Taking a Deep Dive into 2025 Risk Management Issues – MDS Coding Errors, Quality Measures, Source Data, and Results of 5-Claim Audits.

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Operational & Clinical Update – September 2025

- Compliance Issues and resources
- Ongoing Oversight Audits – Surveys and Federal focus on Skilled Facilities
- MDS 3.0 – 1.20.1 implementation 10-1-25 - New items & coding instructions
- Medical Director – Tag F841 – Responsibilities and Survey questions
- Proactive strategies to reduce risk and financial loss

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AI is a Tool, Not a Healthcare Provider – What it Can't Do

- Observe resident behaviors or functional performance in real time
- Document daily care provided
- Use clinical judgment to determine clinical significance
- Interview residents or the staff
- Recognize when documentation is inaccurate
- Assess psychosocial or emotional status
- Make decisions about care planning or individualized goals
- Ensure compliance with facility-specific policies or state-specific guidance
- Take responsibility for accuracy, compliance, or legal attestations

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Nursing Home Reimbursement Compliance

- MDS Accuracy is critical
- Be prepared – audits, ALJ, investigations
- Scope of Practice
- Observation and communication with the resident is required
- AI is a tool, not a healthcare professional

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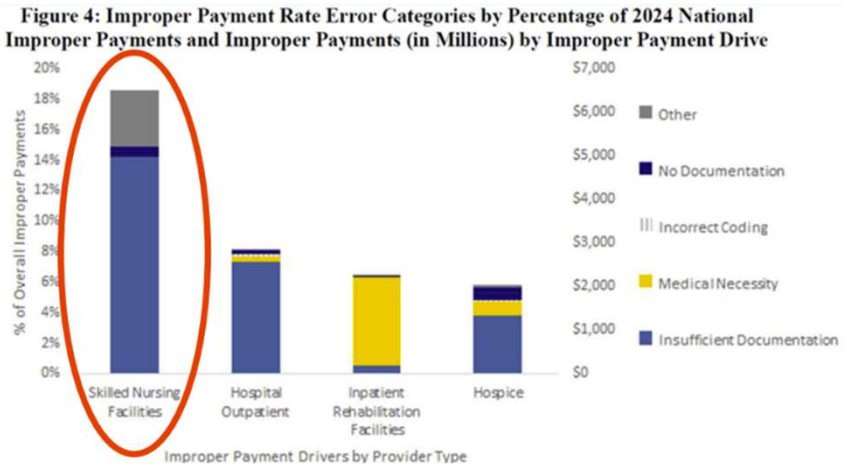
Improper SNF Payments

- Improper payments increased from 13.8% in 2023 to 17.2% in 2024.
- SNF errors were STILL the leaders in overall improper payments.



https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

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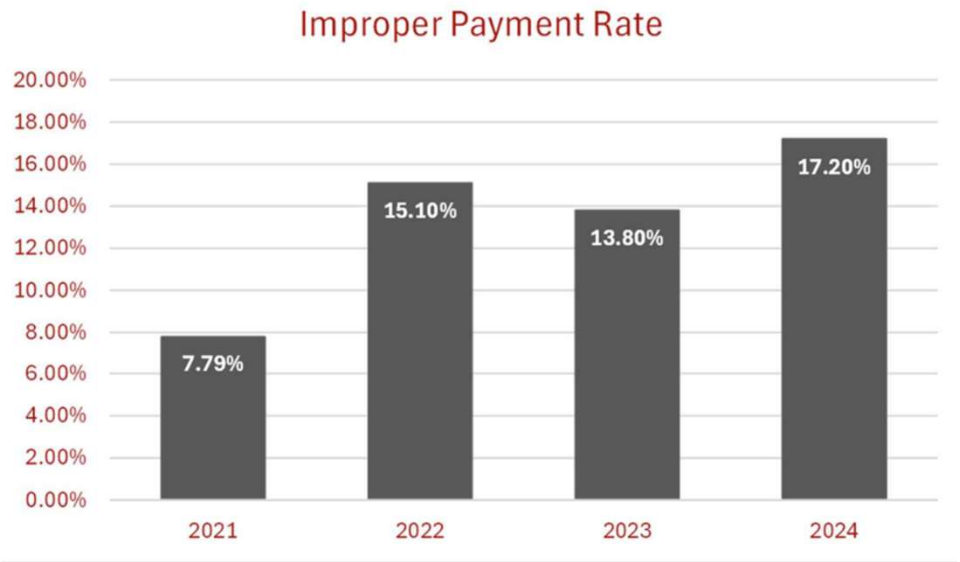

