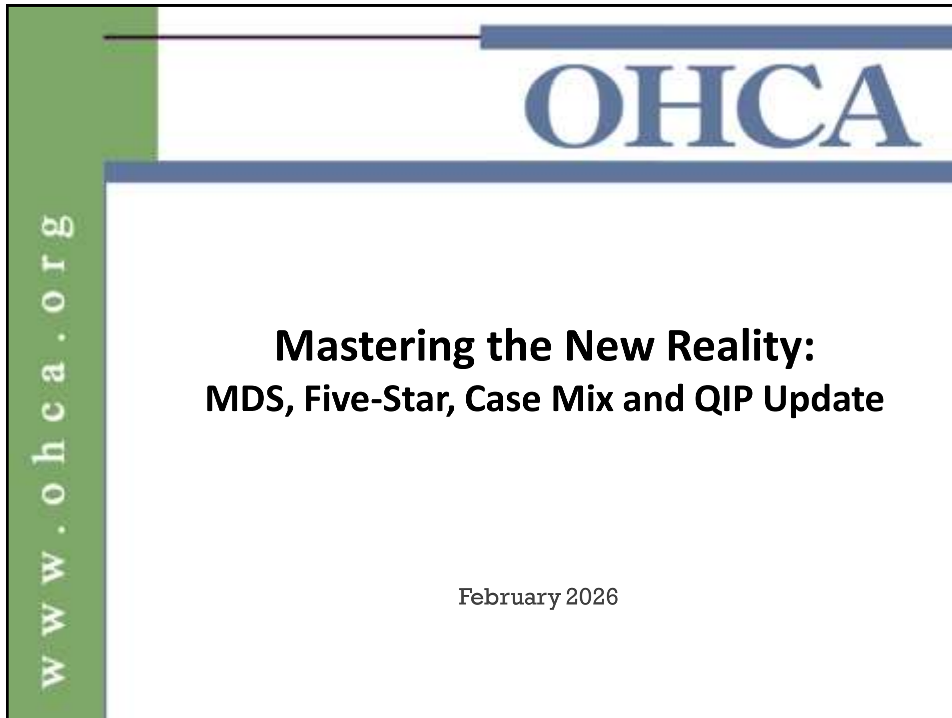
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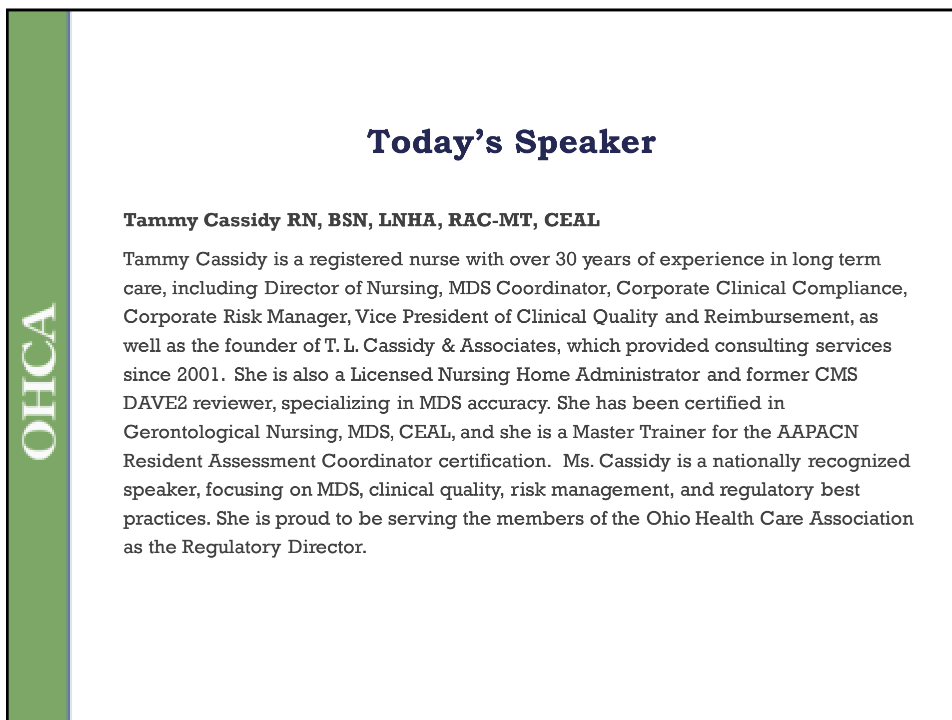
Mastering the New Reality:
MDS, Five-Star, Case Mix and QIP Update
February 2026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Today's Speaker
Tammy Cassidy RN, BSN, LNHA, RAC-MT, CEAL
Tammy Cassidy is a registered nurse with over 30 years of experience in long term care, including Director of Nursing, MDS Coordinator, Corporate Clinical Compliance, Corporate Risk Manager, Vice President of Clinical Quality and Reimbursement, as well as the founder of T. L. Cassidy & Associates, which provided consulting services since 2001. She is also a Licensed Nursing Home Administrator and former CMS DAVE2 reviewer, specializing in MDS accuracy. She has been certified in Gerontological Nursing, MDS, CEAL, and she is a Master Trainer for the AAPACN Resident Assessment Coordinator certification. Ms. Cassidy is a nationally recognized speaker, focusing on MDS, clinical quality, risk management, and regulatory best practices. She is proud to be serving the members of the Ohio Health Care Association as the Regulatory Director.

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## Objectives

- Discuss how the MDS RAI changes will impact communities and identify strategies for successful implementation
- Explain the new scoring methodology of the Health Inspections star rating
- Discuss recent changes to the Quality Measure scoring methodology and proactively establish best practices to improve scores

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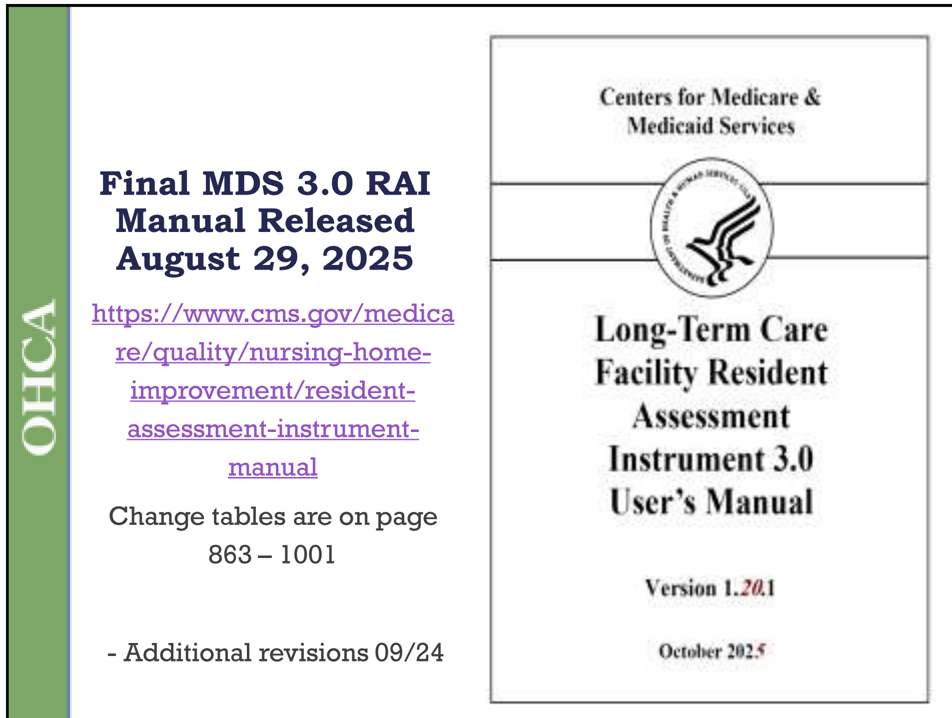
# MDS 3.0 RAI Manual Changes

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## Major MDS 3.0 RAI Changes

Section GG0130 (Self-Care) and GG0170 (Mobility)

- Many coding tips were added:
  - Assessment of 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
    - You can still attempt to assess the resident's ability, even if they don't routinely use the skill.
  - Clarifies that during the assessment timeframe (up to 3 calendar days based on the target date), some activities may be performed by the resident multiple times, whereas other activities may only occur once.

