff Assessment for Mental Status, the resident has a memory problem (C0700 = 1).

Sum a., b., and c. to get the Basic Impairment Count: _____

For each of the conditions below that applies, add one to the Severe Impairment Count.

a. In Cognitive Skills for Daily Decision Making, the resident is moderately impaired (C1000 = 2).

b. In Makes Self Understood, the resident is sometimes understood or rarely/never understood (B0700 = 2 or 3).

Sum a. and b. to get the Severe Impairment Count: _____

C) The resident classifies as moderately impaired if the Severe Impairment Count is 1 or 2 and the Basic Impairment Count is 2 or 3.

D) The resident classifies as mildly impaired if the Basic Impairment Count is 1 and the Severe Impairment Count is 0, 1, or 2, or if the Basic Impairment Count is 2 or 3 and the Severe Impairment Count is 0.

E) The resident classifies as cognitively intact if both the Severe Impairment Count and Basic Impairment Count are 0.

PDPM Cognitive Level: _____

PDPM Payment Component: Nursing

STEP #1

Calculate the resident's Function Score for nursing payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

Table 18: Function Score for Nursing Payment

Admission Performance (Column 1) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Next, calculate the average score for the two bed mobility items and the three transfer items as follows: Average the scores for Sit to Lying and Lying to Sitting on Side of Bed.[1] Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer.[2] Enter the average bed mobility and transfer scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Calculate the sum of the following scores: Eating Function Score, Toileting Hygiene Function Score, Average Bed Mobility Score, and Average Transfer Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for nursing payment**. The PDPM Function Score for nursing payment ranges from 0 through 16.

PDPM NURSING FUNCTION SCORE: _____

STEP #2

Determine the resident's nursing case-mix group using the hierarchical classification below. Nursing classification under PDPM employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the PDPM nursing classification model steps discussed below; the assigned classification is the first group for which the resident qualifies. In other words, start with the Extensive Services groups at the top of the PDPM nursing classification model. Then go down through the groups in hierarchical order: Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 25 individual PDPM nursing groups for which the resident qualifies, assign that group as the PDPM nursing classification.

[1] Calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed. Divide this sum by 2. This is the Average Bed Mobility Function Score.

[2] Calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer. Divide by 3. This is the Average Transfer Function Score.

CATEGORY: EXTENSIVE SERVICES

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP #1

Determine whether the resident is coded for **one** of the following treatments or services:

O0110E1b	Tracheostomy care while a resident
O0110F1b	Invasive mechanical ventilator or respirator while a resident
O0110M1b	Isolation or quarantine for active infectious disease while a resident

If the resident does not receive one of these treatments or services, skip to the Special Care High Category now.

STEP #2

If at least **one** of these treatments or services is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify in the Extensive Services category. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	PDPM Nursing Classification
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Isolation or quarantine for active infectious disease* **without** tracheostomy care* **without** ventilator/respirator*	ES1

*while a resident

PDPM Nursing Classification: ____

If the resident does not classify in the Extensive Services Category, proceed to the Special Care High Category.

CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0520B2 or K0520B3 Feeding tube*
K0520A2 or K0520A3	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to the Special Care Low Category now.

STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify as Special Care High. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

PDPM Nursing Classification: _____

CATEGORY: SPECIAL CARE LOW

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, Nursing Function Score	Cerebral palsy, with Nursing Function Score <=11
I5200, Nursing Function Score	Multiple sclerosis, with Nursing Function Score <=11
I5300, Nursing Function Score	Parkinson's disease, with Nursing Function Score <=11
I6300, O0110C1b	Respiratory failure and oxygen therapy while a resident
K0520B2 or K0520B3	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer or any unstageable pressure ulcer due to slough and/or eschar with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0110B1b	Radiation treatment while a resident
O0110J1b	Dialysis treatment while a resident

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:
M1200A, B Pressure relieving chair and/or bed
M1200C Turning/repositioning program
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer/injury care
M1200G Application of nonsurgical dressings (not to feet)
M1200H Application of ointments/medications (not to feet)
#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to the Clinically Complex Category now.

STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify as Special Care Low. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

PDPM Nursing Classification: _____

CATEGORY: CLINICALLY COMPLEX

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

Table 19: Clinically Complex Conditions or Services

MDS Item	Condition or Service
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D, E	Open lesions (other than ulcers, rashes, and cuts) or surgical wounds with any selected skin treatments*
M1040F	Burns (second or third degree)
O0110A1b	Chemotherapy while a resident
O0110C1b	Oxygen therapy while a resident
O0110H1b	IV Medications while a resident
O0110I1b	Transfusions while a resident

*Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)

If the resident does not have one of these conditions, skip to the Behavioral Symptoms and Cognitive Performance Category now.

STEP #2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #3

Select the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
15-16	Yes	CA2
6-14	No	CBC1
15-16	No	CA1

PDPM Nursing Classification: _____

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP #1

Determine the resident's PDPM Nursing Function Score. If the resident's PDPM Nursing Function Score is 11 or greater, go to Step #2.

If the PDPM Nursing Function Score is less than 11, skip to the Reduced Physical Function Category now.

STEP #2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

If the resident's Summary Score is less than or equal to 9, they classify in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.

If the resident's Summary Score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

STEP #3

Determine the resident's cognitive status based on the staff assessment rather than on resident interview.

Check if **one** of the three following conditions exists:

1.	B0100	Coma (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
2.	C1000	Severely impaired cognitive skills for daily decision making (C1000 = 3)
3.	B0700, C0700, C1000	Two or more of the following impairment indicators are present: B0700 > 0 Usually, sometimes, or rarely/never understood C0700 = 1 Short-term memory problem C1000 > 0 Impaired cognitive skills for daily decision making **and** One or more of the following severe impairment indicators are present: B0700 >= 2 Sometimes or rarely/never makes self understood C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making

If the resident meets one of the three above conditions, then they classify in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If they do not meet any of the three conditions, proceed to Step #4.

STEP #4

Determine whether the resident presents with **one** of the following behavioral symptoms:

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

If the resident presents with one of the symptoms above, then they classify in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If they do not present with behavioral symptoms, skip to the Reduced Physical Function Category.

STEP #5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #6

Select the final PDPM Classification by using the total PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

PDPM Nursing Classification: _____

CATEGORY: REDUCED PHYSICAL FUNCTION

STEP #1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a PDPM Nursing Function Score less than 11, are placed in this category.

STEP #2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #3

Select the PDPM Classification by using the PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
15-16	2 or more	PA2
6-14	0 or 1	PBC1
15-16	0 or 1	PA1

PDPM Nursing Classification: _____

Calculation of Variable Per Diem Payment Adjustment

PDPM incorporates variable per diem payment adjustments to account for changes in resource use over the course of a stay for three payment components: PT, OT, and NTA. To calculate the per diem rate for these components, multiply the component base rate by the case-mix index associated with the resident's case-mix group and the adjustment factor based on the day of the stay, as shown in the following equation:

Component Per Diem Payment = Component Base Rate x Resident Group CMI x Component Adjustment Factor

The adjustment factors for the PT and OT components can be found in the table below.

Table 20: PT and OT Variable Per Diem Adjustment Factors

Day in Stay	PT and OT Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

The adjustment factors for the NTA component can be found in the table below.

Table 21: NTA Variable Per Diem Adjustment Factors

Day in Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate

The total case-mix adjusted PDPM per diem rate equals the sum of each of the five case-mix adjusted components and the non-case-mix adjusted rate component. To calculate the total case-mix adjusted per diem rate, add all component per diem rates calculated in prior steps together, along with the non-case-mix rate component, as shown in the following equation:

*Total Case-Mix Adjusted Per Diem Payment = (PT Component Per Diem Rate * PT Variable Per Diem Adjustment Factor) + (OT Component Per Diem Rate * OT Variable Per Diem Adjustment Factor) + SLP Component Per Diem Rate + (NTA Component Per Diem Rate * NTA Variable Per Diem Adjustment Factor) + Nursing Component Per Diem Rate + Non-Case-Mix Component Per Diem Rate*

CMI Reports

Case-mix Index

The regulations at §1187.2 define a CMI as "A number value score that describes the relative resource use for the average resident utilizing the PDPM nursing component classification methodology and associated weights based on the assessed needs of the resident." For example, residents falling into a PDPM category with a CMI of 1.30 take more than twice the nursing resources as a resident assessed in a PDPM category with a CMI of 0.64. As a number, the CMI is the link between the clinical data submitted for the NF residents and the MA case-mix reimbursement rate. This link is made possible using the CMI report for each PD.

CMI Report Generation

The final step in completing the resident reporting requirements for each PD is the correction and certification of the CMI report by the NF. A CMI report is "generated" by the NIS from all records submitted to iQIES but only contains the list of residents the NIS determines were in the facility on a PD and they have a classifiable assessment. For each of these residents, the resident's name, Assessment Internal ID, ARD, correction number (X0800), assessment type, PDPM category, and appropriate CMI is listed. The first page of the CMI report also includes a certifying statement to be signed by the administrator or acting administrator, and CMI averages of the residents are listed on the remaining page(s).

Initial CMI Report Transition

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

As of October 1, 2013, CMS removed the MDS 2.0 submission link from the CMS MDS Welcome Page. The MDS 2.0 Data Management System is no longer in effect. A new link, MDS State Reports, appeared on the Welcome Page.

As of October 1, 2014, CMS lists the state links that had been used to securely distribute the CMI reports. A new secure file hosting disabled server known as the NFRP was implemented, which enables NF representatives to access the CMI reports over the internet. A certified letter was sent to all nursing home administrators in November 2014 outlining the new procedure and containing the initial password to allow establishment of individual user accounts. A complete step-by-step procedure detailing how to access and use this new system appears on the *NFRP Welcome Page*.

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

An example CMI report is located on pages 66 through 68.

