MDS 3.0 UPDATES

Effective October 1, 2017

PRESENTER

- Ronald A Orth, RN, NHA, CMAC
- Senior SNF Regulatory Analyst with Relias Learning.
- Formerly Chief Clinical Officer with AIS, Inc.
- 25+ years experience in healthcare and LTC
- Has spoken nationally and internationally on topics related to LTC industry.
AGENDA

- Review new MDS 3.0 Items
- Review new coding guidance/clarifications to MDS 3.0 Sections G, GG, H, I, J, M, N, O.
- Review SNF PPS Part A Discharge Requirements NPE Requirements
- Update on QRP Status

MDS 3.0 NEW ITEMS!

Effective October 1, 2017
SECTION N OPIOIDS

- CMS added OPIOIDS as a classification of Medications in N0410.
- Follow same coding rules as other listed medications.
- Applies to all items sets except: NO, NPE, NS/SS, NT/ST

<table>
<thead>
<tr>
<th>N0410. Medications Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Antipsychotic</td>
</tr>
<tr>
<td>B. Antidepressant</td>
</tr>
<tr>
<td>C. Antidepressant</td>
</tr>
<tr>
<td>D. Hypnotic</td>
</tr>
<tr>
<td>E. Antibiotic</td>
</tr>
<tr>
<td>F. Opioid</td>
</tr>
</tbody>
</table>

- Codeine (only available in generic form)
- Fentanyl (Actiq, Duragesic, Fentora)
- Hydrocodone (Hysingla ER, Zohydro ER)
- Hydrocodone/acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine (Demerol)
- Methadone (Dolophine, Methadose)
- Morphine (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR)
- Oxycodone (OxyContin, Oxecta, Roxicodone)
- Oxycodone and acetaminophen (Percocet, Endocet, Roxicet)
- Oxycodone and naloxone (Targiniq ER)
CMS added MDS questions pertaining to an Antipsychotic Medication Review.

- Consists of 5 questions total.
- Depending on answers, some will not be required.
- Applies to comprehensive (NC) and quarterly (NQ) items sets only.

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### SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

<table>
<thead>
<tr>
<th>A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No - Antipsychotics were not received → Skip to 00110, Special Treatments, Procedures, and Programs</td>
</tr>
<tr>
<td>1. Yes - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>2. Yes - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>3. Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Has a gradual dose reduction (GDR) been attempted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No → Skip to N0450D, Physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>1. Yes → Continue to N0450C, Date of last attempted GDR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Date of last attempted GDR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

### N0450. Antipsychotic Medication Review - Continued

<table>
<thead>
<tr>
<th>D. Physician documented GDR as clinically contraindicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No - GDR has not been documented by a physician as clinically contraindicated → Skip to 00110, Special Treatments, Procedures, and Programs</td>
</tr>
<tr>
<td>1. Yes - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Date physician documented GDR as clinically contraindicated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>
NEW ITEMS — SECTION N

NO450A

- Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

- If no, skip to Section 0. You are done with the Antipsychotic medication review.
- If yes, then you must determine if antipsychotics were given on routine basis, PRN or both. If yes, then continue to NO450B

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No - Antipsychotics were not received → Skip to 0010G, Special Treatments, Procedures, and Programs</td>
</tr>
<tr>
<td>1</td>
<td>Yes - Antipsychotics were received on a routine basis only → Continue to NO450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>2</td>
<td>Yes - Antipsychotics were received on a routine basis → Continue to NO450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>3</td>
<td>Yes - Antipsychotics were received on a routine and PRN basis → Continue to NO450B, Has a GDR been attempted?</td>
</tr>
</tbody>
</table>

NEW ITEMS — SECTION N

NO450B, NO450C

- Has a gradual dose reduction GDR been attempted?