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## Major MDS 3.0 RAI Changes

Section GG0130 (Self-Care) and GG0170 (Mobility)

- Many coding tips were added:
  - Clarifies that coding of a dash should be a rare occurrence
  - Clinical assessment may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible
    - Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g. parallel bars, exoskeleton, or overhead track and harness systems)
  - When coding usual performance, if two or more helpers are required to assist the resident in completing the activity, code as 01 (Dependent.)
  - The adequacy of the resident's nutrition or hydration is not considered for GG0130A (Eating.)

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## Major MDS 3.0 RAI Changes

Section GG0130 (Self-Care) and GG0170 (Mobility)

- Clarified that coding examples may describe a single observation of the resident completing the activity, or may describe a summary of several observations of the resident completing an activity across different times of the day and different days

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## Major MDS 3.0 RAI Changes

Section J

- The definition of a fall has changed to:

  Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) or the result of an overwhelming external force (e.g., a resident pushes another resident.)

  An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person – this is still considered a fall.

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## Major MDS 3.0 RAI Changes

Section J

- Definition of a fall:
  - Some previous elements of the fall definition have been moved to coding tips:
    - Falls may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
    - Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
    - Challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and is not a fall.
      - NEW – "However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall."

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## Major MDS 3.0 RAI Changes

- Definition of Fall with Injury (Except Major) has changed to:

  Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or an fall-related injury that causes the resident to complain of pain.

  - Very subjective
  - MDS item sets were updated on September 24, 2025 to reflect the new language.

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## Major MDS 3.0 RAI Changes

- Definition of Fall with Major Injury has changed to:

  Includes, but is not limited to, traumatic bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries

  - Very subjective
  - Will have a significant impact on Quality Measures and Ohio QIP

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## Major MDS 3.0 RAI Changes

- J1900 (Number of Falls Since Admission/Entry or Reentry or Prior Assessment)
  - Clarifies that fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.
  - Example included to demonstrate a fall that occurs during balance training with therapy

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## Differentiating from Traumatic vs. Pathological Fractures Examples

Resident A, who has osteoporosis, falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the resident's bone disease and not a result of the fall.
**Coding:** J1800 would be **coded 1, yes** and J1900C would be **coded 0, none**.

**Rationale:** The physician determined that the fracture was a pathological fracture due to osteoporosis. Because the fracture was determined to be pathological, it is not coded as a fall with major injury.

Resident L, who has osteoporosis, falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the resident's fall and not the resident's history of osteoporosis.
**Coding:** J1800 would be **coded 1, yes** and J1900C would be **coded 1, one**.

**Rationale:** Because the physician determined that the fracture was a result of the fall, it is a traumatic fracture and, therefore, is a fall with major injury.

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## Major MDS 3.0 RAI Changes

Section N

- N0415 (High-Risk Drug Classes: Use and Indication)
  - CMS indicates that facilities may wish to identify a resource that their staff consistently uses to identify pharmacological classification
    - Assessors should be able to identify the source(s) used to support coding the MDS 3.0
    - Language related to consulting resources/links cited in Section N have been removed.
  - Clarified that flushes to keep an IV access patent is not coded in N0415E (Anticoagulant)

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## Major MDS 3.0 RAI Changes

Section O

- O0390 (Therapy Services)
  - New item that replaces O0400 as it related to OT, PT, SLP, and Psychological Therapy days and minutes
  - If O0390D (Respiratory Therapy) is checked, then O0400D (Respiratory Therapy Days) must be completed.
    - All other aspects of O0400 were removed.

**O0390. Therapy Services**
Indicate therapies administered for at least 15 minutes a day on one or more days in the last 7 days

| ↓ Check all that apply | |
|---|---|
| ☐ | A. Speech-Language Pathology and Audiology Services |
| ☐ | B. Occupational Therapy |
| ☐ | C. Physical Therapy |
| ☐ | D. Respiratory Therapy |
| ☐ | E. Psychological Therapy |
| ☐ | Z. None of the above |

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## MDS 3.0 RAI Changes

Section O

- CMS stresses the importance of maintaining as much independence as possible in ADLs, mobility and communication, and lists the possible risks of decline
- CMS states that Rehabilitation Services can help residents attain or maintain their highest level of well-being and improve quality of life

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## Major MDS 3.0 RAI Changes

- The proposed section R (Social Determinants of Health) was removed.
  - Also removed as a possible QRP measure
  - Moved Transportation back to Section A
    - Previous interview items were combined and now the resident will only need to respond one time.
    - References to a lack of transportation have been clarified to a "lack of reliable transportation."

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## QRP and Impact of Section R Removal

QRP = Quality Reporting Program

- Additional data elements were scheduled to be added for FY 2027.
  - Would have included social determinates of health
  - Would have been based off of 5 items in Section R
  - The SNF FY 2026 Final Rule eliminated these elements from QRP
  - CMS estimated the time for collection of this data would result in:
    - 31,791.20 hours of administrative burden
    - $2,228,563.12 cost nationally ($146.11 per SNF)

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## QRP and Impact of Section R Removal

In order to be compliant, SNFs must meet or exceed two data completeness thresholds:

- Threshold 1: 90% completion of the assessment-based quality measures and standardized patient assessment data collected using the MDS and submitted through iQIES
- Threshold 2: 100% completion for quality measures data collected and submitted using the CDC NHSN
- Threshold 3: 100% completion for records selected for the data validation process

QRP Frequently Asked Questions for FY 2026 can be found here:

https://www.cms.gov/files/document/fy2026snfqrpfaqs.pdf

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## QRP and Impact of Section R Removal

A list of FY 2027 Data Elements can be found here:

https://www.cms.gov/files/document/fy2027snfqrpaputableforreportingmeasuresanddata-revised.pdf

A list of FY 2028 Data Elements can be found here:

https://www.cms.gov/files/document/fy2028snfqrpaputableforreportingmeasuresanddata.pdf

Remember – Failure to comply with SNF QRP guidelines will result in a 2% reduction in the SNF's annual rate update (APU)

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## Section X: Correction Request

- Clarified that the modification and inactivation processes do not remove the prior erroneous record from iQIES
  - The previous record remains in the database, but is archived
  - If it is necessary to delete or change a record and not retain any information about the record in iQIES, the facility must complete an MDS 3.0 Individual Correction Request or an MDS 3.0 Individual Deletion Request in iQIES
  - In situations in which the state-assigned facility submission ID (FAC ID) or the state code (STATE CD) is incorrect, an MDS 3.0 Manual Assessment Move Facility Request is required
  - Additional detail about the process can be found in Chapter 5 of the MDS Manual, and in the iQIES Assessment Management: Assessment Submitter Manual:

https://qtso.cms.gov/system/files/qtso/iQIES%20Assessment%20Management%20Manual%20for%20Assessment%20Submitter%20v2.1%20FINAL%2008.11.25_508.pdf

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## Chapter 5 (Submission and Correction of the MDS Assessments)

- Added a link to the iQIES MDS Error Messages Reference Guide:
  [https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals](https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals)

- Establishes that errors resulting in the need for an MDS 3.0 Individual Correction/Deletion or Move Request must be corrected within 14 days after identifying the errors

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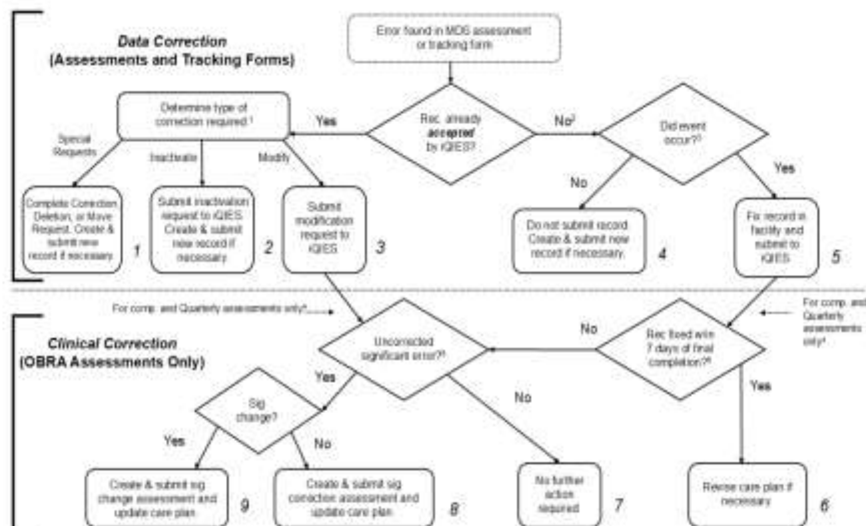
## New Correction Decision Tree Available