Subsequent CMI Reports

If the initial CMI report generated and posted for a PD is not correct, the facility submits further records to iQIES prior to the PD deadline. With each submission batch, a newer CMI report is generated for the facility to review. Usually, the subsequent CMI report is generated and posted within 24 hours of each submission up to the PD deadline.

The facility repeats the submission process until a correct CMI report is generated. The first page of this accurate report must be signed and uploaded by the Certification Page submission deadline.

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

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

CMI Report File Names

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

Reviewing CMI Reports

The facility must review the CMI report carefully for three things:

- Are the correct residents appearing on the report compared to the census of the residents on the PD?
- Is the resident's MA for MA case-mix status correct for the PD?
- Is the correct assessment for a resident appearing on the report for the PD?

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

Residents

The residents appearing on the CMI report should correspond to your facility's census for the PD. When creating a CMI report, residency in the facility on the PD is determined by the record with the effective date closest to or on the PD. The residency status is "No" for the PD if this record is a Discharge Assessment with Return Not Anticipated (A0310F = 10) or a Death in Facility Tracking Record (A0310F = 12), and the resident will not be listed on the CMI report. If this record is a Discharge Assessment with Return Anticipated (A0310F = 11), there are rules described below for establishing residency. If this record is any other assessment or tracking form, the residency status is "Yes" for the PD and the resident will be listed on the CMI report.

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

- For an Admission record (A0310A = 01) the effective date is the Entry Date (A1600).
- For an Annual record (A0310A = 03), a Significant Change record (A0310A = 04), a Significant Correction record (A0310A = 05), a Quarterly record (A031A = 02), a Significant Correction of Quarterly (A0310A = 06), or a Medicare PPS Only record (A0310A = 99; A0310B=01,08) the effective date is A2300 (ARD).
- For a Discharge Assessment/record (A0310F = 10, 11 or 12) the effective date is the Discharge Date (A2000).
- For an Entry tracking form (A0310F = 01) the effective date is the Entry Date (A1600).

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

- Residents that were admitted on the PD day (February 1, May 1, August 1, or November 1) should appear on the CMI report in the MA area if they are MA for MA case-mix on the admission day. If not, the resident should appear in the non-MA area.
- Residents that were discharged on or before the PD day (February 1, May 1, August 1, or November 1) without anticipated return (A0310F = 10) or Death in Facility (A0310F = 12) should not appear on the CMI report.
- Residents that were Discharged with an Anticipated Return (A0310F = 11) will appear in the non-MA section if they have been out of the facility 30 days or less. The submission of a Discharge Assessment with an Anticipated Return converts an MA for MA case-mix resident to non-MA status.
- Residents that were discharged and do not have an Admission assessment (A0310A = 01) or Medicare PPS assessment (A0310A = 99; A0310B = 01) applicable to the new Entry Date (A1600) in iQIES and will not appear on the CMI report. No PDPM group or CMI can be calculated from an Entry record (A0310F = 01) or a Discharge

Assessment/record (A0310F = 10, 11, or 12).

- MA for MA case-mix residents that were out of the facility on therapeutic leave on the PD should appear on the MA portion of the CMI report. An MA for MA case-mix resident who is out of the facility on therapeutic leave on the PD but does not meet the conditions of § 1187.104(2) (e.g., has exceeded the 30 days leave allowed) shall appear in the non-MA portion of the CMI report. The NF should modify the latest NC, NQ, NP, or NT ISC to record S9080A = 0 and S9080B = 31st day of therapeutic leave. When the resident returns, the NF should submit the Entry record (A0310F = 01) with S9080A =1 and S9080B = Date of Reentry (A1700). No discharge assessments should be completed.
- Non-MA residents that were out of the facility on therapeutic leave on the PD should appear on the CMI report in the non-MA area.
- If no classifiable resident assessment has been submitted, the resident will not appear on the CMI report.
- If a resident was admitted on or before the PD, but due to the completion of Entry records (A0310F = 01) and DRA Assessments (A0310F = 11) (e.g., the resident returned to the hospital), the ARD of the Admission Assessment was the 16th of the PD month or later, the resident will not appear on the CMI report. If the resident was DRA (A0310F =11) and has not returned after 30 days, the resident will not appear on the CMI report.
- No resident should be listed twice.

Corrective Activity:
Electronically submit assessments, discharge assessments/records or entry tracking records, as applicable.

Electronically submit modification and inactivation records as necessary. Continue until all residents are properly listed.

Discharge – Return Anticipated

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

If a DRA Assessment is the last record effective for the PD and the discharge date is 30 days or less prior to the PD, the resident will appear in the non-MA section of the CMI report.

However, the NF may have knowledge that the resident will not be returning to the facility. For example, this situation could occur when the resident was discharged to the hospital with an anticipated return, but the resident dies or is admitted to another NF from the hospital. Without further action by the facility, the resident may incorrectly appear in the non-MA section of the CMI report.

Corrective Activity:
Modify the DRA assessment (A0310F = 11) using S8010H1 PD reporting to have the system treat this assessment as a DRNA in creating the CMI report.

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

MA for MA Case-mix Status

MA for MA case-mix status is determined for the CMI report by the response in S9080A appearing on the latest assessment (NC, NQ, NP, or NT) with a date of change to/from MA for MA case-mix (S9080B) date on or before the PD. See *MA for MA Case-mix* for further coding information for MA for MA case-mix status.

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

Corrective Activity:
Submit a modification with S9080A denoting the correct MA status and S9080B denoting the earliest date of change to/from MA.

Assessments

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

- The assessment listed on the CMI report should be the most recent assessment with the ARD (A2300) on or before the PD.

- The modification of an assessment listed on the CMI report should be the most recent modification (X0800) of the assessment received and accepted by iQIES prior to generating the CMI report. Since the automated correction policy was implemented with the system software upgrade on May 23, 2000, facilities can correct a record by transmitting a modification of an assessment or tracking form record to iQIES. When a modification is transmitted to iQIES, the modification becomes the active record. This will result in different modifications of the same assessment being available at different times for use in creating the CMI reports for a PD. When creating a CMI report for a PD, the most recent modification of the applicable assessment that is received and accepted prior to generating the CMI report will be placed on the CMI report.
- **Facilities cannot choose the modification of an assessment to be used on a CMI report.** The facility cannot request that an assessment received on an earlier date be used on a CMI report. The most recent modification received and accepted on or before the submission deadline at the time the CMI report is generated will always be used in creating the CMI report. An original record is transmitted as X0800 = [blank]. However, for purposes of clarity on the CMI report, the original record is identified as X0800 = 00.
- If a resident was admitted or readmitted to the facility within 14 days prior to the PD, the NC or NQ ISC may be listed if the ARD (A2300) is between the PD and the 15th of the PD month, as long as the ARD is within 14 days of the entry date (A1600).
- If a resident was admitted or readmitted to the facility within eight days prior to the PD, a Medicare PPS five-day assessment (NP) may be listed if the ARD (A2300) is between the PD and the eighth of the PD month, as long as the ARD is within eight days of the entry date (A1600).
- Between April 1, 2011 and May 18, 2013, the MDS 3.0 Reason for Assessment (A0310) and the Target Dates (A1600 Entry Date, A2000 Discharge Date, A2300 ARD) could not be modified. The record had to be inactivated (A0050 = 3) and the corrected record submitted to the MDS iQIES Assessment Submission and Processing (ASAP) system. Beginning May 19, 2013, Reasons for Assessment and Target Dates may be modified as long as the ISC remains the same. This change is retroactive; the new rules apply to any assessment submitted on or after May 19, 2013, regardless of the Target Date. The NIS system will select the latest classifiable assessment for inclusion on the CMI report.
- Assessments and tracking form ISCs designated as IPA, NPE, ND and NT are disregarded in generating the CMI report. None of these records contain all the information necessary to calculate a PDPM.

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

Non-Valid Assessments

Of the residents that the NIS determines are in the facility on the PD, the NIS picks the most recent valid classifiable assessment for that resident for placement on the CMI report. "Validity" is based on the age of the assessment compared to the PD. An assessment is considered valid if the ARD (A2300) is within four months of the PD (e.g., for February 1, 2015, the ARD must be October 1, 2014 or later). If no valid assessment is present, the most recent non-valid assessment is placed on the report with a defaulted CMI according to §1187.33(b)(1). Non-valid assessments for a resident with the status of MA for MA case-mix are assigned the lowest CMI for the MA CMI and the highest CMI for the total facility CMI rather than the CMI associated with the PDPM. Non-valid assessments for a non-MA resident are assigned the highest CMI for the total facility CMI. In most cases, the facility should be able to submit the appropriate records to move the resident from the non-valid assessment area of the CMI report to the appropriate MA for MA case-mix or non-MA sections of the report. These corrections should be made and the facility should wait for a new CMI report to be generated prior to uploading the Certification Page. Any residents remaining in the non-valid assessment area of the CMI report have a negative impact on the facility's CMI averages. An assessment may be non-valid for the following reasons:

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

Corrective Activity:
If the difference between the admission date and ARD shows that the assessment was not completed on time, but it is the result of a data entry error at the facility, correct the dates in iQIES database by

submitting a modification. Beginning May 19, 2013, only a modification is needed to correct the record.

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

Duplicate Resident Entries

If assessments for one resident are submitted with differing identification data, iQIES may assign two separate internal resident identification numbers on the FVR and not recognize that the assessments are for the same resident. Depending on the assessments submitted under each resident identification number, both may have an assessment selected for inclusion on the CMI report. In other words, the resident is listed twice and included twice in the count of residents. This must be corrected. Do not sign a Certification Page of a CMI report that contains duplicate residents.

Corrective Activity:
Contact the Pennsylvania MDS Automation Coordinator concerning the duplication. If necessary, the resident data will be merged, and the single proper assessment will appear on the corrected CMI report.