- Yes or No question.
- If yes, continue to NO450C, Date of last attempted GDR.
- If No, go to NO450D, Physician documented GDR as clinically contraindicated.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Has a gradual dose reduction (GDR) been attempted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No → Skip to NO450D, Physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>1</td>
<td>Yes → Continue to NO450C, Date of last attempted GDR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Date of last attempted GDR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
</tr>
</tbody>
</table>
NEW ITEMS — SECTION N

NO450D, NO450E

- Only completed if no GDR has been attempted (N0450B)
- Indicate Yes or No, if there is documentation by a physician indicating a GDR is medically contraindicated.
  - If No, proceed to Section 0.
  - If Yes, then indicate date of documentation in N0405E.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.</td>
<td>Physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>0.</td>
<td>No - GDR has not been documented by a physician as clinically contraindicated</td>
</tr>
<tr>
<td>1.</td>
<td>Yes - GDR has been documented by a physician as clinically contraindicated</td>
</tr>
<tr>
<td>E.</td>
<td>Date physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

Steps for Assessment

- Review the resident’s medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent.
- If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted.
- If a gradual dose reduction was not attempted, review the medical record to determine if there is physician (including NP, PA, CNS) documentation that the GDR is clinically contraindicated.
SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

Coding Tips and Special Populations

- Do not include Gradual Dose Reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).

- Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

Coding Tips and Special Populations

- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated.

- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section.
SECTION N ANTI PSYCHOTIC MEDICATION REVIEW

Coding Tips and Special Populations

- In cases where a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C, Date of last attempted GDR.

- GRADUAL DOSE REDUCTION (GDR) Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.

NEW ITEMS — SECTION P

- CMS incorporated the capture of alarm use in Section P
- Section title changed to Restraints AND Alarms
- Addition of alarms has no impact on Restraint QM.
SECTION P - ALARMS

Steps for Assessment

- Review the resident’s medical record (e.g., physician orders, nurses’ notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
- Consult the nursing staff to determine the resident’s cognitive and physical status/limitations.
- Evaluate whether the alarm affects the resident’s freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

SECTION P - ALARMS

Coding Instructions

Identify all alarms that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:

- **Code 0, not used**: if the device was not used during the 7-day look-back period.
- **Code 1, used less than daily**: if the device was used less than daily.
- **Code 2, used daily**: if the device was used on a daily basis during the look-back period.
**SECTION P - ALARMS**

**Coding Tips**

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.

- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
- **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
  - Review F604 of new Appendix PP for more information related to alarms and restraints, *Determination of the Use of Position Change Alarms as Restraints*.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in his section.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when anyone (including visitors or staff members) exits the door.
When is an NPE item set required?

1. Resident ends a Part A stay and remains in the SNF.
   a. Includes exhaustion of benefits.
2. Resident ends a Part A stay and is physically discharged.
   a. Planned or unplanned is not a deciding factor.
   b. May be combined with OBRA discharge assessment if physical discharge is on or the day after the date at A2400C

When is an NPE item set not required?

1. When a resident dies.
SECTION G — ADL ALGORITHM

- CMS updated Section G Self Performance coding algorithm
- Better corresponds with the Rule of 3
- Addresses the confusion related to Independent episodes that occur at least 3 times, but not every time.

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Start algorithm here: STOP at the First Code That Applies

Did the activity occur at least 1 time?
  Yes → Code 0: Independent
  No → Code 8: Activity Did Not Occur

Did the activity occur 3 or more times?
  Yes → Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?
  No → Code 7: Activity Occurred Once or Twice

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SECTION G — RULE OF 3

START HERE – Review these instructions for Rule of 3 before using the algorithm. Follow steps in sequence and stop at first level that applies.

- Start by counting the number of episodes at each ADL Self-Performance Level.