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# Effect of CMS QSO 25-20-NH

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## Details of CMS QSO-25-20-NH

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality

Ref: QSO-25-20-NH

DATE: June 18, 2025

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Updates to Nursing Home Care Compare

**Memorandum Summary**

- **Post Performance Data for Nursing Home Chains** – "Chains" refers to groups of Medicare-certified nursing homes that are connected through common owners, and operators (also called "affiliated entities"). CMS will begin posting aggregated performance information for these nursing homes on Nursing Home Care Compare in a consumer-friendly format.
- **Drop Third Cycle Standard Surveys from the Nursing Home Care Compare Health Inspection Rating** – To help ensure the Nursing Home Care Compare health inspection rating more accurately reflects current performance at nursing homes, CMS will be removing any inspection in the third cycle, meaning the oldest surveys, from the rating calculation.
- **Incorporate Updated Long-Stay Antipsychotic Measure on Nursing Home Care Compare** – To improve measure accuracy CMS will update the quality measure assessing the number of long-stay residents receiving antipsychotic medications to include Medicare and Medicaid claims and encounter data, in addition to Minimum Data Set (MDS) data currently used in the existing measure.
- **Removing COVID-19 Vaccination Measures** – CMS will be removing the resident and staff COVID-19 Vaccination measures from the main profile page of each nursing home.

- https://www.cms.gov/files/document/qso-25-20-nh.pdf

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## Post Performance Data for Nursing Home Chains

- CMS will began posting aggregated performance information for nursing home chains on Care Compare
- What is considered a "chain"?
  - A group of Medicare-certified nursing homes that are connected through common owners, and operators

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## Post Performance Data for Nursing Home Chains

- Data, including average ratings and performance measures across several staffing and quality measures, has been posted on data.cms.gov since June 2023.
  - Was intended for nursing homes and researchers
- Beginning July 30, 2025, average overall, health inspection, staffing and quality measure ratings for each chain posted on Care Compare
  - Intended to increase transparency

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## Removing COVID-19 Vaccination Measures

- Effective July 30, 2025, CMS removed the COVID-19 vaccination section from the main profile page of each nursing home on Care Compare.
- Information related to COVID-19 vaccination still available on Care Compare in a different location.
- CDC recently updated the definition of up-to-date for COVID vaccines, but there has been no change to MDS guidance yet



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## Drop Third Cycle Standard Surveys from the Nursing Home Care Compare Health Inspection Rating

- Beginning with the July 2025 refresh, the 5 Star Health Inspections no longer includes the third cycle of standard surveys.
- Remaining surveys are reweighted.
- This change is to address the backlog of health inspections, older than 45 months, that are still in cycle three.
  - May not accurately reflect the current performance of nursing homes

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# Drop Third Cycle Standard Surveys from the Nursing Home Care Compare Health Inspection Rating

- Note: Results from the third most recent recertification health inspection and associated deficiencies are displayed on Care Compare but are not used for health inspection ratings

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# Overall Five-Star Design

**Design for *Care Compare* Nursing Home Five-Star Quality Rating System:**

**Technical Users' Guide**

**January 2026**

- https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf

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## Quick Overview of Five-Star Design

**Based on the star ratings for health inspection domain, the staffing domain and the quality measure domain, CMS assigns the overall Five-Star rating in three steps:**

- **Step 1:** Start with the health inspection rating.
- **Step 2:** Add one star to the Step 1 result if the staffing rating is five stars, subtract one star if the staffing rating is one star. The overall rating cannot be more than five stars or less than one star.
- **Step 3:** Add one star to the Step 2 result if the quality measure rating is five stars; subtract one star if the quality measure rating is one star. The overall rating cannot be more than five stars or less than one star.



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Quick Overview of Five-Star Design

**Note:** If the health inspection rating is one star, then the overall rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.

**Note**: If a nursing home is a Special Focus Facility, the maximum Overall rating is 3 stars.

**Note:** Nursing homes that receive the abuse icon have their health inspection rating capped at a maximum of two stars.

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# When is the Abuse Icon Received?

The abuse icon will be displayed if either of the following criteria are met:

1. Harm-level abuse citation in the most recent survey cycle (Scope and Severity of G or higher)
2. Repeat abuse citations where residents were found to be potentially harmed (Scope and Severity of D or higher) on:
   a. the most recent standard survey or
   b. on a complaint or focused infection control survey within the past 12 months, **and**
   c. on the previous (i.e., second most recent) standard survey or
   d. on a complaint survey in the prior 12 months (i.e., from 13 to 24 months ago).

Will be removed as of the first monthly website refresh following when a nursing home no longer meets criteria

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# Deeper Dive into the Health Inspection Calculation

Surveys Used:

- Two most recent standard recertification surveys
- Complaint deficiencies during the most recent three-year period
- Repeat visits needed to verify that required corrections

Table 1
**Health Inspection Score: Weights for Different Types of Deficiencies**

| Severity | Scope | | |
|---|---|---|---|
| | Isolated | Pattern | Widespread |
| Immediate jeopardy to resident health or safety | J<br>50 points*<br>(75 points) | K<br>100 points*<br>(125 points) | L<br>150 points*<br>(175 points) |
| Actual harm that is not immediate jeopardy | G<br>20 points | H<br>35 points<br>(40 points) | I<br>45 points<br>(50 points) |
| No actual harm with potential for more than minimal harm that is not immediate jeopardy | D<br>4 points | E<br>8 points | F<br>16 points<br>(20 points) |
| No actual harm with potential for minimal harm | A<br>0 point | B<br>0 points | C<br>0 points |

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.
Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care. See the Electronic Code of Federal Regulations ([illegible]) for a definition of substandard quality of care.
* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a "G-level" deficiency (i.e., 20 points) are assigned.
Source: Centers for Medicare & Medicaid Services

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# Health Inspection Calculation

**75% of total score:**

- Most recent survey
- Complaints/infection control citations in last 12 months

**25% of total score:**

- Second prior survey
- Complaints/infection control citations in last 13-36 months

5 Stars: Top 10% in state

2-4 Stars: Middle 70% with equal distribution of 23.33% to each

1 Star: Bottom 20% in state

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# Health Inspections Example

**Health Inspections**

The Five-Star health inspection rating listed on the first page of this report is based on the two most recent standard surveys and three years of complaint and focused infection control inspections and incorporates data reported through June 30, 2025.

***Your Health Inspection Rating***

Provided below are the survey dates included in the calculation of the health inspection rating for your facility. The dates listed include standard survey dates as well as dates of complaint inspections and focused infection control inspections that resulted in deficiencies. For more detailed information about the deficiencies cited on each survey, please visit: https://data.cms.gov/provider-data/. This website updates on the same day as the Care Compare website. Any additional revisit points can be found in the 'Provider Information' table at the link provided above.