Occupancy Calculations

Effective July 1, 2010, to qualify for a hospital reserved bed day payment, a facility's overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to either 55 Pa. Code § 1187.104(b)(1)(ii)(B) or 55 Pa. Code § 1189.103(b)(1)(ii)(B). The NF's occupancy rate for a quarter is determined according to either 55 Pa. Code § 1187.104 (b)(1)(iii) or 55 Pa. Code § 1189.103(b)(1)(ii). The occupancy rate is calculated by dividing the total number of assessments listed on the facility's CMI report for that PD by the number of the facility's certified beds. Data is used from the three most recent PDs. The maximum occupancy rate of these three dates determines whether the NF can receive hospital reserved bed day payments for the associated rate quarter.

Beginning with the February 1, 2012 PD, these occupancy rates are summarized on the Payment for Hospital Reserved Bed Days page of the CMI report and the NF was informed whether they may receive these payments for the specified rate quarter. If they may not, instruction is provided concerning the proper billing procedures. See the example on page 68 of this manual.

In the past, bed size information and occupancy calculations for the latest four PDs were located at the end of the CMI report. This information was provided primarily as an aid to reviewing your CMI report and was not a required calculation. As continuing to provide this same information may be confusing when viewed with the CMI report page described above, the old calculations were discontinued

effective with the February 1, 2012 PD.

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

If the occupancy rate is higher than expected for the current PD, submit discharge assessments for residents that were not in the facility on the PD. If the occupancy rate is lower than expected, submit admission or other assessments or entry tracking forms for residents that were in the facility on the PD.

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

Certification Page Submission Deadline

The first page of the CMI report, the Certification Page, contains a statement certifying the accuracy of the CMI report. This statement must be signed and dated by the Administrator or Acting Administrator.

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

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

Do not sign an inaccurate CMI report. If the CMI report is not yet correct by the Certification Page Submission Deadline, contact the Myers and Stauffer help desk for further guidance. Do not sign a CMI report that is “almost right” or “the best of the bunch.” Inaccurate data may affect your facility’s rate for many years and will be considered an error during Field Operations reviews.

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

PD Calendar

§ 1187.33(a)(5) states "The nursing facility shall correct and verify that the information in the quarterly CMI report is accurate for the PD and in accordance with paragraph (6) and shall sign and submit the CMI report to the Department postmarked no later than 5 business days after the 15th day of the third month of the quarter." This date may vary depending on the day of the week on which the 15th falls. To assist facilities with meeting PD requirements, a calendar highlighting the dates for the current FY may be found on DHS' *Long-Term Care Case-mix Information* page and the Bulletins section of the NFRP.

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

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

Shortly after the initial CMI report posting date, access the NFRP. Locate the CMI report under the CMI reports folder. Click on the desired report and save the report to your computer. Steps may vary depending on your browser. Open and print the report for review. Use the census document established on the PD to review the report for accuracy.

Submit any additional records to the CMS MDS 3.0 Data Collection System to obtain an accurate CMI report prior to the last date for data submission for the PD. Remember that it may take up to 24 hours after a submission to receive a subsequent CMI report. The NF should consider starting the review process as soon as they can after the 20th of the PD month to have time to review the CMI report and still have time to submit further records for corrections.

PD Closure

Approximately two months after the signed Certification Pages have been received from NFs participating in the MA program, the PD is deemed to be closed. No changes can be made to any assessments used in the CMI report after closure. The PD CMI averages are calculated and posted on the DHS website. The final data is stored for use in the rate setting process.

Commonwealth of Pennsylvania
Department of Human Services

Page 1
11/20/2025
10:23:00

CMI Report for the November 2025 Picture Date

Facility Id: 123402
Provider Number: 9999999999999
Provider Name: TEST PROVIDER
File: CMI-Nov2025-99999999999999-20251120-102300.pdf

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

I hereby certify that the information submitted for these residents and the File: CMI-Nov2025-9999999999999-20251120-102300.pdf is true, accurate and correct for this Picture Date. The Medical Assistance for the MA Case-Mix status for each resident is correct for the assessment date, reentry date, or the date of change to/from MA applicable to the Picture Date. I understand that any false claims or statements, or concealment of material facts may be prosecuted under applicable Federal and State laws. Alteration of this statement is not allowed and will result in an invalid CMI Report.

Residents with Non-Valid Assessments	1
Number of Medical Assistance Residents	3
Total Number of Residents	7
CMI Average for Medical Assistance Residents	2.21
CMI Average for Total Facility	1.84

* Signature of Administrator/Acting Administrator: _____

Print or Type Name: _____

Date: _____

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

The contents of this report are based on the MDS records received up to and including batch #1234567

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

Commonwealth of Pennsylvania
Department of Human Services

Page 2
11/20/2025
10:23:00

CMI Report for the November 2025 Picture Date

Facility Id: 123402
Provider Number: 9999999999999
Provider Name: TEST PROVIDER
File: CMI-Nov2025-9999999999999-20251120-102300.pdf

Residents with Non-Valid Assessments

Resident Name	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	Case-Mix Group	MA CMI	Facility CMI
UNKNOWN, ANN	42935362	00	05/31/2025	Comprehensive	CBC1		1.30

Medical Assistance Residents

Resident Name	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	Case-Mix Group	MA CMI	Facility CMI
ANYONE, EARL S	50600270	01	09/01/2025	Quarterly	CDE2	1.82	1.82
DOE, MARGARAET L	50642171	01	08/02/2025	Comprehensive	HBC1	1.81	1.81
EXAMPLE, WANDA	50336391	01	09/27/2025	Quarterly	ES2	2.99	2.99

Non Medical Assistance Residents

Resident Name	Assessment Internal ID	Correction Number	Assessment Date	Assessment Type	Case-Mix Group	MA CMI	Facility CMI
PERSON, SHIRLEY O	48333413	00	09/21/2025	Quarterly	HDE1		1.94
SAMPLE, HIGH	48687030	00	09/27/2025	Comprehensive	CDE1		1.58
SOMEBODY, DONNA R	50336389	00	10/31/2025	Comprehensive	PDE1		1.43

Number of Residents with Non-Valid Assessments	1
Number of Medical Assistance Residents	3
Total Number of Residents	7
CMI Average for Medical Assistance Residents	2.21
CMI Average for Total Facility	1.84

Commonwealth of Pennsylvania
Department of Human Services

Page 3
11/20/2025
10:23:00

Payment for Hospital Reserved Bed Days for the January 2026 Rate Quarter

Facility Id: 123402
Provider Number: 9999999999999
Provider Name: TEST PROVIDER
File: CMI-Nov2025-9999999999999-20251120-102300.pdf

In order to qualify for a hospital reserved beds days payment for the rate quarter January 1, 2026 through March 31, 2026, the facility's overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to 55 Pa. Code Chapter 1187.104(b)(1)(ii)(B) or Pa. Code Chapter 1189.103(b)(!)(II)(B).

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

Picture Date	Certified Beds	Total Assessments	Occupancy Rate
11/01/2025	12	7	58%
08/01/2025	12	8	66%
05/01/2025	12	8	66%
Maximum of latest three Picture Dates			66%

Based on the calculations above, your facility IS NOT ELIGIBLE for hospital reserved bed day payments for dates of service October 1, 2025 through December 31, 2025. If you disagree with the occupancy percent calculated for your facility, you may request an appeal by filing a request for a hearing in writing with the Department of Human Services' Bureau of Hearing and Appeals and mail to:

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

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

Office of Long-Term Living
Division of Provider Operations
Forum Place, 6th Floor
PO Box 8025
Harrisburg, PA 17105-8025
Attention: Provider Operations

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

Electronic billing guideline
https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/837%20Institutional%20UB-04%20Claim%20Form.pdf.

UB-04 billing guidelines
https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/promise-guides/documents/UB-04%20Billing%20Guide%20for%20PROMISe%20Nursing%20Facilities%20for%20County%20and%20Non-Public%20Nursing%20Facilities%20and%20State%20Restoration%20Cntrs.pdf.

For further information, please read the *Resident Data Reporting Manual* which can be found in the *CMI Report Resources* section of the *Nursing Facility Report Portal* at https://nfrp.pamfsubmit.com.

MA Case-mix Rates

Overview of MA Case-mix Reimbursement

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

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

Annually, peer group medians and prices are calculated and used in the July, October, January, and April quarterly rates. These prices are calculated for each of three categories: Resident Care, Other Resident Care, and Administrative. Separately, a capital rate is also calculated. In the early stages of calculating the annual prices, the resident care costs reported by the NF are divided by the total facility CMI from the February CMI report closest to the age of the cost reporting period that is used to calculate the price. This is called case-mix neutralizing. It establishes a resident care cost per case-mix point that allows comparison with other NFs in the facility’s peer group.

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

Table 6. Calculation of Case-mix Rates

Calculation of Case-mix Rates							
Rate Quarter	PD	MA CMI	Resident Care Per Diem	Other Resident Care Per Diem	Admin Per Diem	Capital Costs	Per Diem Date
July	February	1.20	120.00 ($100 x 1.20)	60.00	28.00	10.00	$218.00
October	May	1.00	100.00 ($100 x 1.00)	60.00	28.00	10.00	$198.00
January	August	0.80	80.00 ($100 x 0.80)	60.00	28.00	10.00	$178.00

Calculation of Case-mix Rates							
Rate Quarter	PD	MA CMI	Resident Care Per Diem	Other Resident Care Per Diem	Admin Per Diem	Capital Costs	Per Diem Date
April	November	0.90	90.00 ($100 x 0.90)	60.00	28.00	10.00	$188.00

Table 6 illustrates the importance to both the facility and the Department that MDS data be accurately submitted, and that the CMI report reflect the status of the resident population on the PD. After these calculations are completed, a budget adjustment factor (BAF) may be applied. The facility will receive this rate for every MA day of care billed even though that particular resident's data may not have been used in setting the rate.