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Table B8: Medicare FFS Projected Improper Payments by State (Dollars in Millions)
(Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
CA	6,331	$4,019.5	8.4%	7.1% - 9.6%	12.3%
FL	3,864	$2,829.0	8.8%	7.4% - 10.3%	8.6%
TX	3,503	$2,392.0	7.9%	6.5% - 9.3%	7.3%
NY	2,860	$2,041.2	7.1%	5.3% - 9.0%	6.2%
PA	2,200	$1,477.4	9.2%	7.2% - 11.1%	4.5%
OH	1,758	$1,459.9	10.4%	6.9% - 13.8%	4.5%
IL	2,114	$1,397.4	8.2%	5.9% - 10.5%	4.3%
NJ	1,528	$1,052.3	8.5%	6.2% - 10.8%	3.2%
GA	1,303	$1,048.2	9.7%	6.5% - 12.8%	3.2%
MD	1,213	$955.4	7.1%	3.9% - 10.3%	2.9%
AZ	1,111	$878.4	13.1%	9.4% - 16.9%	2.7%
NC	1,547	$843.2	7.9%	5.5% - 10.3%	2.6%
MA	1,366	$793.7	6.2%	4.0% - 8.4%	2.4%
KY	722	$785.3	15.3%	6.8% - 23.9%	2.4%
CO	655	$777.1	14.0%	7.0% - 21.1%	2.4%
MI	1,262	$686.5	6.3%	4.5% - 8.0%	2.1%
TN	1,269	$685.4	7.0%	4.3% - 9.7%	2.1%
VA	1,271	$638.5	5.7%	3.7% - 7.7%	2.0%
SC	817	$633.1	10.7%	6.7% - 14.8%	1.9%
AL	713	$594.1	10.1%	5.9% - 14.4%	1.8%

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Targeted Probe & Educate (TPE)

- Designed to help providers and suppliers reduce claim denials and
- appeals through one-on-one help
- MACs work with providers in person to identify errors and help correct
- them
- Error Rate: Percentage based on claim errors
- A win on appeal does not change the claim error rate
- Common claim errors:
- The physician did not sign the certification
- Notes did not support all elements of eligibility
- Documentation did not support medical necessity
- Missing or incomplete initial certification or recertification

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Recovery Audit Contractor (RAC)

- Identify and correct Medicare improper payments
- May look back up to 3 years from the claim paid date to review claims
- If an error is found, a file is sent to the claims processing MAC to be adjusted for over- or underpayment

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Supplemental Medical Review Contractor (SMRC)

- Use data mining (e.g., profiling of providers, services, or beneficiary
- utilization) for aberrant patterns
- Topics as directed by CMS
- Perform medical review
- Perform extrapolation
- Make interagency referrals
- Refer to the MAC for recoupment and appeals

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Unified Program Integrity Contractor (UPIC)

- Identifies potentially fraudulent Medicare providers
- Investigate instances of suspected fraud, waste, and abuse
- Perform data analysis
- Request medical records and documentation – 15 to 30 days to submit!
- Conduct interviews & onsite visits
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold or Suspend Medicare payments
- Refer cases to law enforcement for civil or criminal prosecution
- Identify recoupment situations and refer to the MACs for the recoupment and appeals

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Top Reasons for Claim Denial

- No response to ADR or request for records
- Missing information
- Technical information
- Improper coding
- Physician's orders – medical necessity
- Physician certification/recertification
- Insufficient Supporting Documentation
  - Primary diagnosis
  - Active diagnoses
  - Respiratory therapy
  - GG functional status
  - Shortness of breath lying flat
  - Isolation
  - BIMS/PHQ-2 to 9 interviews dated after the ARD in Z0400
  - NTAs

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12th Annual Healthcare Fraud and Abuse Review
-Bass, Berry & Simms

Most FCA Allegations against healthcare defendants do not involve blatantly false statements or "obviously wrong" conduct, but instead deal with purported violations of highly complex statutory and regulatory requirements.

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Compliance

- Compliance is a big picture for the entire organization – F Tag 895 rewrite (October 2022)
- Must be honest and open – review where investment is being made.
- Start with compliance related to payment– eligibility– documentation– federal coverage documents.
- Internal compliance requires audits to confirm practice and policy implementation.
- Review provider agreements – Part A Medicare – insurance, therapy, and other contracts
- HIPAA is a new federal focus – implications for the MDS because of data use and sharing
- Cannot cover up bad practice
- Excellent opportunity for QAPI programs and Quality Assurance focus.

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Part A Medicare

- Medicare Provider Agreement must be in place for you to admit and bill for Medicare Benefits in the SNF
- What document tells you the federal rules and coverage guidelines for Part A Medicare?
- Who needs to have the specific guidelines for admission, coverage of services, documentation, and certification?
- MEDICARE BENEFIT POLICY MANUAL – CHAPTER 8 is the reference – the only reference – Who has copies and knows specific content?
- All claim denials and audit denials need to be justified from this document – have been for many years.
- WHO HAS THIS DOCUMENT IN YOUR CORPORATE COMPLIANCE OFFICE AND ON SITE IN THE FACILITIES WHERE ADMISSION AND COVERAGE DECISIONS ARE MADE?
- YOU MUST DOCUMENT THAT ADMISSIONS & SERVICES ARE COVERED TO THE PART A STANDARD and Documentation in the Medical Record.
- Use the Medicare Benefit Policy Manual (chapter 8) for orientation, in-services, documentation guidelines, coverage decisions, and certification rules.
- Document the sections of chapter 8 in your documentation notes or utilization minutes to confirm coverage.
- None of the Medicare Part A requirements change with P.D.P.M.