*Health Inspection Surveys Weighted at 3/4 (standard survey in bold):*

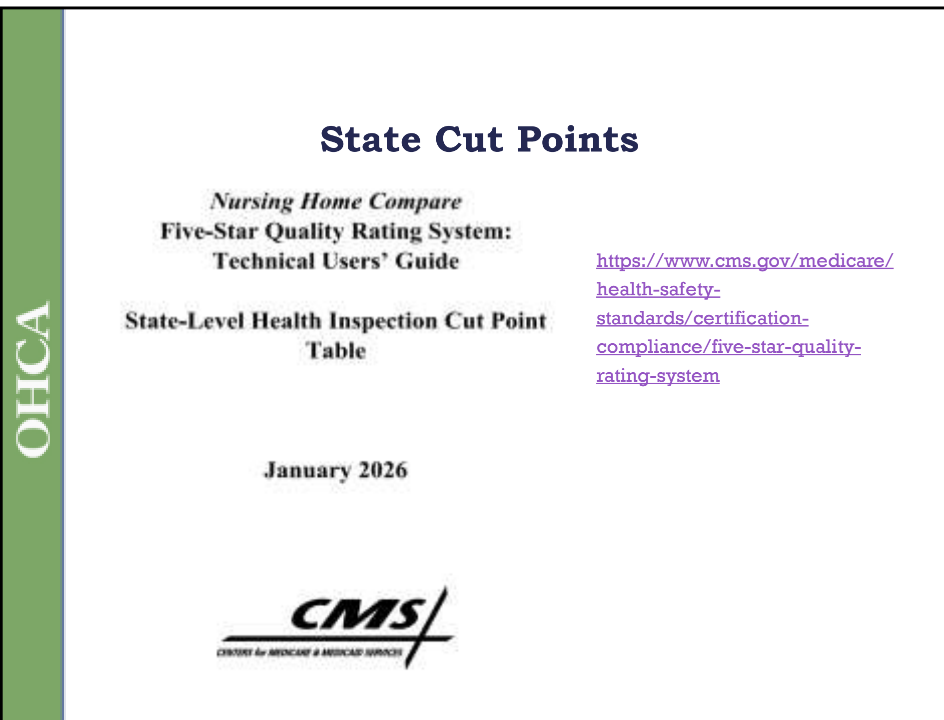
**May 16, 2024** September 24, 2024

*Health Inspection Surveys Weighted at 1/4 (standard survey in bold):*

**April 22, 2021** December 4, 2023 March 28, 2024

*Total weighted health inspection score for your facility: 33.0*

| State-level Health Inspection Cut Points for Ohio | | | | |
|---|---|---|---|---|
| 1 Star | 2 Stars | 3 Stars | 4 Stars | 5 Stars |
| >117.75 | 70.01-117.75 | 41.01-70.00 | 15.01-41.00 | 0.00-15.00 |

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## State Cut Point Examples

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Ohio | 916 | >117.750 | ≤117.750 | >70.000 | ≤70.000 | >41.000 | ≤41.000 | >15.000 | ≤15.000 |
| Oklahoma | 284 | >117.000 | ≤117.000 | >59.000 | ≤59.000 | >36.000 | ≤36.000 | >13.000 | ≤13.000 |
| Oregon | 128 | >122.500 | ≤122.500 | >74.000 | ≤74.000 | >51.000 | ≤51.000 | >21.000 | ≤21.000 |
| Pennsylvania | 657 | >120.500 | ≤120.500 | >63.000 | ≤63.000 | >28.000 | ≤28.000 | >8.000 | ≤8.000 |
| Puerto Rico | 6 | >145.000 | ≤145.000 | >129.500 | ≤129.500 | >94.000 | ≤94.000 | >92.000 | ≤92.000 |
| Rhode Island | 73 | >190.250 | ≤190.250 | >79.250 | ≤79.250 | >62.000 | ≤62.000 | >25.000 | ≤25.000 |
| South Carolina | 187 | >71.250 | ≤71.250 | >45.000 | ≤45.000 | >22.000 | ≤22.000 | >6.000 | ≤6.000 |
| South Dakota | 96 | >101.000 | ≤101.000 | >54.000 | ≤54.000 | >39.000 | ≤39.000 | >14.000 | ≤14.000 |
| Tennessee | 300 | >83.125 | ≤83.125 | >39.000 | ≤39.000 | >23.000 | ≤23.000 | >9.000 | ≤9.000 |
| Texas | 1,174 | >173.750 | ≤173.750 | >95.000 | ≤95.000 | >53.000 | ≤53.000 | >24.000 | ≤24.000 |

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Notes: A higher score indicates worse performance on health inspections. The cut points are based on facility health inspection scores and are set separately for each state to achieve this distribution:

- 5 stars: ≤10th percentile
- 4 stars: >10th percentile and ≤ 33.33rd percentile
- 3 stars: >33.33rd percentile and ≤ 56.667th percentile
- 2 stars: >56.667th percentile and ≤ 80th percentile
- 1 star: >80th percentile

Due to the small number of facilities, the cut points for Guam and the Virgin Islands are based on the national distribution of health inspection scores.

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## Health Inspection Calculation

Note:

- Citations under IDR/IIDR will be listed on Care Compare, but will not be included in the Five-Star rating.
- Facilities with only one standard health inspection are considered to have insufficient data, and will have no health inspection, overall, staffing or quality measure ratings.
- State cut points are recalculated each month, but the total weighted health inspection score is only compared to the cut points if there is a change in your score.

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## Health Inspection Calculation

•Note:

- Citations under F731 (Waiver of requirement to provide licensed nurses on a 24-hour basis) and F884 (COVID-19 reporting to the Centers for Disease Control) are not included in the Health Inspection calculation.
- Other deficiencies indicating that a waiver has been granted, will not be included in the Health Inspection calculation.
- Life Safety surveys are not included in the Health Inspection calculation.
- Deficiencies from Federal Comparative Surveys are not included in rating calculations, though the results of State Survey Agency determinations made during a Federal Oversight Survey are included.

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## Incorporate Updated Long-Stay Antipsychotic Measure on Nursing Home Care Compare

- CMS is concerned that the MDS data may not accurately reflect the number of antipsychotic medications provided to residents.
- Now includes Medicare and Medicaid claims data and Medicare Advantage encounter data in the quality measure.
- Posting began with January 2026 Refresh
  - Additional changes were posted in February to Q1 2025 and Q2 2025
    - Why is this important to Five Star and QIP?

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MDS 3.0 Quality Measures

USER'S MANUAL

(v18.0)

Effective January 1, 2026

https://www.cms.gov/medicare/quality/nursing-home-improvement/quality-measures

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## Antipsychotic Medication - LS

Considerations:

- Now a hybrid measure
- Will trigger if the resident received an antipsychotic during the assessment period – OR –
- Resident has a claim or encounter record for antipsychotic during the target period while a resident of the facility

Table 2-31
Percent of Residents Who Received an Antipsychotic Medication (LS)
(CMS ID: N047.01) (CMIT Measure ID: 526)

Measure Description

Measure Specifications

*Numerator*

*Denominator*

*Exclusions*

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# Antipsychotic Medication - LS

Considerations:

- What if the resident receives an order for an antipsychotic but is never administered the medication?
  - Based on fill date
- What the resident receives an antipsychotic at the doctor's office?
- What if the resident receives an antipsychotic in the emergency room, is not admitted to the hospital and returns to the nursing home in under 24 hours?
- What if the resident is admitted to the hospital and receives an antipsychotic while an inpatient?

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# Antipsychotic Medication - LS

Potential exclusions:

- If the resident is not continuously enrolled in either Medicare Part A&B&D or Medicare Part C&D or Medicaid only during each month from the beginning of the target period until the end of the episode
- If the resident is not continuously enrolled in either Medicare Part A&B or Medicare Part C or Medicaid only during each month of the measure exclusion lookback window
  - Measure exclusion lookback window is the same date one year prior to the target date until the target date.

Table 2-31
Percent of Residents Who Received an Antipsychotic Medication (LS)
(CMS ID: N047.01) (CMIT Measure ID: 526)

Measure Description

Measure Specifications

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## Antipsychotic Medication - LS

Potential exclusions:

- If a resident is private pay or has another payor such as VA Contract, they are excluded.
- CMS has confirmed that if a resident switches from Medicare A to Managed Care, or vice versa, during the exclusion lookback window, they will be excluded.