County Nursing Facility Reimbursement

On June 23, 2006, 55 Pa. Code Chapter 1189 was published creating a new methodology by which rates are set and payments made to county NFs for services provided to MA residents. For the rate year 2006-2007, the per diem rate paid to a county NF for a rate year was the facility's April 1, 2006, case-mix per diem rate as calculated under Chapter 1187, Subchapter G (relating to rate setting), multiplied by a BAF determined in accordance with the Commonwealth's approved State Plan. For each rate year beginning on or after July 1, 2007, the per diem rate paid to a county NF for a rate year will be the facility's prior year per diem rate multiplied by a BAF to be determined in accordance with the Commonwealth's approved State Plan. The Department, at its discretion, may revise the per diem rates for county NFs by calculating updated case-mix per diem rates in accordance with Chapter 1187, Subchapter G or under an alternative method specified in the Commonwealth's approved State Plan.

County NFs must continue to submit CMI certification pages and must also submit the initial MDS record within seven days of completion as is required for NFs beginning October 1, 2006.

Help Desk

Myers and Stauffer Help Desk

Myers and Stauffer is a consultant to DHS, contracted to administer the NIS, the NFRP, calculate MA case-mix reimbursement rates, and provide technical support for the submission of records to the CMS MDS 3.0 Data Collection Systems and the correction of CMI reports. The Myers and Stauffer help desk is available for questions from vendors and providers concerning MDS 3.0 technical information and CMI reports.

- The hours and days of operation for the help desk are Monday through Friday from 8:00 a.m. to 5:00 p.m.
- The phone number for the help desk is (717) 541-5809. If staff is unable to answer your call directly due to heavy call volume or during non-business hours, leave a voicemail message with your name, facility, and phone number.
- The fax number for the help desk is (717) 541-5802.
- The email address is pahelpdesk@mslc.com. Be as descriptive as possible so the help desk representative may research your question prior to calling you. Include your facility name, Pennsylvania identification number, the name of the facility contact person, and a telephone number with area code and extension. The help desk will contact you as soon as possible. Please do not send the same message multiple times.
- Be discreet in the information you fax or email. The help desk fax machine is located in a secure area of the help desk area and is not used for any other business purpose. However, CMS has indicated that MDS information should not be faxed or emailed in an unsecure mode. Resident identification information should not be included in a fax or email.
- Periodically, the help desk posts bulletins on the NFRP. These bulletins may be accessed at https://nfrp.panfsubmit.com by selecting the Bulletins link. Bulletin topics may include information on PDs, copies of the RAI Spotlight, currently occurring problems, and future changes that will occur in the system.

Help Desk Assistance

The following types of problems will be supported by the Myers and Stauffer help desk:

- Working with the NFRP system.
- Discerning different MDS record types.
- Determining the correct sequence in which to complete and transmit assessments.
- Determining date consistency among the dates within the MDS and previous records.

- Assistance concerning the deadlines for submission of assessment information, both state and federal.
- Response to questions concerning acceptable responses for MDS items as defined in the data specifications. If it is beyond the scope of the help desk representative (clinical question), the caller will be instructed to call DOH at (717) 787-1816.
- Determining discrepancies in PDPM/CMI calculations.
- Questions concerning Section S elements.
- Establishing the proper MA for MA case-mix status for a PD.
- Inquiries concerning the CMI report.
- Identifying steps to be taken to complete necessary corrections.

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

Problems Not Supported

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

- Questions regarding vendor software, including running the vendor program, transmitting the files, and troubleshooting any errors within the program. Technical support must be provided to the facility by the vendor.
- Support for installation of hardware devices (modems, printers, etc.).
- Support for internet browsers other than what has been developed by CMS for public use.
- Restoration of data or complete data backup procedures. The help desk will not be able to restore or recover the facility's data from iQIES. CMS is also unable to restore or recover a facility's data. CMS requires that facilities have a backup system in place with the ability to have immediate access to the last 15 months of assessments within their system along with the ability to provide the assessment forms.

  Recommendation of specific software to support the backup and restoration of data. Because of the large amount of different backup devices and software available, no backup procedures will be supported. It is the responsibility of the facility to choose backup software and develop recovery procedures.
- Policy questions concerning Medicare PPS assessments (e.g., dealing with default classifications, billing questions, etc.) cannot be answered. Contact your MAC about these problems.

- Interpreting QM reports. Contact DOH for assistance at (717) 787-1816.

Field Operations Review

About Bureau of Provider Support Field Operations Reviews

Field Operations review is defined as "A review conducted by the Department's medical and other professional personnel to monitor the accuracy and appropriateness of payments to nursing facilities and to determine the necessity for continued stay of residents" (55 Pa. Code §1187.2). As part of the review process, Field Operations personnel may assess the integrity of the MDS data used in the MA case-mix reimbursement system.

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

- Are the responses that appear on the MDS in the facility the same as those that appear in iQIES?
- Is there sufficient documentation in the resident's record to support the MDS response that was coded and transmitted?
- Does the CMI report accurately reflect the resident population and MA for MA case-mix status on the PD?

Preparing For a Field Operations Team Visit

In preparation for reviewing the CMI report, the NF should have a facility billing census for the applicable PD available. The residents appearing on the Field Operations CMI report sample will be evaluated to ensure their MA for MA case-mix status was accurately reported and that no residents were improperly included or omitted.

Documentation Guidance

Field Operations representatives may determine if there is sufficient documentation in the resident's record to support an MDS coded response indicating that the condition or activity was present or occurred. CMS requirements for documentation are defined on pages 1-2 through 1-8 of the MDS 3.0 RAI Manual: "While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals…it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."

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

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

Disclaimer

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

Appealing Field Operations Reviews

Your facility's Field Operations representative is always willing to discuss coding issues with you and will share the most current information. If you have further concerns, request consultation with your facility's Field Operations representative's supervisor. Contact information from each regional Field Operations team is listed below.

Harrisburg Field Operations Office
Email: ra-pwharfldopmainlin@pa.gov
Phone: (717) 783-9823
Fax: (717) 346-7142

Pittsburgh Field Operations Office
Email: ra-pwoltlpittfieldop@pa.gov
Phone: (412) 770-2770
Fax: (412) 770-2798

Norristown Field Operations Office
Email: ra-pwopsnorristown@pa.gov
Phone: (610) 270-1906 OR (610) 270-1907
Fax: (610) 270-1911

Wilkes-Barre Field Operations Office
Email: ra-pwopswhitehaven@pa.gov
Phone: (570) 443-4124
Fax: (570) 443-4038

Please contact the Director of the Division of Fee-For-Service Operations, Marion Boggs at mboggs@pa.gov (email) or (717) 724-6543 (phone).

Documentation Guidelines

Instructions for completing MDS items that are on the federally required assessments can be found in the respective section of Chapter 3 of the MDS RAI 3.0 User's Manual.

Column Explanations

Table 7 contains three columns of the MDS 3.0 RAI Manual documentation guidelines, which are described below.

MDS 3.0 Location, Item Description, RAI Manual Page

This column identifies the MDS 3.0 location by section letter and item number, and the description of the MDS item. A notation of Brief Interview for Mental Status (BIMS) 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 categories potentially impacted by the MDS item. Items that do not impact any PDPM categories are labeled as Demographic.

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.

Table 7. MDS 3.0 RAI Manual Guidelines

MDS 3.0 RAI Manual Guidelines		
MDS 3.0 Location, Item Description, RAI Manual Page	**PDPM Categories Impacted**	**Minimum Documentation and Review Standards Required within the Specified Observation Period**
Section A: Identification Information		
A0100B CMS Certification Number RAI Manual Page A-3	*~Demographic*	• Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities. • Enter the six-digit federal number which begins with 39. • Medicaid-only facilities have a federal and a state number. The Medicaid federal number has a "letter" in the third box.
A0100C State Provider Number RAI Manual Page A-3	*~Demographic*	• The identification number assigned to the NF by the Medicaid program. • Enter the 13-digit state MA PROMISe provider number including any leading zeros.

MDS 3.0 RAI Manual Guidelines		
MDS 3.0 Location, Item Description, RAI Manual Page	**PDPM Categories Impacted**	**Minimum Documentation and Review Standards Required within the Specified Observation Period**
A0500 Legal Name of Resident RAI Manual Page A-12	*~Demographic*	• Resident's name as it appears on the Medicare card. • If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document. • If resident has no middle initial, leave A0500B blank. • If the resident has two or more middle names, use the initial of the first middle name. • A0500A First name must not be skipped (^).
A0600A Social Security Number RAI Manual Page A-13	*~Demographic*	• A tracking number assigned to an individual by the U.S. federal government for taxation, benefits, and identification purposes. • If no SSN is available for the resident, the item may be left blank. • Do not enter nine of any one number, start this number with 000 or enter 123456789. • Must not be blank if A0700 Medicaid number contains a number.
A0600B Medicare Number RAI Manual Page A-13	*~Demographic*	• An identifier assigned to an individual for participation in national health insurance program. • If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. • CMS has issued new Medicare beneficiary identifier numbers to Medicare recipients. This number should be used as soon a beneficiary receives this card. • If no Medicare number or RRB number is known or available, the item may be left blank. • May only be a Medicare (HICN) number or an RRB number. Do not enter an MCO number. • For a Medicare PPS assessment (A0310B = 01, 08), a Medicare number or comparable railroad insurance number (A0600B) must be present.

MDS 3.0 RAI Manual Guidelines		
MDS 3.0 Location, Item Description, RAI Manual Page	**PDPM Categories Impacted**	**Minimum Documentation and Review Standards Required within the Specified Observation Period**
A0700 Medicaid Number RAI Manual Page A-14	*~Demographic*	• Record this number if the resident is a Medicaid recipient. • For a PA Medicaid recipient, enter the resident's 10-digit MA number from the PA ACCESS card. • Enter the out-of-state MA number for residents being served in PA NFs under contract with other states' MA agencies. • Enter the MA number even if the resident is currently in a MC Part A stay. • Enter a "+" in the leftmost box if the number is pending. • If not applicable because the resident is not a Medicaid recipient, enter "N" in the leftmost box. • It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment; just include it on the next assessment.
B0100 **Comatose** RAI Manual Page B-1	***~ Special Care High*** ***~Behavioral Symptoms and Cognitive Performance***	Comatose is defined as a pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The resident is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g., pain). Persistent Vegetative State is defined as sometimes residents who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres. ***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 a physician, nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. ***Does NOT include:*** • Resident in advanced stages of progressive neurological disorders (e.g., Alzheimer's disease).