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Name_____

Admission Date_____

Admission Primary Diagnosis_____

M.B.P.M. Section 30 Skilled Nursing Facility Level of Care – General

Care in a SNF is covered if all of the following four factors are met:

_____The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see 30.2-30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;

____The patient requires these skilled services on a daily basis (see 30.6); and

____As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See 30.7)

____The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

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Essential Review MBPM – Chapter 8

- Updated 10-05-2023 – Important
- Section 20.1 Three-Day Prior Hospitalization (Page 8 &10)
- Section 30 Skilled Nursing Facility Level of Care (Page 18 & 19)
- Section 30.2.1 Skilled Services Defined (Page 23)
- Section 30.2.2.1 Documentation to Support Skilled Care Determinations (Page 25 & 27)
- Section 30.2.3.3 Teaching and Training Activities (Page 31 & 32)
- Section 30.3 Direct Skilled Nursing Services (Page 32 & 33)
- Section 30.4.1 Skilled Physical Therapy (Page 34 & 35)
- Section 30.5 Non-Skilled Supportive on Personal Care Services (Page 39 & 40)
- Section 40 Physician Certification and Recertification (Page 44 & 45)
- Section 40.1 Who May Sign the Certification or Recertification for Extended Care Services (Page 45 & 46)
- Section 70.4 Services Furnished Under Arrangements with Provider (Page 54 & 55)

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Artificial Intelligence, HIPAA, Right of Access

- Artificial Intelligence (AI), HIPAA and Healthcare Regulations
- HIPAA and HITECH compliance requirements
  - -Government Enforcement of HIPAA Law
  - -42 CFR Part 2 and HIPAA
  - -Right of Access & the HIPAA Privacy Rule
- Quality of Care & Compliance Considerations
- RAI Manual Chapter 1, Pages 1-12 to 1-16. HIPAA Requirements for resident notification of MDS Data Transmission to Federal Database.
- Form must be given to resident at admission – Page 1-14 to 1-16.
- Does not need to be signed – Put in into Admission Packet.

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Compliance Program Infrastructure - 7 Elements of a Successful Compliance Program:

1. Written Policies and Procedures
2. Compliance Leadership and Oversight
3. Training and Education
4. Effective Lines of Communication with the Compliance Officer and Disclosure Program
5. Enforcing Standards: Consequences and Incentives
6. Risk Assessment, Auditing, and Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives

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Element 1 – Written Policies and Procedures

Some common compliance risk areas are:

- billing - coding - quality of care
- sales - marketing - patient incentives; and
- Arrangements with physicians, other health care providers, vendors, and other potential sources or recipients of referrals of health care business.

The Compliance Committee should ensure that a system exists to ensure that the entity's policies and procedures foster rather than undermine the entity's compliance culture.

- Entities should set up a regular schedule for reviewing and revising, as necessary, all policies and procedures. OIG recommends that entities review policies and procedures at least annually to ensure that such policies and procedures reflect any modifications to applicable statutes, regulations, and Federal health care program requirements. This includes job descriptions and organizational charts.
- If the procedure for policy revision and approval impedes rapid implementation of a needed process change, OIG recommends that the entity devise a means of communicating and documenting interim policies and procedures to the relevant impacted individuals.

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Operational Responsibilities for data Formulation, Coding on the MDS 3.0, Transmission and Validation. Ownership, Managers & Administrators

- How do you view your Data Formulation and Reporting Process using the MDS Data Set?
- Is this process part of your Operational planning and Risk Management Process?
- Who is ultimately responsible for the data quality and transmission?
- What is your management activity, financial investment, and monitoring of the Data Formulation and Transmission Process?
- Do you have a designated RN Assessment Co-Ordinator?
- Which facility employees formulate and code data into the MDS Data Set? (Contractors?)
- Where is the current and the soon to be implemented (10-1-25) RAI Manual that directs all data coding , transmission and impact on Care Planning?
- How often do you meet with the RN Co-Ordinator or IDT Coding the MDS Data Set?

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MDS Assessments – Tag F641 (Revised)

- §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.
- *§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.*
- *§483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.*
- *§483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly—*

(i)Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii)Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

- *§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.*

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MDS Assessments – Tag F641 (Revised) (Cont)

GUIDANCE

- "Accuracy of Assessment" means that the appropriate, health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (e.g. comprehensive, quarterly, significant change in status).
- Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
- The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.
- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.
- The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.