- Exceptions to Rule of 3:
  - The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
  - The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

Rule of 3:
1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule only applies if there are NOT ANY LEVELS that are 3 or more episodes at any one level. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3) – if this change makes 3 episodes at Extensive Assistance (3), code as Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

If none of the above are met, code Supervision (1).
SECTION G - RULE OF 3 EXAMPLE

Resident bed mobility documentation reveals the following:
- Independent – 8 episodes
- Limited assistance – 2 episodes
- Extensive Assistance - 1 episode

Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)

Rule # 1 Applies

SECTION G - RULE OF 3 EXAMPLE

Resident bed mobility documentation reveals the following:
- Independent – 3 episodes
- Limited assistance – 2 episodes
- Extensive Assistance - 2 episode
- Total Dependence - 2 episodes

Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)

Rule # 1 Applies
**SECTION G - RULE OF 3 EXAMPLE**

- Resident bed mobility documentation reveals the following:
  - Independent – 2 episodes
  - Limited assistance – 2 episodes
  - Extensive Assistance – 1 episode
  - Total Dependence – 2 episodes

**Rule # 3a Applies**

- Code 3: Extensive Assistance
  - Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level? (Item 3a Rule of 3)
  - Yes
  - No

**SECTION G - RULE OF 3 EXAMPLE**

- Resident bed mobility documentation reveals the following:
  - Independent – 2 episodes
  - Limited assistance – 2 episodes
  - Extensive Assistance – 1 episode
  - Total Dependence – 1 episode

**Rule # 3c Applies**

- Code 2: Limited Assistance
  - Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3b Rule of 3)
  - Yes
  - No
SECTION G- OTHER CLARIFICATIONS

- Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer.

- Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support.

SECTION G- OTHER CLARIFICATIONS

- How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting.

- When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.
SECTION G — OTHER CLARIFICATIONS

Check G0600C, wheelchair (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.

SECTION GG—CLARIFICATIONS

- No real changes to how this section is coded.
- CMS provided language/text revisions to clarify current coding directives.
- When is Section GG required:
  - On any assessment coded as a 5-day SNF PPS assessment (A0310B =1)
  - On any OBRA/NPE discharge assessment except the following:
    - D/C is unplanned.
    - D/C is to the hospital
    - SNF Part A stay is < 3 days.
SECTION GG - CLARIFICATIONS

Combined 5-day w/ Discharge assessment example:

- Resident admitted on Sunday, discharged back to the hospital on Tuesday. Provider is completing a 5-day/DC assessment.
  - Admission Performance GG is still required.
  - Admission Goal (1) is still required.
  - Discharge Performance is NOT required.

- Provided clarification that functional assessment can and should be conducted even if therapeutic interventions started.

- Provided further clarification related to wheelchair coding:
  - If the resident walks, and is not learning to mobilize with a wheelchair, but uses the wheelchair for transportation purposes only, then code the wheelchair gateway items as "no".

SECTION H

H0100D

- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization. This includes self-catheterizations using clean technique.

- Removed the word "sterile" from definition of Intermittent Catheterization.
SECTION I — UTI

CURRENT Criteria

Code only if all of the following are met:

- Physician documented diagnosis
- Sign or symptom attributed to UTI.
- “Significant Laboratory Findings”
- Current medication or treatment

NEW Criteria

Code only if both of the following are met in the past 30 days:

- It was determined that a resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the past 30-days.
- A physician, (or nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state licensure laws) diagnosis of a UTI in last 30 days,

SECTION I

- In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility’s surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.

- Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility’s Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.
MCGEER UTI CRITERIA

New Criteria for UTI without a Catheter (Both criteria 1 and 2 must be present)

Criteria 1

At least one of the following sign or symptom criteria:

a. Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate
b. Fever or leukocytosis (see Constitutional Criteria Table) and at least one of the following localizing urinary tract subcriteria:
   i. Acute costovertebral angle pain or tenderness
   ii. Suprapubic pain
   iii. Gross hematuria
   iv. New or marked increase in incontinence
   v. New or marked increase in urgency
   vi. New or marked increase in frequency

b. In the absence of fever or leukocytosis, then 2 or more of the following subcriteria:
   i. Suprapubic pain
   ii. Gross hematuria
   iii. New or marked increase in incontinence
   iv. New or marked increase in urgency
   v. New or marked increase in frequency

Criteria 2

a. At least 105 cfu/mL of no more than 2 species of microorganisms in a voided urine sample
b. At least 102 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter

With the new change in surveillance guidelines, it is not only important that we train our staff but that we look at how to operationalize infection prevention strategies.
SECTION J

Simple, but important clarification related to intercepted falls.