MDS 3.0 RAI Manual Guidelines		
MDS 3.0 Location, Item Description, RAI Manual Page	**PDPM Categories Impacted**	**Minimum Documentation and Review Standards Required within the Specified Observation Period**
B0700 **Makes Self Understood** RAI Manual Page B-7	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • Evidence of the resident's ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination of these. ***Does include:*** • Reduced voice volume. • Difficulty in producing sound. • Difficulty in finding the right word, making sentences, writing, and/or gesturing.
Section C: Cognitive Patterns		
C0200 **Repetition of Three Words (BIMS)** **C0300 A, B, C** **Temporal Orientation (BIMS)** **C0400 A, B, C** **Recall (BIMS)** RAI Manual Page C-3	***~Behavioral Symptoms and Cognitive Performance***	***Does require***: • Validation of completion of interview items C0200, C0300 A, B, C and C0400 A, B, and C at Z0400 dated on or before the ARD and within the 7-day observation period.
C0700 **Short-Term Memory Cognitive Performance Scale (CPS)** RAI Manual Page C-21	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** documenting the resident's ability to: • Describe an event five minutes after it occurred if the resident's response can be validated, **OR** • Follow through on a direction given five minutes earlier.

MDS 3.0 RAI Manual Guidelines		
MDS 3.0 Location, Item Description, RAI Manual Page	**PDPM Categories Impacted**	**Minimum Documentation and Review Standards Required within the Specified Observation Period**
C1000 **Cognitive Skills for Daily Decision-Making (CPS)** RAI Manual Page C-26	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, code 3 severely impaired. • If the resident makes decisions, although poorly, code 2 moderately impaired. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices). • Seeking information from others to plan the day. • Acknowledging need to use appropriate assistive equipment (e.g., 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.
Section D: Mood		
D0150A-I, Column 2 **Resident Mood Interview (PHQ-2 to 9)** RAI Manual Page D-3	***~Special Care High*** ***~Special Care Low*** ***~Clinically Complex***	***Does require:*** • Validation of completion of interview items D0150 A-I at Z0400 dated on or before the ARD and within the observation period.
D0500A-J, Column 2 **Staff Assessment of Resident Mood (PHQ-9-OV)** RAI Manual Page D-12	***~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. • Evidence of the interviews during the 7-day look-back period based on the ARD.

Section E: Behavior		
E0100A **Hallucinations** RAI Manual Page E-1	***~Behavioral Symptoms and Cognitive Performance***	**Hallucination** is defined as the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. ***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 description of the hallucination(s) per occurrence(s). ***Does include:*** • Auditory, visual, or involve smells, tastes, or touch.
E0100B **Delusions** RAI Manual Page E-1	***~Behavioral Symptoms and Cognitive Performance***	**Delusion** is defined as a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. ***Does require:*** • **Example(s) and date(s)** of a fixed, false belief not shared by others that the resident holds true 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 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*** RAI Manual Page E-4	***~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 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.

E0200B **(code 2 or 3) Verbal Behavioral Symptoms *directed toward others*** RAI Manual Page E-4	***~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 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 *<u>not</u> directed toward others*** RAI Manual Page E-4	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's other behavioral symptoms NOT directed toward others. • 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, including a 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** RAI Manual Page E-14	***~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 description of the rejection of care, per occurrence(s). ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care, including verbally declining, statements of refusal, or through physical behaviors that convey aversion to result in avoidance of or interfere with the receipt of care. • Hindering the delivery of care by disrupting the usual routines or processes 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 the resident's values, preferences, or goals.
E0900 **(code 2 or 3) Wandering** RAI Manual Page E-18	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's 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 exhibited wandering, including a description of the wandering, per occurrence(s). ***Does NOT include:*** • Pacing (repetitive walking with 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).

Section GG: Functional Abilities

Steps for Assessment

- Assess the resident's self-care and mobility performance based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the resident during the assessment period.
- **For residents in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay.** The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.
- **When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.**
- Documentation of the resident's **usual performance** needs to be in the resident's medical record during the three-day assessment period.

Coding Instructions

- When coding the resident's usual performance, use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by themself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity. o Code 04, Supervision or touching assistance: if the resident requires only verbal cueing to complete the activity safely.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
    - ***Code 01, Dependent:*** if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.
    - ***Code 01, Dependent:*** if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.

GG0130A Self-Care: Eating *The ability to use suitable utensils to bring food to the mouth and swallow food and/or liquid once the meal is placed before the resident.* *Tube feedings and parenteral nutrition are not considered when coding this activity.* RAI Manual Page GG-20		***Coding Tips*** • Assessment of the GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking might be assessed for a resident who did/does/will use a wheelchair as their primary mode of mobility, stair activities might be assessed for a resident not routinely accessing stairs). ***Does require:*** • Documentation during the observation period to accurately capture 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. • Corrections must be made in accordance with the Medical Record Correction Policy. • The IDT should determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record. • The IDT meeting note must be clear as to who participated in the meeting and decisions reached for each Section GG item.
GG0130C Self-Care: Toileting Hygiene *Managing clothing and perineal cleansing; takes place before and after the use of the toilet, commode, bedpan, or urinal.* RAI Manual Page GG-20		
GG0170B Mobility: Sit to Lying *The ability to move from sitting on side of bed to lying flat on the bed.* RAI Manual Page GG-38		
GG0170C Mobility: Lying to sitting on side of bed *The ability to move from lying to sitting on the side of the bed and with no back support.* RAI Manual Page GG-38		
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.* RAI Manual Page GG-38		

GG0170E Mobility: Chair/bed to chair transfer *The ability to transfer to and from a bed to a chair (or wheelchair)* RAI Manual Page GG-38		• 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. • A dash (-) indicates "No information." CMS expects dash use to be a rare occurrence. • See GG0130: Self-Care and GG0170: Mobility decision tree located in the RAI Manual Page GG-16 for additional information. • 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)
GG0170F Mobility: Toilet transfer *The ability to get on and off a toilet or commode.* RAI Manual Page GG-38		

Section H: Bladder and Bowel		
H0200C Current Urinary Toileting Program or Trial *(Restorative Nursing)* RAI Manual Page H-3	***~Behavioral Symptoms and Cognitive Performance*** ***~Reduced Physical Function***	***Does require:*** • Documentation of a toileting program trial that includes an individualized, resident-centered toileting program of **at least three days** of toileting patterns with prompting to toilet and a **documented response to the trial toileting program**. • Following program trial and response, documentation of a current toileting program being used to manage urinary continence during the seven-day lookback period must include: 1) implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern; 2) documentation that the 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 resident's response to the toileting program by a licensed nurse **during the observation period**. • Systematic toileting program that is being managed four or more days of the seven-day lookback period. ***Does include:*** • Program if only used by day (when documented that the resident does not want awakened at night). ***Does NOT include:*** • Less than four 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)* RAI Manual Page H-13	***~Reduced Physical Function*** ***~Behavioral Symptoms and Cognitive Performance***	***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 bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.

Section I: Active Diagnoses

DEFINITIONS

ACTIVE DIAGNOSES

Physician-documented diagnoses (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 seven-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.

FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).

STEPS FOR ASSESSMENT:

(RAI Manual Page I-8)

There are 2 look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for UTI, which does not use the active 7-day look-back period).

Note:

Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is **active**. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

I2000 **Pneumonia** RAI Manual Page I-5	***~Clinically Complex*** ***~Special Care High***	**See Active Diagnoses Definition. See Step 2 above.** ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period. • Pneumonitis
I2100 **Septicemia** RAI Manual Page B-1	***~Special Care High***	**See Active Diagnoses Definition. See Step 2 above.** ***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
I2900 **Diabetes Mellitus** RAI Manual Page B-1	***~Special Care High***	**See Active Diagnoses Definition. See Step 2 above.** ***Does include:*** • Diabetic retinopathy. • Diabetic nephropathy. • Diabetic neuropathy.
I4400 **Cerebral Palsy** RAI Manual Page I-5	***~Special Care Low***	**See Active Diagnoses Definition. See Step 2 above.** ***Does require***: • Nursing function score less than or equal to 11.
I4900 **Hemiplegia/Hemiparesis** RAI Manual Page I-5	***~Clinically Complex***	**See Active Diagnoses Definition. See Step 2 above.** ***Does require:*** • Nursing function score less than or equal to 11. ***Does include:*** • Left or right-side paralysis. ***Does not include***: • Left or right sided weakness

I5100 **Quadriplegia** RAI Manual Page I-5	***~Special Care High***	**See Active Diagnoses Definition. See Step 2 above.** ***Does require:*** • Nursing function score less than or equal to 11. • Physician documentation of an injury to the spinal cord that causes 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** RAI Manual Page I-5	***~Special Care Low***	**See Active Diagnoses Definition. See Step 2 above.** ***Does require*:** • Nursing function score less than or equal to 11.
I5300 **Parkinson's Disease** RAI Manual Page I-5	***~Special Care Low***	**See Active Diagnoses Definition. See Step 2 above.** ***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.
I6200 **Asthma, Chronic Obstructive Pulmonary Disease or Chronic Lung Disease** RAI Manual Page I-5	***~Special Care High***	**See Active Diagnoses Definition. See Step 2 above.** ***Does include:*** • Chronic bronchitis. • Restrictive lung diseases (such as asbestosis, pulmonary fibrosis, etc.). • Emphysema. ***Does NOT include:*** • Obesity hypoventilation syndrome.
I6300 **Respiratory Failure** RAI Manual Page I-5	***~Special Care Low***	**See Active Diagnoses Definition. See Step 2 above.** ***Does NOT include:*** • I6300 Respiratory Failure may not be coded under I6200.