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MDS Assessments – Tag F641 (Revised) (Cont)

Inaccurate MDS Diagnosis Coding

- *CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia.* For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.
- *Surveyors should investigate this concern through record review and interviews with staff who completed the assessment. Surveyors are not questioning the physician's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.*
- *If the facility is unable to provide documentation which supports the MDS coding of the new diagnosis in question, then noncompliance exists at §483.20(g) and (i)(2). Supporting documentation should include, but is not limited to, evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation.*

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MDS Assessments – Tag F641 (Revised) (Cont)

One or two assessments with inaccurate MDS diagnosis coding should be cited as isolated. If the surveyor identifies a pattern (i.e., three or more) of inaccurate coding for any new diagnosis (such as schizophrenia) with no supporting documentation by a physician, the surveyor should cite the scope of the non-compliance at a minimum of pattern or widespread as appropriate, make a referral to the State Board of Nursing, and see the guidance below in Investigative Procedures for making a referral to the Office of the Inspector General.

When concerns related to a diagnosis that lacks sufficient supporting documentation are identified, surveyors should review:

- *F658: to determine if the documentation supports a diagnosis in accordance with standards of practice.*
- *F644: to determine if the facility made a referral to the state designated authority when a newly evident or possible serious mental disorder was identified.*
- *F758: to evaluate psychotropic medication use based on a comprehensive assessment.*
- *F841: to evaluate the medical director's oversight of medical care.*

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Z0400 - Signature of Persons Completing the Assessment or Entry/Death Reporting
Attestation Statement – Legal Responsibility

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

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MDS Assessments – Tag F641 (Revised) (Cont)

Certification of Accuracy and Completion

Whether Minimum Data Set (MDS) assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the assessment.

Electronic Signatures

When MDS forms are completed directly on the facility's computer (i.e., no paper form has been manually completed), then each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s) they completed.

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MDS Assessments – Tag F641 (Revised) (Cont)

NOTE: *Where state law or regulations are more restrictive than federal requirements, the provider needs to apply the state law standard.*

Backdating Completion Dates

-Backdating completion dates is not acceptable – note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.

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MDS Assessments – Tag F641 (Revised) (Cont)

Patterns of MDS Assessment and Submissions

MDS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures.

All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

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MDS Assessments – Tag F641 (Revised) (Cont)

A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher Patient Driven Payment Model (PDPM) scores, untriggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures. Such practices may include, but are not limited to, a pattern or high prevalence of the following:

- *Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine) or tracking records, where the information does not accurately reflect the resident's status as of ARD, or the Discharge or Entry date, as applicable;*
- *Submitting correction(s) to information in the internet Quality Improvement Evaluation System (IQIES) where the corrected information does not accurately reflect the resident's status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claimsto correct does not appear to have been in error;*
- *Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error;*
- *Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;*
- *Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to information in the IQIES system.*

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MDS Assessments – Tag F641 (Revised) (Cont)

PROBES

- Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?
- Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?
- *Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed?*

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Tag F841 – Definitions – Many new requirements – All facilities will need to communicate Tag and Survey questions

§483.70(g) Medical director.

§483.70(g)(1) The facility must designate a physician to serve as medical director.

§483.70(g)(2) The medical director is responsible for—

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

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Tag F841 - Definitions

DEFINITIONS

"Medical director" *refers to* a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

"Physician/practitioner" (physician assistant, nurse practitioner, clinical nurse specialist) *refers to* the individual who has responsibility for the medical care of a resident.

"Current professional standards of practice" refers to approaches to care, procedures, techniques, treatments, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

"Resident care policies" refers to the facility's overall goals, directives, and governing statements that direct the delivery of care and services to residents consistent with current professional standards of practice.

GUIDANCE

If the medical director does not hold a valid license to practice in the State where the nursing home is located refer to F839 -§483.70(e) Staff qualifications. The facility must designate a physician to serve as medical director (unless waived per §488.56(b) by CMS).

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Medical Director Responsibilities

- The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility. This may be included in the medical director's job description or through a separate facility policy. Facilities and medical directors have flexibility on how all the duties will be performed.
- The facility must ensure *that* all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. For example, some, but not all duties may be conducted remotely using various technologies (e.g., phone, email, fax, telehealth, etc., that is compliant with all confidentiality and privacy requirements).
- It is important that the medical director's responsibilities require that he/she be knowledgeable about current professional standards of practice in caring for long term care residents, and about how to coordinate and oversee other practitioners.

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Medical Director Responsibilities Cont.

If the medical director is also an attending physician, there should be a process to ensure there are no concerns with the individual's performance as a physician (i.e., otherwise, the medical director is monitoring his/her own performance). If there are concerns regarding his/her performance, the facility's administration should have a process for how to address these situations.