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## Antipsychotic Medication - LS

Potential exclusions:

- The resident is 65 or older at the time of admission but is not continuously enrolled in either Medicare Part A&B or Medicare Part C or Medicaid only during each month of the preadmission lookback window
- Residents with any of the following diagnoses can be excluded ONLY IN CERTAIN CIRCUMSTANCES:
  - Schizophrenia
  - Tourette's Syndrome
  - Huntington's Disease

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## Antipsychotic Medication - LS

Potential Exclusions:

- Residents under hospice care may be excluded ONLY IN CERTAIN CIRCUMSTANCES
  - Based on claims data, not MDS

**Measures Specifications Continued**

5. The resident receives Medicare Part A- or Medicaid-covered hospice services or is enrolled in hospice during any month between the beginning of the target period and the end of the episode.
   - 5.1. Resident has at least one Medicare Part A Hospice claim with a claim from date or through date overlapping with the period between the beginning of the target period and the end of the episode *or*
   - 5.2. Resident has at least one Medicaid hospice claim/encounter record where the beginning service date and ending service date overlaps with the period from the beginning of the target period to the end of the episode *or*
   - 5.3. Resident has a hospice eligibility group code (44: "individuals receiving hospice care") in Medicaid eligibility data for at least one month from the beginning of the target period to the end of the episode.[13]

**Covariates**

Not applicable.

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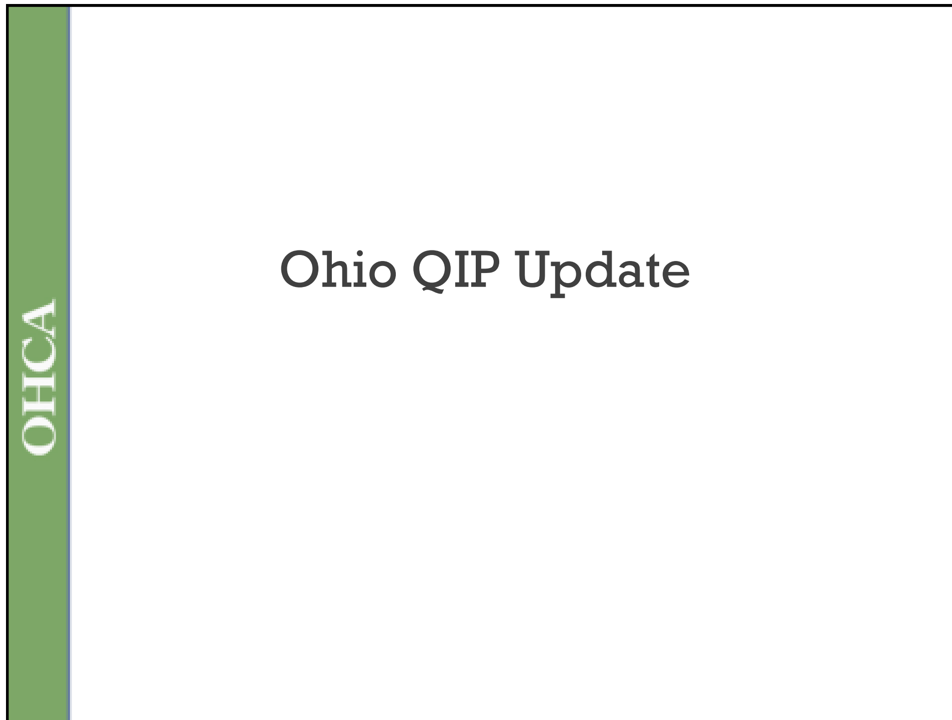
## Antipsychotic Medication - LS

Considerations:

- Talk to Medical Director and other physicians about antipsychotic use and need for accurate claims
- Talk to Hospice related to accurate claims data
- Monitor reports closely for accuracy

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## Ohio QIP Update

**Measures Included in Ohio QIP**

- Long Stay Pressure ulcers – 5 points
- Long-Stay urinary tract infection – 5 points
- Long-Stay ability to move independently worsened – 7.5 points
- Long-Stay catheter – 5 points
- Long-Stay activities of daily living – 7.5 points
- Long-Stay falls with major injury – 5 points
- Long-Stay antipsychotic medication – 7.5 points
- Staffing – 5 points
- Total Maximum Occupancy Points = 3 points

Maximum Points Available = 50.5 points

Maximum QM Points Available = 42.5 points

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# Quick Review of QIP QM Calculation

| MDS Long-Stay Measures | Provider ████ | | | | | Rating Points | OH | US |
|---|---|---|---|---|---|---|---|---|
| | 2024Q2 | 2024Q3 | 2024Q4 | 2025Q1 | 4Q avg | | 4Q avg | 4Q avg |
| *Lower percentages are better* | | | | | | | | |
| Percentage of residents experiencing one or more falls with major injury | 4.9% | 2.2% | 1.1% | 0.0% | 2.0% | 80 | 3.5% | 3.3% |
| Percentage of residents with pressure ulcers[1] | 0.8% | 0.6% | 0.7% | 0.7% | 0.7% | 100 | 4.1% | 5.4% |

- Each Quality Measure is compared to the national 4 Quarter average, and receives a point value, based on specified cut points
- The point value received is divided by 20 in order to calculate QIP

Be mindful of differences in the denominator, and ensuring calculations are accurate. Always double check the final 5 Star report for the quarter

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## To Determine Facility Points, Start with the 5 Star Report

| Quality Measure | Points | Min | Max |
|---|---|---|---|
| Percentage of residents with a urinary tract infection (long-stay) | 100 | 0.0000 | 0.0070 |
| | 80 | 0.0071 | 0.0160 |
| | 60 | 0.0161 | 0.0272 |
| | 40 | 0.0273 | 0.0452 |
| | 20 | 0.0453 | 1.0000 |
| Percentage of residents experiencing one or more falls with major injury (long-stay) | 100 | 0.0000 | 0.0134 |
| | 80 | 0.0135 | 0.0246 |
| | 60 | 0.0247 | 0.0356 |
| | 40 | 0.0357 | 0.0514 |
| | 20 | 0.0515 | 1.0000 |
| Percentage of residents who got an antipsychotic medication (long-stay) | 150 | 0.0000 | 0.0529 |
| | 135 | 0.0530 | 0.0795 |
| | 120 | 0.0796 | 0.1036 |
| | 105 | 0.1037 | 0.1264 |
| | 90 | 0.1265 | 0.1485 |
| | 75 | 0.1486 | 0.1726 |
| | 60 | 0.1727 | 0.2014 |
| | 45 | 0.2015 | 0.2395 |
| | 30 | 0.2396 | 0.2982 |
| | 15 | 0.2983 | 1.0000 |

- Cut points from the 5 Star Technical Users' Manual are used to determine the point values in each category. Updated 01-2026

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## Sample QIP Tracking

| July 1, 2025 Rate Setting | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Average | Finalized | Points | QIP Points |
| ADL Increased | | | | | | | | |
| Ability to Walk Worsened | | | | | | | | |
| Pressure Ulcer | | | | | | | | |
| Catheter | | | | | | | | |
| Urinary Tract Infection | | | | | | | | |
| Falls with Major Injury | | | | | | | | |
| Antipsychotic Medication | | | | | | | | |
| Total Nurse Staffing | | | | | | | | |
| Occupancy >75% | | | | | | | | |
| | | | | | | | | |
| Total Point Value | | | | | | | | |

- July 2025 rate setting was the first QIP to use the new/revised quality measures, and did not have any frozen data
  - Tremendous affect on some communities – Some good. Some bad.
- Bottom 25% cut off for July 1, 2025 = 32 Points
  - Cut point is only adjusted one time per year. Will remain 32 points for January 2026

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## Sample QIP Tracking

| January 1, 2026 Rate Setting | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Average | Finalized | Points | QIP Points |
| ADL Increased | 4.80% | 10.60% | 5.50% | 5.70% | 6.62% | | 150 | 7.5 |
| Ability to Walk Worsened | 2.80% | 6.90% | 7.10% | 0.00% | 4.37% | | 150 | 7.5 |
| Pressure Ulcer | 2.60% | 1.30% | 1.50% | 1.40% | 1.69% | | 100 | 5 |
| Catheter | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | | 100 | 5 |
| Urinary Tract Infection | 1.30% | 3.80% | 1.20% | 2.50% | 2.18% | | 60 | 3 |
| Falls with Major Injury | 2.60% | 3.80% | 6.00% | 3.80% | 4.09% | | 40 | 2 |
| Antipsychotic Medication | 14.70% | 14.70% | 14.60% | 7.70% | 12.91% | | 90 | 4.5 |
| Total Nurse Staffing | 3.061 | 3.222 | | | 3.1415 | | 30 | 2 |
| Occupancy >75% | | | | | | | | |
| | | | | | | | | |
| Total Point Value | | | | | | | | 36.5 |

- It is not anticipated that the QIP will be recalculated for 1/2026 rate setting based on the changes to Q1 and Q2 of the Antipsychotic Measure
- The new Antipsychotic QM will affect 7/2026 QIP.
  - Impact of Q1 and Q2 changes

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## ODM Process

- Similar to the self-tracking process; however, they use information from the CMS database.
- CMS data can be found at this link:

https://data.cms.gov/provider-data/search?theme=Nursing%20homes%20including%20rehab%20services

- In some cases, the information from the CMS database does not match the information on the 5 Star report (imputed data)
  - In this case, ODM will use the information from the CMS database
  - Most common with smaller communities
  - Example: Walking Independently Worsened

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## ODM Process

- Because of small census, or a small of amount residents in the denominator, some quality measures may include imputed data
- Footnote on the 5 Star report:

[2]This measure includes some imputed data because there are fewer than 20 resident assessments or stays across the four quarters. This value is used in calculating the QM points and used in the QM rating calculation but will not be displayed on Care Compare.