Section J: Health Conditions		
J1100C **Shortness of Breath or Trouble Breathing When Lying Flat** RAI Manual Page J-25	***~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 observation period.
J1550A **Fever** RAI Manual Page J-29	***~Special Care High***	***Does require:*** • Fever of 2.4 degrees Fahrenheit (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** RAI Manual Page J-29	***~Special Care High***	***Does require:*** • Documentation of regurgitation of stomach contents.

Section K: Swallowing/Nutritional Status		
K0300 **(code 1 or 2) Weight Loss** RAI Manual Page K-4	**~Special Care High**	**5% WEIGHT LOSS IN 30 DAYS** Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight. **10% WEIGHT LOSS IN 180 DAYS** Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight. • Current weight is the most recent measure in the last 30 days. (See Steps for Assessment for item K0200B). ***Does require:*** • Documentation of a resident's weight both 30 days and/or 180 days prior to the current weight during the observation period. • 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.

K0520A2 or K0520A3 Parenteral or IV Feedings ***While a Resident*** ***While NOT a Resident*** RAI Manual Page K-11	***~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. **Key documentation components for TPN/IV feeding:** • **Solution Verification (prior to initiation):** Document the verification of the TPN solution against the provider's order, including the specific formula components (e.g., dextrose concentration, amino acids, lipids), expiration date, and integrity of the bag (no leaks separations, or particulate matter). • **Infusion Rate and Method**: Record the exact, ordered infusion rate (usually in mL/hr) and verify it is running via an electronic infusion pump. • **Site Assessment**: Document the assessment of the central venous access device (CVAD) or peripheral site, checking for signs of infection, infiltration, or phlebitis (using standard scales). The assessment should note that the dressing is clean, dry, and intact. • **Routine Maintenance**: Document changing the IV tubing and bag according to facility policy (e.g., every 24 hours for TPN). • **Safety Checks**: Record the use of a "no-touch" or strict sterile technique during dressing changes and when connecting new bags or tubing. **Patient Monitoring and System Metrics** • **Intake and Output (I&O):** Record total 24-hour fluid balance in milliliters to monitor for fluid overload. • **Glucose Monitoring:** Document blood glucose levels as ordered (e.g., every 4–6 hours) to monitor for hyperglycemia or hypoglycemia associated with high-dextrose feeding. • **Weight Monitoring:** Document daily weights to assess the nutritional effectiveness of the feeding. • **System Integrity**: Document that the tubing was traced from the patient to the point of origin to prevent tubing misconnections.

		Does include: • IV fluids or hyperalimentation, including total parenteral nutrition, administered continuously or intermittently. • IV running at KVO (keep vein open). • IV fluids contained in IV piggybacks. • Hypodermoclysis and subcutaneous ports in hydration therapy. • IV fluids can be coded in K0520A, if needed, to prevent dehydration if the additional fluid intake is specifically needed for nutrition and 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 medications. • 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.
K0520B2 or K0520B3 Feeding Tube K0710A3 51% or more of total calories, OR K0710A3 26% to 50% of total calories AND K0710B3 is 501cc or more per day fluid enteral intake in the last seven days. RAI Manual Page K-11	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the resident in the last seven days either at the nursing home or at the hospital as an outpatient or 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:*** • Nasogastric tubes, gastrostomy tubes, J-tubes, percutaneous endoscopic gastrostomy tubes. • Any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. • Evidence in the clinical record to include time, type, amount and rate of administration.

K0710A3 **Proportion of Total Calories the Resident Received Through Tube Feeding** *Column 3 – during entire seven days* **K0710A3** **51% or more of total calories, OR** **K0710A3 26% to 50% of total calories AND** **K0710B3 is 501cc or more per day fluid enteral intake in the last seven days.** RAI Manual Page K-15	***~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 during the entire seven-day observation period. See example in the RAI Manual page K-16. • For resident receiving both oral nutrition and tube feeding, documentation must demonstrate how the facility calculated the percent of calorie intake the tube feeding provided and must include: ○ Calories tube feeding provided each day within observation period. ○ Calories oral feeding provided each day within observation period. ○ Percent of total calories provided by tube feeding within the observation period.
K0710B3 **Average Fluid Intake Per Day by Tube Feeding.** *Column 3 – during entire seven days* **K0710A3** **51% or more of total calories, OR** **K0710A3 26% to 50% of total calories AND** **K0710B3 is 501cc or more per day fluid enteral intake in the last seven days.** RAI Manual Page K-15	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation to support average fluid intake per day by tube feeding during the entire seven-day observation period. *Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:* ○ Adding the total amount of fluid received each day by tube feedings only. ○ Divide the week's total fluid intake by seven to calculate the average of fluid intake per day *(Divide by seven even if the resident did not receive IV fluids or tube feeding on each of the seven days.)*

Section M: Skin Conditions		
M0300B1 Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar RAI Manual Page M-12	***~Special Care Low***	**STAGE 2 PRESSURE ULCER** Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister. **STAGE 3 PRESSURE ULCER** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-19). **STAGE 4 PRESSURE ULCER** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. ***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 aligning with RAI description requirements. • Documentation must include complete history of pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. • Documentation of a healing pressure ulcer/injury(s) must include descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, identification of the wound as a pressure ulcer, 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 lookback 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.

M1030 **Venous/Arterial Ulcers** RAI Manual Page M-12	***~Special Care Low***	***Does require:*** • Documentation 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 description requirements. ***Does NOT include:*** • Pressure ulcers/injuries coded in M0300.
M1040A **Infection of the Foot** RAI Manual Page M-32	***~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 in M0300.
M1040B **Diabetic Foot Ulcer** RAI Manual Page M-32	***~Special Care Low***	***Does require:*** • Documentation of diabetic foot ulcer must include, but is not limited to, identification of the wound as a diabetic foot ulcer, location, and description of appearance. ***Does include:*** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. **Note:** Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300. • Pressure ulcers/injuries that occur on the heel of a diabetic resident.
M1040C **Other Open Lesion on the Foot, (e.g., cuts, fissures)** RAI Manual Page M-32	***~Special Care Low***	***Does require:*** • Documentation of open lesion must include, but is not limited to, location and description. • Documentation that the lesion is open during observation period. ***Does NOT include:*** • Open lesions to the ankle. • Pressure ulcers/injuries coded in M0300.

M1040D **Open Lesion Other Than Ulcers, Rashes, Cuts** RAI Manual Page M-32	***~Clinically Complex***	***Does require:*** • Description of open lesion must include, but is not limited to, location and description. • Documentation that the lesion is open during observation period. ***Does include:*** • Open lesions that develop as a result of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles. ***Does NOT include:*** • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears, cuts/lacerations, abrasions, or rashes.
M1040E **Surgical Wound** RAI Manual Page M-32	***~Clinically Complex***	***Does require:*** • Description of the surgical wound must include, but is not limited to, identification of the wound as a surgical wound, location, and description aligning with RAI description 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. • Peripherally inserted central catheter (PICC) sites, central line sites, peripheral IV sites. • Pressure ulcers/injuries that have been surgically debrided.
M1040F **Burn(s)** RAI Manual Page M-32	***~Clinically Complex***	***Does require:*** • Description of the second- or third-degree burn must include, but is not limited to: degree, type, cause, location and description. ***Does include:*** • 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* RAI Manual Page M-37	***~Special Care Low***	***Does require:*** • Documentation of use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • A facility policy identifying use of pressure reducing/relieving/redistributing mattresses on each resident bed will be considered sufficient documentation for the bed. Facility policy needs to be reviewed if for all residents in the facility. • These general treatments should guide more individualized and specific interventions in the care plan. ***Does include:*** • Foam, air, water, gel, or other cushioning placed on chair, wheelchair or bed. • Pressure relieving, reducing, redistributing devices. ***Does NOT include:*** • Egg crate cushions of any type. • Donut or ring devices in chairs and wheelchairs. • A physician order for a pressure relieving device without documentation of implementation is not sufficient for supporting documentation.
M1200C Turning/Repositioning Program RAI Manual Page M-37	***~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 interventions and frequency of program. *(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 resident's response to the program within the observation period.
M1200D Nutrition or Hydration Intervention to Manage Skin Problems RAI Manual Page M-37	***~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/or supplements when administration is an intervention for managing a skin problem and when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment.

M1200E **Pressure Ulcer/Injury Care** RAI Manual Page M-37	***~Special Care Low***	***Does require:*** • Documentation of intervention(s) for treating pressure ulcers/injuries identified at M0300B, C, D, and F. ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical, or surgical debridement. • Wound irrigations. • Negative pressure wound therapy. • Hydrotherapy.
M1200F **Surgical Wound Care** RAI Manual Page M-37	***~Clinically Complex***	***Does require:*** • Documentation of 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. • Observation only of the surgical wound.

M1200G **Application of Non-Surgical Dressings Other Than to Feet** RAI Manual Page M-37	***~Special Care Low*** ***~Clinically Complex***	***Does require:*** • Documentation of 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(s) to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers/injuries other than to feet; use pressure ulcer/injury care (M1200E). • Adhesive bandages (e.g., Band-Aids). • Wound closure strips. • IV and port dressings.
M1200H **Application of Ointments/ Medications** **Other Than to Feet** RAI Manual Page M-37	***~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/injury(s); 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** RAI Manual Page M-37	***~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.
Section N: Medications		
N0350A **Days of Insulin Injections** RAI Manual Page N-3	***~Special Care High***	***Does require:*** • Documentation must be consistent with physician orders and insulin administration records. • Documentation to include the number of days that insulin injections were received during the observation period. ***Does include:*** • The number of days the resident actually required a subcutaneous injection to restart the subcutaneous insulin pump.
N0350B **Days of Orders for Insulin** RAI Manual Page N-3	***~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 different dose of insulin administered based on an existing sliding scale order.