While medical directors who work for multi-facility organizations, such as corporate or regional offices, may be involved in policy development, the facility's individual policies must be based on the facility's unique environment and its resident's needs, and not based on a broad, multi-facility structure.

Although the medical director is not required to sign policies, the facility must be able to show that the development, review, and approval of resident care policies included his/her input.

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Medical Director Responsibilities Cont.

Medical director responsibilities must include:

• *Implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care.*

• Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. (Refer to F86*8*).

• *Addressing i*ssues related to the coordination of medical care *and implementation of resident care policies identified* through the facility's quality assessment and assurance committee and other activities.

• *Active involvement in the process of conducting the facility assessment (Refer to F838).*

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Additional Responsibilities

- In addition, the medical director responsibilities should include, but are not limited to:
- Administrative decisions including recommending, developing and approving facility policies related to resident care. Resident care includes the resident's physical, mental and psychosocial well-being;
- Ensuring the appropriateness and quality of medical care and medically related care;
- Assisting in the development of educational programs for facility staff and other professionals;
- Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents. Refer to Infection Control requirements at §483.80;
- Cooperating with facility staff to establish policies for assuring that the rights of individuals (residents, staff members, and community members) are respected;

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Additional Responsibilities Cont.

- Supporting and promoting person-directed care such as the formation of advance directives, end-of-life care, and provisions that enhance resident decision making, including choice regarding medical care options;
- Identifying performance expectations and facilitating feedback to physicians and other health care practitioners regarding their performance and practices;
- Discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care, for example, physicians assigning new psychiatric diagnoses and/or prescribing psychotropic medications without following professional standards of practice; and
- Assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners (e.g., nurse practitioners) who may perform physician delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law.

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Medical Director Interview

Interview the medical director about his/her:

- Involvement in assisting facility staff with resident care policies, medical care, and physician issues;
- Understanding of his/her roles, responsibilities and functions and the extent to which he/she receives support from facility management for these roles and functions;

Process for providing feedback to physicians and other health care practitioners regarding their performance and practices, including discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current professional standards of care;

- Input into the facility's scope of services including the capacity to care for residents with complex or special care needs, such as dialysis, hospice or end-of-life care, respiratory support with ventilators, intravenous medications/fluids, dementia and/or related conditions, or problematic behaviors or complex mood disorders;
- His/her participation or involvement in conducting the Facility Assessment and the Quality Assessment and Assurance (QAA) Committee.

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Medical Director Responsibilities

The medical director, who is responsible for overseeing the medical care in the facility, was made aware of residents newly diagnosed with schizophrenia by their physician and/or other practitioner and their medical records did not contain documentation to support the new diagnoses. The medical director did not review the medical records for these residents nor did he/she discuss the new diagnoses with the residents' physician and/or diagnosing practitioner. This practice resulted in residents being potentially misdiagnosed with schizophrenia and receiving antipsychotic medications. None of the residents experienced harm, but they were at risk for harm by receiving treatment, including antipsychotic medications, when they may not have been clinically indicated. Note: If this occurred on three or more residents, at minimum, this would be cited at a scope of pattern (e.g., "E").

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Preparing the Medical Director for Survey Changes

- Supply the Medical Director with a copy of the Regulatory Tag #841.
- Documentation in Administrative records that the New Regulatory Tag was supplied to the Medical Director – Helps to have them sign that they have received the document showing the changes.
- Print the Tag 841 document showing he changes in red and use those topics for discussion.
- Amend any Policies or Procedures to be compliant with the new Regulations.
- Surveyors are frequently requestioning an interview with the Medical Director.
- Remember CMS focus on Schizophrenia and Psychotropic medications.

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MDS 1.20.1
10-1-2025 Issues

- A0810 – Sex - Must match what is on file in the Social Security System
- Section R – Health-Related Social Needs – REMOVED
- A1255 – Transportation – “In the past 12 months”
- D0150 – Resident Mood Interview

  Coding Tip – In the rare situation that the resident cannot provide a frequency following a Yes response to a symptom in Column 1, enter a dash in Column 2. CMS expects a dash response to be rare. RAI Manual October 2025. P. D-7

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14 DAY LOOK-BACK DOCUMENTATION RECORD

Please document the elder's care providers during the 14 day look-back period.