CMS understands that challenging a resident's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

SECTION M - TERMINOLOGY

- Last year the NPUAP changed the terminology used when referring to pressure ulcers. The new term of Pressure Injury was adopted instead of the use of Pressure Ulcer.

- CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore.

- It is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure.
SECTION M – OTHER CLARIFICATIONS

- Mucosal ulcers related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc., should not be coded as pressure ulcers under M0210.

- Do not code pressure ulcers, venous or arterial ulcers, diabetic foot ulcers or skin tears under M1040D, Open Lesions other than Ulcers, Rashes, Cuts. These are elsewhere on the MDS under their respective conditions.

SECTION N – OTHER CLARIFICATIONS

N0410

- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine (Compazine) is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic.
SECTION N – OTHER CLARIFICATIONS

N0410 E Anticoagulants

- Include Target Specific Oral Anticoagulants
  - Eliquis
  - Pradaxa
  - Xaralto

N0410D Hypnotic

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root).

- Also, do not code OTC medications in N0410D. (Not new)
SECTION 0- 00400 RESPIRATORY THERAPY

- Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment.

- Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

SECTION 0- ITEMS 00600 & 00700 — PHYSICIAN EXAMINATIONS/ORDERS

- CMS no longer requires these two items to be completed!!!

- HOWEVER! These items are qualifiers for the Clinically Complex RUG category under the RUG III system.
  - Any state that uses the RUG III will most likely still require these two items.
  - Some states may still want these items completed.

- CHECK WITH YOUR STATE RAI COORDINATOR ON COMPLETION REQUIREMENTS.

- If the State does not require the completion of this item, use the standard “no information” code (a dash, “-”).
SECTION 0- ITEMS 00600 & 00700 — PHYSICIAN EXAMINATIONS/ORDERS

- Definition of Physician has changed related to coding of O0700 Physician Orders.
  - Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, **qualified dietitians, clinically qualified nutrition professionals, or qualified therapists** working in collaboration with the physician as allowable by state law.

- Review F715 and F808 for more information and definition related to qualified dietitians, clinically qualified nutrition professionals.
QRP UPDATE

REVIEW AND CORRECT REPORTS

- Two issues identified with these reports:
  - If modifications to assessment records was submitted, not being used to update data – RESOLVED
  - Calculation issue in Functional Assessment measure – not resolved.
- CMS will extend correction period till May 15th, 2018.
- August 15th deadline for 1st Quarter 2017 will be reopened once issue is fixed.

<table>
<thead>
<tr>
<th>Reporting Quarter</th>
<th>Start Date</th>
<th>End Date</th>
<th>Data Correction Deadline</th>
<th>Data Correction Period as of Report Run Date</th>
<th>Number of SNF Stays Included in the Numerator for this Measure*</th>
<th>Number of SNF Stays Included in the Denominator for this Measure*</th>
<th>Your SNF's Observed Performance Rate</th>
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<tbody>
<tr>
<td>Q1 2017</td>
<td>01/01/2017</td>
<td>03/31/2017</td>
<td>08/15/2017</td>
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<td>-</td>
<td>-</td>
<td>7</td>
<td>93</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
RESOURCES

Evidence-based UTI criteria:

- MDS Manual w/ Change Tables
  - Appendix PP – State Operations Manual, New and Revised

CERTIFIED MDS ASSESSMENT COORD. (CMAC)

- Relias offers an MDS Certification (CMAC)
- Formally AIS MDS Certification
- 100% online MDS Certification
- 6 months to complete from date of enrollment!
- Stay up to date w/ annual recertification
- Now used by many large LTC organizations.
- More cost effective.
- Visit https://www.aissystems.com/mds3-certification/
THANK YOU!