Section O: Special Treatments, Procedures, and Programs		
O0110A1b **Chemotherapy** ***While a Resident*** RAI Manual Page O-1	***~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** RAI Manual Page O-1	***~Special Care Low***	***Does require:*** • Documentation of administration of radiation inside or outside of facility. • Documentation must indicate that the resident actually received the radiation and not just left the building (or remained in the building) with the intent to receive radiation. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant.
O0110C1b **Oxygen Therapy** RAI Manual Page O-1	***~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 bilevel positive airway pressure (BiPAP)/continuous positive airway pressure (CPAP) machines. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.

O0110E1b **Tracheostomy Care** RAI Manual Page O-1	***Extensive Services***	***Does require:*** • Documentation of cleansing of the tracheostomy and/or cannula during the observation period. ***Does include:*** • Documentation of the resident performing their own tracheostomy care. • Changing a disposable cannula. • Laryngectomy tube care.
O0110F1b **Invasive Mechanical Ventilator (ventilator or respirator)** RAI Manual Page 0-1	***Extensive Services***	***Does require:*** • Documentation of use of any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration. ***Does include:*** • Any resident being weaned from the respirator or ventilator during the observation period. • Any resident who was weaned from the respiratory or ventilator in the last 14 days. **Does NOT include:** • Times when used as a substitute for BiPAP or CPAP.
O0110H1b **IV Medications** RAI Manual Page O-1	***~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 resident's 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** RAI Manual Page O-1	***~Clinically Complex***	***Does require:*** • Documentation of the administration of blood or any 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 transfusion. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.

O0110J1b **Dialysis** RAI Manual Page O-1	***~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. • Continuous arteriovenous hemofiltration. • Continuous ambulatory peritoneal dialysis. • Resident performing their own dialysis. ***Does NOT include:*** • IV, IV medication and blood transfusion administered during dialysis.

O0110M1b **Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)** RAI Manual Page O-1	***RAI Requirements Page O-8*** ***~ Extensive Services***	**Code for "single room isolation" only when all of the following conditions are met:** 1. The 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. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in their room. This requires that all services 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 active infectious disease (i.e., symptomatic and/or 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.

O0400D2 **Respiratory Therapy Days** RAI Manual Page O-34	***~Special Care High***	**RESPIRATORY THERAPY DEFINITION:** Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above 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 (*RAI Manual, Appendix A)*. In Pennsylvania an **LPN cannot assess**, therefore they cannot meet this criterion alone, there is a need for an RN or Respiratory Therapist to fill that part of the requirement. ***Does require:*** Only medically necessary therapies that occurred after admission/readmission to the facility that were: • Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan. • Documented in the resident's medical record. • 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 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 rate, 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. • Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective.

		• Documentation that the respiratory nurse (licensed nurse) has been trained in the modalities provided through 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. • The therapist's time spent on documentation or on initial evaluation. • Time that a resident self-administers a nebulizer treatment without the supervision of the respiratory therapist or respiratory nurse. • Metered dose or dry powder inhalers. • When the performance of a maintenance program does not require the skills of a therapist because it can be safely accomplished by the resident or with assist of a non-therapist. • Incentive spirometry utilization except for time spent on assessments (before, during, and after), equipment preparation, and patient education on how to use the device.

O0500A-J **Restorative Nursing Program Days** RAI Manual Page O-43	***~Behavioral Symptoms and Cognitive Performance*** ***~Reduced Physical Function***	***Does require:*** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each 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 documented separately for each restorative program. • Documentation must include the following 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. 2. Periodic Evaluation of the program by a licensed nurse. 3. Staff trained in the proper techniques; and 4. Supervised by licensed nurse; and 5. No more than four 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 the CNA and co-signed by a licensed nurse once the purpose and objectives have been established (contingent upon state Nurse Practice Act and any other applicable state laws). ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • For both passive and active 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.

Z0400	***Signature of Persons Completing the Assessment of 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. • If Section C and Section D are completed on different dates, distinct line entries are required for each date. • Interviews are validated at Z0400. If the date at Z0400 is after the ARD, the facility would not receive credit for the interview section.

Glossary

Common Terms and Abbreviations

This manual section provides definitions of terms and abbreviations that a user may hear not only while completing the resident reporting requirements for medical assistance (MA) case-mix reimbursement purposes but also within the larger minimum data set (MDS) environment. Each section of this document begins with the set of glossary terms used within that section.

1101 Regulation
MA Regulation, Chapter 1101 – General Provisions which apply to all providers, including long-term care (LTC). Among the provisions in this chapter are Recipient Eligibility, Provider Enrollment Procedures, and Third-Party Resources. Also referred to as 55 Pa. Code Chapter 1101.

1187 Regulation
MA Regulation, Chapter 1187 – Nursing Facility (NF) Services; Case-mix Reimbursement System. A specific provider regulation for NF reimbursement. Also referred to as 55 Pa. Code Chapter 1187.

1189 Regulation
MA Regulation, Chapter 1189 – County NF Services. A specific provider regulation for County NF reimbursement. Also referred to as 55 Pa. Code Chapter 1189.

ACCESS Card
See Pennsylvania ACCESS Card.

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

Admission Date Assessment Internal ID
A unique number assigned to an MDS assessment or tracking form when it is submitted to the Internet Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing (ASAP) system. It can be found on the Final Validation Report (FVR).

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

Billing Census
A monthly report accounting for each NF resident's daily payer source and status (i.e., in house, hospitalized, therapeutic leave, or discharge).

Budget Adjustment Factor
An adjustment to the calculated per diem rate based on the funding that is appropriated for NF services

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

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

Case-Mix Group (CMG)
System used in patient classification system to group together patients with similar characteristics. This provides a basis for describing the types of patients a hospital or other health care provider treats (its case mix). Case mix groups are used as the basis for the Health Insurance Prospective Payment System (HIPPS) rate codes used by Medicare in its prospective payment systems.

Case-mix Index
A number value score that describes the relative resource use for the average resident utilizing the patient-driven payment model (PDPM) nursing component classification methodology and associated weights based on the assessed needs of the resident (§1187.2).

Case-mix Reimbursement System
For a NF, 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 & Medicaid Services (CMS)
The federal agency that is located in the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.

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

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

Classifiable Assessment
An MDS 3.0 assessment that contains all items necessary to run the PDPM group system. Assessments with an Item Subset Code (ISC) of NC (Comprehensive), NQ (Quarterly), and NP (prospective payment system [PPS]) meet this standard.

CMI Report
A report generated by the Department of Human Services (DHS or Department) from submitted resident

assessment records and tracking forms and verified by a NF each calendar quarter that identifies the total facility and MA CMI average for the PD, the residents of the NF on the PD and the following for each identified resident:

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

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

CMSNet/Verizon
The communication system used to electronically submit data to iQIES. Each person at the NF who is submitting data must have an individual password.

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

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

Control
The first section of an MDS assessment file submitted to iQIES. This portion of the file contains facility, state, and software vendor information for that file.

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

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

County NF
A LTC NF that is licensed by the Department of Health (DOH), enrolled in the MA program as a provider of NF services, and controlled by the county institution district or by county government if no county institution district exists.

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

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

Department
See DHS.

DHS (formerly the Department of Public Welfare)
DHS is the Commonwealth agency designated as the single state agency responsible for the administration of the Commonwealth's MA program (§1187.2).

Department of Public Welfare
See Department of Human Services.

Dually Certified Facilities
NFs that participate in both the Medicare and MA programs.

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

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

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

Federal Register
The official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as Executive Orders and other presidential documents. It is a publication of the National Archives and Records Administration and is available by subscription and online.

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

FVR
The FVR is a report generated by iQIES and placed in a folder in the facility's Certification and Survey Provider Enhanced Reporting (CASPER) application after a file containing MDS 3.0 assessments/tracking forms is completely processed, detailing the records processed and any errors that were identified.

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

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

Health Care Financing Administration (HCFA)
HCFA is the federal agency located in the U.S. Department of Health and Human Services that administers Medicare and Medicaid. Currently known as CMS.

Health Insurance Prospective Payment System (HIPPS) Codes
HIPPS assessment indicators are used on the UB-04 billing document when submitting payment claims to the FI for Medicare services.

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

Hospital-Based NF
A NF that was receiving a hospital-based rate as of June 30, 1995, and is located physically within or on the immediate grounds of a hospital, operated or controlled by the hospital, and licensed or approved by DOH and meets the requirements of 28 Pa. Code §101.31 (relating to hospital requirements), and shares support services and administrative costs of the hospital.

Hospital Reserved Bed Day
A resident receiving NF services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. A NF resident in the hospital on a PD who was discharged with return anticipated (A0310F =11), a common situation when a resident is transferred to a hospital, is considered non-MA regardless of what the MA for MA case-mix status was prior to the discharge. The resident properly appears in the non-MA CMI report area. Hospital reserved bed days for a rate quarter may be billed only when the NF's occupancy rate was 85% for the rate quarter in which the hospital bed day occurred as

detailed under the Occupancy Calculations section.**In the Facility**
See In the Facility on the PD.

In the Facility on the PD
Residents who are in the facility on the PD will appear on the CMI report. In some cases, the resident does not have to be physically present in the facility on the PD to be considered "In the Facility." If a resident is on therapeutic leave on the PD, the resident is considered to be "In the Facility" for PD purposes and will appear in the correct section based on his MA for MA case-mix status. If a resident has been discharged with return anticipated (A0310F = 11) and has not been out of the facility for more than 30 days, the resident is considered to be "In the Facility" for PD purposes.

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

Initial Federally Approved Pennsylvania-Specific MDS Record
The MDS 3.0 entry tracking form (A0310F = 01)(A1700=1) has been designated as the Initial MDS Record to meet the requirement at § 1187.22(18). The entry tracking form must be completed within seven days of the entry date (A1600) and submitted within 14 days of the entry date.

Internal Assessment ID
See Assessment Internal ID.

iQIES ASAP System
The ASAP system is a national database to which all MDS 3.0 assessments and records are submitted.

iQIES Technical Support Office
A CMS contractor that provides technical support to the state agencies housing iQIES.

iQIES
iQIES is the "umbrella" system that encompasses MDS, Outcome and Assessment Information Set, Automated Survey Process Environment, and CASPER.