Day 7	Day 6	Day 5	Day 4	Day 3	Day 2	Day 1
						Date Of Interview SNF
Date:	Date:	Date:	Date:	Date:	Date:	Date:
Day 14	Day 13	Day 12	Day 11	Day 10	Day 9	Day 8
Date:	Date:	Date:	Date:	Date:	Date:	Date:

Patient Name:	
Date of Mood Interview:	
Staff Completing Interview:	
Calendar Date Range:	
Notes:	

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14 DAY LOOK-BACK DOCUMENTATION RECORD

Documentation Example

Day 7	Day 6	Day 5	Day 4	Day 3	Day 2	Day 1
Hospital	Hospital	SNF	SNF	SNF	SNF	Date Of Interview SNF
Date: 11-23-2023	Date: 11-24-2023	Date: 11-25-2023	Date: 11-26-2023	Date: 11-27-2023	Date: 11-28-2023	Date: 11-29-2023
Day 14	Day 13	Day 12	Day 11	Day 10	Day 9	Day 8
Hospital	Hospital	Home	Home	Hospital	Hospital	Hospital
Date: 11-16-2023	Date: 11-17-2023	Date: 11-18-2023	Date: 11-19-2023	Date: 11-20-2023	Date: 11-21-2023	Date: 11-22-2023

Patient Name:	John Doe
Date of Mood Interview:	11-29-2023
Staff Completing Interview:	Sally Smith LSW
Calendar Date Range:	14 day look back 11-16-2023
Notes:	

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Mood Severity Score
Impact on Nursing Payment

- Impact Special Care High. Special Care Low, and Clinically Complex Categories
- Most of skilled admissions will be in these categories
- Very big impact on dollars per day
- Know Steps for the Assessment in RAI manual
- Big issues 14 day look back period Chapter 3, Section D pages 1 thru 17.
- Scoring is very important.
- This test does not diagnose depression.
- Back up documentation in the record during the ARP is very important.
- Appendix D & E of the RAI manual has important information for completing and scoring Mood interview.
- Document staff training from these resources.

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Nursing Case-Mix Classification Groups

RUG-IV Nursing RUG	Clinical Condition	Depression	GG- Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
ES1	Infection		0-14	ES1	2.85	$328.18	$313.56	C
HE2/HD2	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	Yes	0-5	HDE2	2.33	$268.30	$256.35	D
HE1/HD1	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	No	0-5	HDE1	1.94	$223.39	$213.49	E
HC2/HB2	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	Yes	6-14	HBC2	2.18	$251.03	$239.84	F
HC1/HB1	Serious Medical Conditions E.G. Comatose, Septicemia, Respiratory Therapy	No	6-14	HBC1	1.81	$208.42	$199.14	G
LE2/LD2	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	Yes	0-5	LDE2	2.02	$232.60	$222.24	H
LE1/LD1	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	No	0-5	LDE1	1.68	$193.45	$184.83	I
LC2/LB2	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	Yes	6-14	LBC2	1.67	$192.30	$183.73	J

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Nursing Case-Mix Classification Groups Continued

RUG-IV Nursing RUG	Clinical Condition	Depression	GG-Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
LC1/LB1	Serious Medical Conditions E.G. Radiation Therapy or Dialysis	No	6-14	LBC1	1.39	$160.06	$152.93	K
CE2/CD2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	0-5	CDE2	1.82	$209.57	$200.24	L
CE1/CD1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	0-5	CDE1	1.58	$181.94	$173.83	M
CC2/CB2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	6-14	CBC2	1.51	$173.88	$166.13	N
CA2	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	Yes	15-16	CA2	1.06	$122.06	$116.62	O
CC1/CB1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	6-14	CBC1	1.30	$149.70	$143.03	P
CA1	Conditions Requiring Complex Medicare E.G. Pneumonia, Surgical Wounds, Burns	No	15-16	CA1	0.91	$104.79	$100.12	Q

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Nursing Case-Mix Classification Groups Continued

RUG-IV Nursing RUG	Clinical Condition	GG-Based Function Score	PDPM Nursing Case-Mix Group	Nursing Case Mix Index	Urban	Rural	Nursing Case Mix Group
BB2/BA2	Behavioral or Cognitive Symptoms	11-16	BAB2	1.01	$116.30	$102.57	R
BB1/BA1	Behavioral or Cognitive Symptoms	11-16	BAB1	0.96	$110.54	$97.33	S
PE2/PD2	Assistance with Daily Living and General Supervision	0-5	PDE2	1.53	$176.18	$154.90	T
PE1/PD1	Assistance with Daily Living and General Supervision	0-5	PDE1	1.43	$164.66	$144.43	U
PC2/PB2	Assistance with Daily Living and General Supervision	6-14	PBC2	1.19	$137.03	$120.36	V
PA2	Assistance with Daily Living and General Supervision	15-16	PA2	0.69	$79.45	$70.12	W
PC1/PB1	Assistance with Daily Living and General Supervision	6-14	PBC1	1.10	$126.67	$100.94	X
PA1	Assistance with Daily Living and General Supervision	15-16	PA1	0.64	$73.70	$64.89	Y

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GG0100C Prior Functioning Stair Activity

- Completing the stair activity for GG0100C indicates that a resident went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment and/or with or without some level of assistance.
- Going up and down a ramp is not considered going up and down stairs for coding this item.
- Additional coding tip:

  "By any safe means" may include scooting up or down the stairs on their buttocks

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GG0130 Self-Care & GG0170 Mobility

- Assessment of the GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device, regardless of whether the activity is being/will be routinely performed.
- The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once

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GG Changes in RAI Manual that Impact Coding

- CMS provided several clarifications focused on device use, such as using clinical judgment to identify devices and appropriately assessing usual performance when devices are used.
- CMS clarified that some tasks may only occur once during the 3-day period; assessment of usual performance should be based on this occurrence.
- CMS clarified that a resident can be “dependent” with walking when two helpers are required.
- CMS clarified that stairs and step items do not include moving to or from the stairs or sit to stand; assessment starts with the resident standing at the stairs or step.

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RAI Manual Track Changes Document- Ch 3 Section GG 0100 – GG 0170 -Pages 1-13

- Many changes in examples and directions for coding.
- Provide team members with Change documents and discuss documentation specifics. Include Nurses, Therapists, and Direct Care Givers.
- Usual Performance codes need to be documented with notes and specific observations correlated by Clinical professionals.
- Document training and orientation topics for new staff.

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What changes are in Store?

Also, CMS is proposing to change the clinical category assignment for thirty-four new ICD-10 codes that were effective October 1, 2024. Most of these codes, with the exception of Serotonin Syndrome are being reassigned from "Medical Management" to "Return to Provider".

- Type 1 Diabetes Mellitus - Codes E10.A0, E10.A1, E10.A2 and E10.9
- Hypoglycemia - Codes E16.A1, E16.A2, E16.A3, E16.0, E16.1, E16.2, E16.3, E16.4, E16.8 and E16.9
- Obesity - Codes E66.811, E66.812, E66.89, E66.01, E66.09, E66.1, E66.3 and E66.9
- Anorexia Nervosa, Restricting Type – Code F50.010 Anorexia Nervosa, Binge Eating/Purging Type - Codes F50.020 and F50.021
- Bulimia Nervosa - Codes 21 and F50.22
- Binge Eating Disorder - Codes F50.810 and F50.81
- Pica and Rumination Disorder - Codes F50.83, F50.84, F98.21 and F98.3
- Serotonin Syndrome - Code G90.81 from "Acute Neurologic“ to "Medical Management".

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Section J – Fall Documentation Changes

- New fall definition includes a fall related to overwhelming external force.
- CMS moved the clarification for intercepted fall excluding therapy balance test from the definition to a coding tip.
- CMS clarified in the major injury definition that the list is not all inclusive and expanded the list of major injury examples.
- CMS clarified in the coding tip and examples the difference between pathological and traumatic fracture; pathological fracture is not considered an injury from the fall.
- Two new examples for difference between pathological and traumatic fracture.

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Sections K & M – Track Changes

- Terminology Change from Dietician to Dietary Staff in Section K and Section M content.
- Clarification of weight comparison values closest to 30 days and 180 days.
- Section M – Clarification of Present on Admission.
- Identify of resource that the staff uses to identify pharma classification.

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N0415 High-Risk Drug Classes

- Facilities may wish to identify a resource that their staff consistently use to identify pharmacological classification, and should be able to identify the source(s) used to support coding the MDS.
- MDS Assessors should consult the manufacturer's package insert, which may contain the medication's pharmacological classification.
- Work with the pharmacist to confirm the medication classification(s) for a resident's medication(s).

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Section O – Track Changes

- Vaccine links and examples were updated.
- CMS replaced O0400 with O0390; removed detailed therapy information from O0400 (individual minutes, concurrent minutes, group therapy, co-treat, start and end dates); the new item is a checkbox only for services received.
- Added new Coding examples for therapy.
- Removed O0420 – Distinct Calendar Days of Therapy.
- CMS maintained days of respiratory therapy at O0400D.

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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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O0390- Therapy Services – Minutes of Therapy

- If a resident returns from a hospital stay, an initial evaluation must be performed after entry/reentry to the facility
- Only therapy that was provided since admission/reentry to the facility and after the initial evaluation can be counted, except in the case of an interrupted stay
- Section O0390 items do not require at least 15 minutes of a single mode of therapy to be checked on the MDS
- Minutes from the same therapy discipline (e.g., physical therapy) but different therapy modes (e.g., individual and concurrent) may be combined to meet the "at least 15 minutes" of skilled therapy in a day requirement
- The therapist's time spent on documentation or on initial evaluation is not included
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted
- Family education when the resident is present is counted and must be documented in the resident's record

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Skilled Therapy Services

Skilled therapy services must meet all the following conditions:

Medicare Benefit Policy Manual Chapter 8 – Surveyors and Auditors use definitions.