- Example:
  - "Whispering Pines" nursing facility specializes in treatment of Multiple Sclerosis, ALS, and other high acuity neurological conditions. While their census is high, they have fewer than 20 resident assessments over four quarters indicating a resident walks 10 feet for purposes of the MDS. The data on the 5 Star was imputed, and as a result, the 5 Star report shows a score of 150 points for "Walking Independently Worsened." This would result in 7.5 QIP points. Instead, they received zero QIP points in this area, dropping them below the 25% percentile, because the data in the CMS files, showed n/a versus the imputed numbers.
  - What can you do this case?

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# Impact of Change to PDPM

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# Ohio PDPM Transition

- Will be based on PDPM Nursing Component only

- Transition
  - July 1, 2025 – December 31-2025: Use Q4 2024 & Q1 2025 RUG-IV case mix score unless frozen. If frozen, the frozen case mix will apply
  - January 1, 2026 – June 30, 2026: Phase-in using 1/3 PDPM from Q2 2025 & Q3 2025, 2/3 RUGs*
  - July 1, 2026 – June 30, 2027: Phase-in using 2/3 PDPM, 1/3 RUGs*
  - July 1, 2027 – Full PDPM Implementation

- RUGs used for phase-in comparison is semiannual score used for January 1, 2025 (or frozen)

Bottom Line – Focus needs to be on PDPM scores

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# Ohio PDPM Transition

Conversion Factor

- ORC 5165.19: (4) The department shall multiply each cost per case-mix unit determined under division (C)(1) of this section by the peer group average case-mix score in effect on December 31, 2025, divided by the peer group average case-mix score determined under section 5165.192 of the Revised Code for the semiannual period beginning January 1, 2026. The product determined under this division for each nursing facility's peer group shall be the cost per case-mix unit used to determine the nursing facility's per Medicaid day payment rate for direct care costs under division (A)(1) of this section for the period beginning January 1, 2026, and ending on the day before the department's next rebasing conducted after that date takes effect.
- Why is this needed?
  - The PDPM scores are lower than the RUG-IV case mix weights.
  - Levels the playing field

| | Peer Group One | Peer Group Two | Peer Group Three |
|---|---|---|---|
| Case Mix Multiplier | 1.9907 | 1.9854 | 2.0337 |

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# Current Medicaid Case Mix Weights (Does not include conversion factor)

| Nursing PDPM Score | HIPPS Code 3rd Digit | Case-Mix Index |
|---|---|---|
| ES3 | A | 3.84 |
| ES2 | B | 2.90 |
| ES1 | C | 2.77 |
| HDE2 | D | 2.27 |
| HDE1 | E | 1.88 |
| HBC2 | F | 2.12 |
| HBC1 | G | 1.76 |
| LDE2 | H | 1.97 |
| LDE1 | I | 1.64 |
| LBC2 | J | 1.63 |
| LBC1 | K | 1.35 |

| Nursing PDPM Score | HIPPS Code 3rd Digit | Case-Mix Index |
|---|---|---|
| CDE2 | L | 1.77 |
| CDE1 | M | 1.53 |
| CBC2 | N | 1.47 |
| CA2 | O | 1.03 |
| CBC1 | P | 1.27 |
| CA1 | Q | 0.89 |
| BAB2 | R | 0.98 |
| BAB1 | S | 0.94 |
| PDE2 | T | 1.48 |
| PDE1 | U | 1.39 |
| PBC2 | V | 1.15 |
| PA2 | W | 0.67 |
| PBC1 | X | 1.07 |
| PA1 | Y | 0.62 |

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# PDPM – Other Items of Note

- Low rate for PA1/PA2 residents and exclusion from CMI not changed
  - These provisions are in statute and weren't amended by HB 96

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## Why are our PDPM Scores Lower?

- The PDPM case mix weights are lower than those of RUG-IV
  - Based on Medicare weights effective October 2023 (FY 2024)
- Did your team focus on PDPM case mix during the freeze?
- Is additional education needed related to PDPM case mix?
- Does your community specialize in cognitive, or other lower clinical acuity conditions, and relied on therapy?
- Frozen PDPM measures were at the height of RUG-IV case mix or you would not have froze.

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## PDPM Considerations

**Nursing Function Score**

- Every Nursing Component classification is affected by section GG (ADLs).
- Ensure your team understands the GG definitions and documentation requirements.
- Take this time to determine if the nurses and nurse aides will be documenting GG ADLs in the medical record, and provide education accordingly.
- GG is meant to be an interdisciplinary process. Determine the process your group will use to discuss the accuracy of GG coding.
- If the nursing function score is 15 or 16, resident will default from Extensive Services, Special Care High or Special Care Low to Clinically complex.
  - How difficult is a 14 or below?

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# Nursing Function Score

**Includes Section GG Items:**

- Eating
- Toileting Hygiene

The average of:

- Sitting to Lying
- Lying to Sitting on the Side of the Bed

The average of:

- Sitting to Standing
- Chair/bed-to-chair Transfer
- Toilet Transfer

| Section GG Coding | Function Score |
|---|---|
| 05 (Set Up or Clean Up)<br>06 (Independent) | 4 |
| 04 (Supervision or Touching) | 3 |
| 03 (Partial/Moderate) | 2 |
| 02 (Substantial/Maximal) | 1 |
| 01 (Dependent)<br>07, 09, 10, 88 (Not Attempted) | 0 |

- All components are added for the final nurse function score
- Scores can ranged from 0-16

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# PDPM Considerations

- Isolation – Isolation isn't just for COVID-19

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.).

- Can you code isolation for C-Diff?

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## PDPM Considerations

- Use the orders as needed to assist with supporting documentation
  - Shortness of breath while lying flat
  - Active diagnoses without treatment or medication

- IV Fluids
  - Move the assessment reference date as needed to capture IV fluids both provided in-house and while in the hospital, for additional fluid or nutrition needs.
  - Build strong communication with the medical records team at the hospital to obtain not only the medication administration record, but the IV administration records as well.

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## PDPM Considerations

- Respiratory Therapy – Not just HHNs

| Respiratory Therapy | 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. |
| --- | --- |

  - The medical record should clearly indicate what deficiency or abnormality of pulmonary function requires the use of therapy.

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## PDPM Considerations

- Oxygen use – If the resident is receiving oxygen, consider querying the physician to determine if a diagnosis such as Respiratory Failure, or a Chronic Lung Condition would be appropriate. Attempt to determine the root cause of the oxygen need.

- Restorative – Consider if a Restorative or Functional Maintenance program would be appropriate for your residents. In addition to the quality of life benefits to your residents, Restorative will also affect both the Behavioral Cognitive category and the Reduced Physical Function category.