Invalid Record
According to the MDS Correction Policy, this is a record which was accepted into iQIES databases but should not have been submitted (e.g., no such event occurred).

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

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

Latest Classifiable Assessment
The latest MDS 3.0 assessment that has all the items necessary to classify a resident according to PDPM. This includes only assessments with ISCs of NC, NQ, and NP.

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

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

LTC Handbook
A handbook issued by the Department for providers of MA NF services containing all information necessary to participate in the Pennsylvania MA program.

Long-Term Services and Supports
The designation for the CHC benefit package that includes NF services and home and community-based services that were covered in the Aging, Omnibus Budget Reconciliation Act (OBRA), Independence, COMMCare, AIDS, and Attendant Care waiver programs.

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

MA CMI
The arithmetic mean CMI for MA residents in the NF for whom the Department paid an MA day of care on the PD.

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

counted as an MA day of care.

MA for MA Case-mix
A payor status used by the MA case-mix reimbursement system. The resident must have a valid recipient number and a current MA NF effective date from the PA/FS 162 except during the first 30 days of a MA MCO covered stay (this includes HealthChoices). Identified by a response of '1' in S9080A.

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

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

Medicaid (MA Program)
At the federal level, the MA program is referred to as Medicaid.

MA
Medical services provided under a State Plan approved by the U.S. Department of Health and Human Services under Title XIX of the Social Security Act (SSA).

MA in Pennsylvania
MA is a federal and state program that pays for specific kinds of medical care and treatment for low-income families. Any payment made to a provider for services rendered is subject to the provisions of Title XIX of the SSA and the Pennsylvania Public Welfare Code, 55 Pa. Code Chapter 1101. Information necessary to participate in the Pennsylvania MA program may be found in the *LTC Handbook*.

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

MAC
A MAC is an organization designated by CMS to process Medicare claims. Previously known as FIs. In Pennsylvania, Novitas Solutions is the MAC. They may be contacted at (877) 235-8073.

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

MDS
A set of forms and process mandated by CMS to be used to assess every NF resident. MDS 3.0 v. 1.20.1 (October 1, 2025) with the standard CMS quarterly form and the state-specific Section S is required in Pennsylvania. The Medicare PPS assessment form (NP) may also be used in Pennsylvania.

Modification
A type of correction allowed under the MDS Correction Policy. A modification is requested when a valid MDS record is in the iQIES database but the information in the record contains errors. Each modification results in an increase in the correction number at MDS item X0800.

Non-MA
A payer status used by the MA case-mix reimbursement system to indicate that a resident does not meet the requirement for MA for MA case-mix status. It is also the default status if no information concerning MA for MA case-mix status is received from the NF.

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

Nursing Facility
For the MA case-mix reimbursement system, a LTC NF that is licensed by DOH; enrolled in the MA program as a provider of NF services; owned by an individual, partnership, association, or corporation; and operated on a profit or nonprofit basis.

The term does not include intermediate care facilities for individuals with intellectual disabilities, federal or state-owned LTC NFs, or Veteran's homes.

NIS
The comprehensive automated database of NF, resident, and fiscal information needed to operate the Pennsylvania case-mix reimbursement system.

NFRP
A secure file transfer protocol site that allows NF representatives to access CMI reports over the internet, upload the signed Certification Page, and submit cost report information.

Nursing Home Administrator
An individual licensed by the Commonwealth to administer a NF.

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

assessments.

OBRA
A final piece of legislation passed each year by Congress that incorporates any outstanding issues that must be resolved to move into the next fiscal year.

OBRA of 1987 Nursing Home Reform Act
In 1987, Congress enacted major nursing home reform legislation that affected all NFs participating in the MA program as part of the federal budget OBRA-87. These provisions were addressed in the Pennsylvania Bulletin, Volume 18, Number 52, on December 24, 1988 and MA Bulletin 1181-88-08, issued December 28, 1988.

Optional State Assessment (OSA)
This assessment must be completed every federally required assessment. This assessment may not be combined with any other assessment; however, it must be completed with every federally required assessment submitted. The OSA would have the same ARD as the federally required assessment.

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

PA/FS 162
See Notice to Applicant.

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

Pennsylvania ACCESS Card
A permanent plastic identification card issued to all recipients eligible for public assistance benefits. The 10-digit MA recipient number is found on this card and may be used by MA providers to verify an MA consumer's eligibility for MA services through the Eligibility Verification System.

Pennsylvania Bulletin
The Commonwealth's official gazette for information and rulemaking. It is available by subscription and online.

Per Diem
For the MA case-mix reimbursement system, a comprehensive rate of payment to a NF for covered services for a resident MA day of care.

PD
The first calendar day of the second month of each calendar quarter (§1187.2). A "snapshot" of residents in Pennsylvania NFs participating in the MA program is taken for rate setting purposes. Assessments for both MA for MA case-mix and non-MA residents are listed on the CMI report for all PDs (February 1, May 1, August 1, and November 1) beginning with the November 1, 2006 PD.

PD Deadline
The last date that MDS and tracking form records may be submitted to automatically generate a new CMI report for a PD. Refer to the PD calendar on DHS' *Long-Term Care Case-mix Information* site and the Bulletins section of the NFRP Welcome Page.

Preventable Serious Adverse Event
An event that could have been anticipated that led to an MA resident's death or serious injury could have been avoided and was a result of an error or other system failure within the NF.

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

Provider Number
The 13-digit Provider Reimbursement and Operations Management Information System (PROMISe) number assigned to the MA NF by DHS. The first nine digits are assigned by the DHS Master Provider Index for a given Federal Employer Identification Number. The last four digits reflect the service location code that is based on provider type, specialty, and physical location. Providers process MA billing using the correct 13-digit number based on the appropriate four-digit service location. The number can be found in the Provider Notice received shortly after enrolling in the MA program.

PROMISe
PROMISe is the Health Insurance Portability and Accountability Act-compliant claims processing and management information system implemented by the Department in March 2004. PROMISe replaced the MA Management Information System and incorporates claims processing and information management activities of the Department's Offices of Medical Assistance Programs, Mental Health and Substance Abuse Services, Mental Retardation, and Social Programs.

Quality Measure (QM) Reports
The QM reports available from the CASPER reporting option on the CMS MDS Welcome Page.

RAI
The designation for the complete resident assessment process mandated by the CMS, including the MDS, CAAs, and care planning decisions.

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

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

Resident Assessment Instrument (RAI) Manual
The Long-Term Care Facility RAI 3.0 User's Manual v.1.20.1 October 2025 issued by CMS covering the MDS, CAAs, and Utilization Guidelines.

Resident Data Reporting Manual
The Department's manual of instructions for submission of resident assessment records and tracking forms and verification of the CMI report.

Recipient Number
A 10-digit number found on the Pennsylvania ACCESS Card and PA/FS 162. This is a number permanently assigned to each recipient.

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

Resident
A person being cared for in a NF.

Resource Utilization Group (RUG) Version III
A category-based resident classification system used to classify NF residents into groups based on their characteristics and clinical needs (§1187.2). The Pennsylvania MA case-mix reimbursement system previously used version 5.12.44.

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

Submission Period
The period from the PD to the day before the certification page upload deadline. If data has not been submitted prior to the PD, all data that affects the PD must be submitted during this period. If the period is extended, any information affecting the PD received by the facility during this extended period must also be submitted (e.g., receipt of a PA/FS 162 changing the resident's MA for MA case-mix status).

The Department
See DHS.

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

Title XVIII
Designation for the federal Medicare statute.

Title XIX
Designation for the federal Medicaid statute.

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

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

Acronyms

Common Acronyms

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

ARD – Assessment Reference Date

BAF – Budget Adjustment Factor

BIMS – Brief Interview for Mental Status

BiPAP – Bilevel positive airway pressure

CAA – Care area assessment

CAO – County Assistance Office

CHC – Community HealthChoices

CMG – Case-Mix Group

CMI – Case-Mix Index

CMS – Centers for Medicare & Medicaid Services

CPAP – Continuous positive airway pressure

CPS – Cognitive performance scale

DHS – Department of Human Services (formerly Department of Public Welfare)

DOH – Department of Health, Division of Nursing Care Facilities

DPW – Department of Public Welfare (currently DHS)

FVR – Final Validation Report

HCFA – Health Care Financing Administration (currently CMS)

HICN – Medicare Health Insurance Claim Number

IDT – Interdisciplinary team

IPA – Interim Payment Assessment

ISC – Item Subset Code

iQIES – Quality Improvement and Evaluation System

iQIES ASAP – Quality Improvement and Evaluation System Assessment Submission and Processing [system]

LIFE – Living Independence for the Elderly

LTC – Long-Term Care

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

MA – Medical Assistance, Medicaid

MAC – Medicare Administrative Contractor

MCO – Managed Care Organization

MDS – Minimum Data Set

NF – Nursing Facility

NFRP – NF Report Portal

NIS – Nursing (Facility) Information System

NPE – Non-payment evaluation

NPO – Nothing by mouth, no oral intake

OBRA – Omnibus Budget Reconciliation Act

OLTL – Office of Long-Term Living

OSA – Optional State Assessment

PA – Pennsylvania

PA/FS 162 – Notice to Applicant

PD – Picture Date

PDA – Pennsylvania Department of Aging

PDPM – Patient-Driven Payment Model

PH-MCO – Physical Health Managed Care Organization

PPS – Prospective Payment System

PRN – Pro re nata

PROMISe – Provider Reimbursement and Operations Management Information System

PSAE – Preventable Serious Adverse Event

QM Reports – Quality Measures Reports

RAI – Resident Assessment Instrument

RRB – Railroad Retirement Board

RUG III – Resource Utilization Group Version III

SNF – Skilled Nursing Facility

SSN – Social Security Number

XX – Inactivation request MDS set