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## PDPM Considerations

- Depression Signs and Symptoms
  - Have all team members been trained prior to conducting the PHQ2-9?
  - Is one PHQ2-9 conducted during the assessment period, or is there variation in days and times?
  - Consider discussing recent PHQ2-9s during morning meeting
  - Do residents and staff understand that interview items should be answered regardless of cause
  - Coding of symptoms does not necessarily mean that the resident has a diagnosis of depression

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## Additional Strategies for PDPM Success

- Ensure that case mix review is an interdisciplinary process
  - Make sure that all interdisciplinary team members understand what will affect the score
  - Assess your morning meeting. Is the MDS team getting all of the information they need?
- Look at the Assessment Reference Dates
  - Assessment Reference Dates can be moved, as long as they are not late, in order to capture changing acuity levels of your residents
- Ensure the Interdisciplinary Team feels comfortable asking questions, and challenging each other

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## Quality Assurance

- Internal tracking of the case mix is the best way to ensure accuracy of the case mix score
  - Allows for real time tracking
  - Allows the team to monitor trends
  - Allows the team to understand what areas need to be focused on
  - There are multiple methods and software programs for internal tracking
- The MDS Coordinator should know the current case mix score and how it compares to previous scores
- Monitor state averages when available
  - If your residents are not drastically different than the rest of the state, but your scores are significantly different than the averages, analyze the cause

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## Reports Worth Monitoring

- Preliminary and Final Case Mix Reports
  - Posted on the PNM site
  - Communities have 45 days from the end of the quarter to make corrections to the preliminary case mix report
- Semi-annual Case Mix Reports
- Annual Case Mix Reports
- Weekly Successfully Grouped Records Reports
  - Posted on the PNM site
  - Allows the team to review case mix for accuracy, before the preliminary reports are received

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# Lessons Learned from Recent Exception Reviews

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## Ohio Exception Review Update

- Restarted in October 2025
- Reviewed Quarter 2, 2025 – First PDPM Quarter
  - Always confirm the quarter when you receive notification
- Ohio Department of Medicaid (ODM) has released four resources to clarify the Exception Review and PDPM processes, as well as the steps for assessment and documentation of Section GG.
  - MDS Exception Review Process for PDPM – Provides an overview of the process that will be used for Exception Reviews. The process will primarily remain the same as with previous years. One notable change is that the sample will now be 100% Medicaid residents.
  - PDPM Overview – Reviews each component of PDPM. Please note that only the Nursing Component of PDPM will be used for Ohio case mix.
  - Section GG Functional Status 2025 – Provides a review of Section GG RAI manual guidelines, as well as documentation and coding requirements.
  - Nursing Facility Fact Sheet – Section GG Functional Status – Reviews the section GG guidelines from the RAI manual, and provides tips for coding and documentation.

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## Ohio Exception Review Update

Primary Areas of Concern to this Point:

- Section GG Documentation
  - Ensure proof of an interdisciplinary process is present
  - GG not supported by documentation will be recoded to Independant
- PHQ2-9 Staff Interviews and overall timing/documentation
  - Information from all shifts, if a staff interview
  - Follow through
- IV Drip Therapy
  - https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/LongTermCare/NursingFacility/IV_Therapy_Services.pdf
- Diagnoses active in the last 7 days

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## Ohio Exception Review Update

- Respiratory Therapy
  - Medical Necessity based on respiratory condition
- The MDS must be reproducible
  - Example: Outpatient treatments - If the resident is receiving an outpatient treatment such as dialysis, chemotherapy or radiation, ensure there is documentation from the center to validate that the services were actually received, not just ordered.

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## SNF Validation Audits

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## SNF Validation Audits

Purpose: To evaluate the accuracy of quality measure data elements derived from the MDS, which are used in the SNF Value-Based Purchasing (VBP) and Quality Reporting Programs (QRP) for assessing quality of care and measuring quality of care improvement.

- Reviews began in January 2026.
- Notification letters are found in the iQIES MDS 3.0 Provider Preview Report folder
  - This is the only notification that will be received

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## SNF Validation Audits

- Medical record documentation will be requested for 10 MDS assessments
- Providers have 5 business days from the date of notification to submit a point of contact
- Providers have only 45 calendar days from the day of notification to submit the requested records
- If data is not submitted timely, it may result in a 2% reduction in Medicare reimbursement for the fiscal year
- SNFs may only be randomly selected once per fiscal year
- A Frequently Asked Questions document is available at this link: https://www.cms.gov/files/document/snf-validation-program-frequently-asked-questions-faqs.pdf

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## SNF Validation Audits

Very specific submission requirements:

- Face sheets should not be included, and social security numbers must be redacted
- Medical record information must be bundled, by resident into one PDF per resident
- The PDF document must be arranged in a specific order, and bookmarked.
- No other formats will be accepted

Now is the time to determine if your software systems are capable of audit requirements.

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# Targeted Probe and Educate Reviews and Other Audits

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# Background of Targeted Probe and Educate (TPE) Audits

Types of Probe and Educate Reviews

- Targeted Probe and Educate Review
- Skilled Nursing Facility 5-Claim Probe and Educate Review

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# Background of Targeted Probe and Educate (TPE) Audits

Traditional Targeted Probe and Educate Review

- Designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.
- Intended to increase accuracy
- Not every provider will have a traditional Targeted Probe and Educate Review

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## Traditional Targeted Probe and Educate Reviews

Common Claim Errors

- Signature of certifying physician was not included
- Encounter notes did not support all elements of eligibility
- Documentation does not meet medical necessity
- Missing or incomplete initial certifications or recertifications

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## Traditional Targeted Probe and Educate Reviews

Facilities who fail to improve after three rounds of TPE will be referred to CMS for further action, which may include:

- 100% pre-pay review
- Extrapolation
- Referral to a Recovery Auditor (RA)
- Other action

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## SNF 5 Claim Probe and Educate Review

SNF 5 Claim Probe and Educate Review

- Designed to lower Skilled Nursing Facility improper payment rates, and help them avoid future claim denials and adjustments
- MACs will review a small number of claims from EVERY Medicare-billing SNF in the country.

Why are the reviews being done?

- The Comprehensive Error Rate Testing (CERT) program found an improper payment rate of 7.79% for SNFs in 2021
- In 2022, the SNF error rate increased to 15.1%

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## SNF 5 Claim Probe and Educate Review

Similar to traditional TPE Review

- A sample of Medicare claims will be reviewed
- One-on-one education will be provided to the provider

Difference from traditional TPE Review

- Each SNF will undergo only one round of review
- Amount of claims reviewed is typically smaller
- Education offered will be individualized based on the claim review errors identified in the probe.

Sample

- Facilities have 45 days to submit requested information
- Reviews are pre-pay

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## SNF 5 Claim Probe and Educate Review

- Reviewers will attempt to validate HIPPS score
- Reviewers will also ensure that Medicare A technical requirements have been met such as:
  - Three-day qualifying stay
  - Medicare Secondary Payor (MSP)
  - Physician certification and recertifications
  - SNF ABN

The supporting documentation needed is very similar no matter what type of audit is conducted

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## Best Practices for Information Gathering

- Make the audit as easy as possible for the reviewer
- Consider a TPE checklist to ensure that all needed material has been gathered
- Consider a cover letter which indicates:
  - The dates of service
  - Reason the resident required skilled service
  - Where documentation to support each component of the score and each technical requirement can be found
  - Contact name and phone number if the reviewer has any questions

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## Best Practices for Information Gathering

- Verify the dates of service
- Verify the submission deadline
- Include all information requested in the review letter
- Include all information to support each component of the HIPPS score
  - Consider arranging the documentation in order of each component for ease of review
- Ensure that the nurse assessment coordinator is the last team member to review the documentation before submission
- Maintain an identical copy of the documentation in the event an appeal is necessary

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## Common TPE Pitfalls

Late or Incomplete documentation

- Be mindful of submission deadlines. Information received after the deadline will not be considered except for good cause. (Natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause)

- Documentation needed to validate the service dates may have actually occurred weeks or months prior
  - Ensure information from the MDS observation period is included

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## Common TPE Pitfalls

Lack of technical requirement documentation

- Physician certification and recertifications
  - Ensure dates are in compliance with CMS guidelines
  - Include delayed certification information if needed
- Proof of three-day qualifying a stay
  - May need to include hospital documentation
- Proof of medical necessity
  - Does the documentation prove that services at a skilled level were required?

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## Common TPE Pitfalls

Lack of Information to meet tube feeding 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

- Ensure that documentation is present to verify the total number of calories taken in and the daily fluid intake

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## Common TPE Pitfalls

B0700 Ability to be Understood

- While interview items should be attempted for all residents, there should be consistency with B0700
- If the resident is "rarely to never understood" this has significant impact on the BIMS and PHQ-2 to 9 interviews
- Ensure documentation is present to validate that the resident was rarely to never understood during the assessment period

**B0700. Makes Self Understood**

Enter Code [ ]

**Ability to express ideas and wants,** consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

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## Common TPE Pitfalls

**Interview Items**

- Interview items on MDS, have stringent timeframes in which they must be conducted
  - BIMS and PHQ-2 to 9 = 7-day look back from ARD
  - Pain Interview = 7-day look back from ARD
  - Staff interviews must also be conducted within same look-back from ARD
- If interview should have been completed and wasn't, appropriate response is to dash (-) interview
- Signing Z0400:
  - All staff who completed any part of the MDS must enter their signatures, titles, sections or portions of the sections 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 members signs, use the date the item originally was completed

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## Common TPE Pitfalls

Section GG

- 3-Day performance period
  - First three days of the skilled stay for 5-Day assessments
  - ARD and two preceding days for interim payment assessments (IPAs)
- Consider all information in the medical record, interviews, and observation when coding
- Resolve discrepancies between the medical record and MDS with additional progress notes as needed

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## Common TPE Pitfalls

Active Diagnoses in the last 7 Days

Must meet two criteria:

1. Identify Diagnoses: The disease conditions in this section require a physician-documented diagnosis (or extender) in the last 60 days. Documentation may be found in:
   - Progress notes
   - Most recent history and physical
   - Transfer documents
   - Discharge summaries
   - Diagnosis/problem list (signed by physician or extender)
   - Ancillary physician notes
   - Other resources as available

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## Common TPE Pitfalls

Active Diagnoses in the last 7 Days

Must meet two criteria:

2. Determine whether diagnoses are active. Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses have a direct relationship with the resident's current:
   - Functional
   - Cognitive
   - Mood or behavior status
   - Medical treatments
   - Nursing monitoring
   - Risk of death

Do not include conditions that have 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.

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## Common TPE Pitfalls

**I4900 hemiplegia or hemiparesis**
- Consider how data is collected for this condition to be "active" for the resident

**I5300 Parkinson's Disease**
- Consider how data is collected for this condition to be "active" if the resident is not on active medication for Parkinson's Disease

**I5600 Malnutrition (protein or calorie) or at risk for malnutrition**
- Consider how this is documented by the physician within 60-day look back for each ARD, if still active

**Active diagnoses when no medications ordered**
- Consider how staff are documenting this condition for it to be considered "active" in the last 7 days

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## Common TPE Pitfalls

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.).

- Enhanced Barrier Precautions (EBP) are not coded in section O
- Do not code isolation for UTIs, encapsulated pneumonia, wound infections, or a history of infectious disease only
- Do not code isolation if the resident is cohorted

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## Common TPE Pitfalls

Respiratory Therapy

- Ensure documentation is present to support that the nursing team has been trained in the services being provided
- Do not include administration of metered-dose and/or dry powder inhalers
- Do not include time treatments were self-administered

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## After the 5-Claim Probe and Educate Review is Completed

- The MAC will send a detailed results letter after the review
- Results letters will include individualized, claim-by-claim denial reasons
- Results letters will also include an offer to discuss the issues with the interdisciplinary team during one-on-one telephone education
  - If the error rate is 20% or less (1/5 claims in error) education will be widespread
  - If the error rate is over 20% the threshold, more individualized training will be provided

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## Preparing for Future Audits

- Ensure that persons opening the mail understand who your MAC/Fiscal Intermediary is and they know who to provide any notifications to
- Who will monitor Administrator/Billing Office mail, and email, if they are not available?
- Consider a review of supporting documentation during the triple check process
- Utilize tracking tools to collect needed data for MDS completion
  - Can utilize physician orders for example, MAR/TAR tracking (Example: SOB while lying flat, hemiplegia, Parkinson's Disease)
- Utilize physician query process for clarification as needed

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## Where to go for Help?

CMS Targeted Probe and Educate Q&A

- https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/downloads/tpe-qas.pdf

CMS Pub 100-20 One-Time Notification Transmittal 12037

- https://www.cms.gov/files/document/r12037OTN.pdf

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## What's Next?

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# Effect of Fall with Major Injury Changes

OIG Findings

- A recent OIG report indicates 43% of nursing homes failed to accurately report falls with major injury and hospitalization among Medicare-enrolled residents
- Between 21 – 35% were not accurately reported in Ohio
- The report can be found here:
  https://oig.hhs.gov/documents/evaluation/10969/OEI-05-24-00180_NiVGuCQ.pdf

Fall with Major Injury Technical Expert Panel

- Discusses CMS' fear that MDS reporting for falls with major injury is not accurate
- Proposes to include claims-based data
- Proposed changes to falls and falls with major injury definition
- The report can be found here:
  https://www.cms.gov/files/document/may-2025-cross-setting-falls-major-injury-tep-summary-report.pdf

Effects

- Anticipate an increase in Fall with Major Injury on Quality Measures
- Will change Ohio QIP results

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# Fall with Major Injury Quality Measure - Watch for changes

- https://www.cms.gov/files/document/fmi-technicalspecificationsreport-nh.pdf

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# Additional Resources

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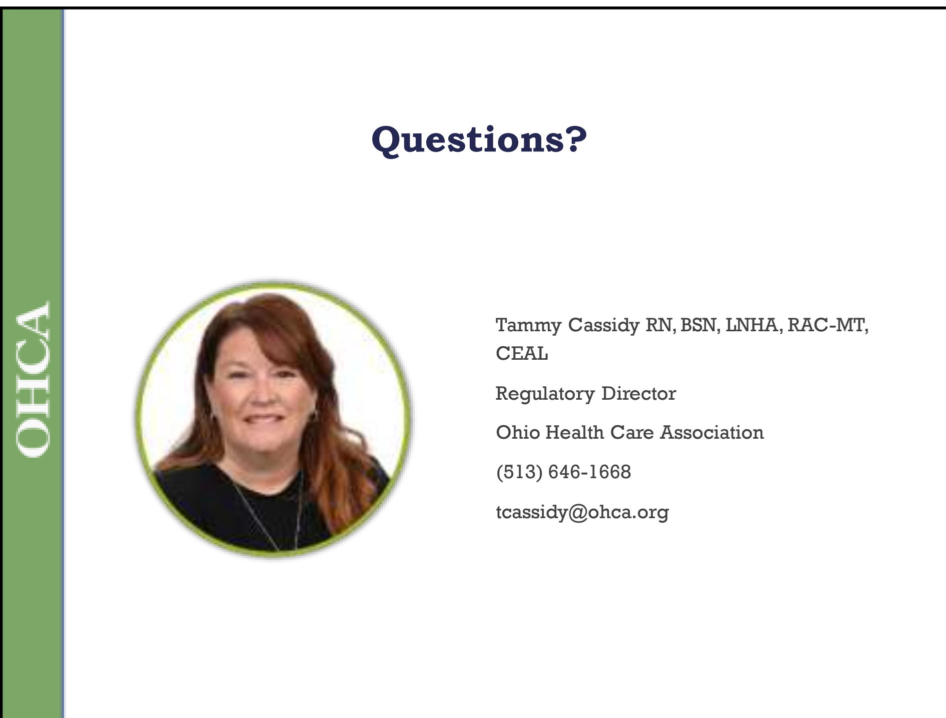
## Ohio PREP

- Provider Resources & Education Program (PREP)
- A free program that provides education and resources for providers
- Includes CEUs as needed
- Multiple programs including (Not all-inclusive):
  - Cultural Competence in Long-term Care Facilitie
  - Enhanced Barrier Precautions
  - Pressure Ulcers
  - Physical and Chemical Restraints
  - Respiratory Care Survey Readiness
  - Transfers and Discharges
  - Teepa Snow's Positive Approach to Care

https://odh.ohio.gov/know-our-programs/nursing-homes-facilities/provider-resources-education-program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Questions?
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