- Part A -services must be ordered by a physician.
- Part B -the plan of care must be certified by a physician following the therapy evaluation.
- Services must be directly and specifically related to an active written treatment plan that is approved by the physician – signed and dated after evaluation.
- Services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist.
- Services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period; OR
- Services must be necessary for the establishment of a safe and effective maintenance program; OR
- Services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
- Services must be reasonable and necessary for the treatment of the resident's condition, including the requirement that the amount, frequency, and duration of the services must be reasonable, and they must be furnished by qualified personnel. Diagnosis Coding is very important.

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O0390D Respiratory Therapy

Must be ordered by a physician

- The physician's order includes a statement of frequency, duration, and scope of treatment
  - For the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function
  - Includes 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

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Other Changes

- A1255 Transportation – added to the Discharge assessment
- A2000 Discharge Date – removed from NPE
- A2400A Has the resident had a Medicare-covered stay since the most recent entry? – skip pattern on the NPE was changed
- B0100 Comatose – added to the NPE
- I7900 None of the Above (active diagnoses within the last 7 days) added to the Quarterly, OBRA discharge, PPS, and Swing-bed assessments

Section X and Chapter 5

- Clarification on manual deletion process.
- New data correction decision tree.

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New SNF Audits Coming—How to be Ready

- The Minimum Data Set (MDS) plays a vital role in driving resident care through the resident-centered care plan process, regulatory compliance, Medicare and Medicaid reimbursement, quality outcomes, and reporting programs. MDS data accuracy has been under increased scrutiny from surveyors on the regulatory side and Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs) and other contract entities focused on accuracy as it relates to Medicare and Medicaid reimbursement. With this in mind, CMS has recently announced the implementation of an **MDS validation process** to assess the accuracy of data as it relates to the SNF quality reporting (SNF QRP) and Value Based Purchasing (VBP) programs. Understanding the ins and outs of this process is key to avoiding penalties related to non-compliance.

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What is the SNF Validation Program?

- The SNF Validation Program is an audit-driven initiative which focuses on assessing the accuracy of the MDS data used in calculating the quality measures. The goal of the program is to ensure the data used for the quality measures is accurate, reliable and complies with regulations.

How the validation process works:

- Beginning this fall (FY2026) CMS will select a random sample of up to 1,500 SNFs to participate in the program each fiscal year—requiring selected SNFs to provide documentation for validation for up to 10 residents. Any SNF who submitted at least one MDS assessment through IQIES during both the preceding fiscal year and current calendar year may be eligible for selection, but a facility may only be selected for review once per fiscal year.

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Notification of selection:

- SNFs will be notified of their selection through their IQIES provider preview reports folder. Most facilities check this folder regularly to access their Five Star Provider Rating Reports, and reviewing this folder will be essential going forward. The notification letter will provide the facility with the following information:
  - Instructions for submitting the requested documentation
  - List of the sample residents for which the medical record documentation is requested with detailed data requests for medical records associated with MDS assessments under review
  - Contact information of the contractor completing the audit
- SNFs must use the link contained within the notification to designate and submit Point of Contacts to receive audit-related email notifications, including file uploads, documentation submissions, and any issues with medical records. If needed, the contact information can be revised and updated via the provided link.

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Submission Requirements:

- Facilities selected for audit must respond to the notification by submitting the requested documentation for each resident identified in the sample list within 45 days of the date of the notice. The documentation must be submitted in PDF format through the secure portal. Facility POCs will receive an email notification (1) when the documentation is successfully uploaded and (2) once the uploaded documents have been verified. Failure to submit the requested documentation timely will result in the facility being found non-compliant.

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Validation Audit Results and Penalties:

- SNFs will receive an audit summary report through IQIES approximately 3 months after the submission deadline. The report will contain the SNF's audit results for each measure and MDS item, including detailed results from each sampled assessment and medical chart audited. The good news for the SNF is that the reports are for informational purposes only and no penalties will be applied based on identified errors or error rates. Facilities that are found to be non-compliant due to the failure to respond to the notification of selection and do not submit records for review timely will be subject to a **2% reduction in the annual payment update for the subsequent fiscal year.**

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Strategies for Success:

- Be alert and responsive: Recognize your facility may be selected for validation at any time and check IQIES for a notice on a weekly basis to allow for a complete and timely response
- Validate the presence of medical record documentation to support the coding of data used in calculating the SNF quality measures including:
  - Section GG – Functional Assessment
  - Pressure ulcers
  - Falls and fall related injuries
  - Completion of resident interviews (BIMS, Pain, PHQ2-9, social isolation, health literacy,
  - Completion of drug regimen review process and provision of reconciled medication list to residents and subsequent provider
- Provide ongoing education and staff training for the IDT MDS staff on coding and supportive documentation guidelines.
- Ensure documentation exists to support the submission of complete and accurate MDS data.
- Review validation reports for errors related to incomplete submissions. Utilize the Review and Correct process to make corrections when supported by the documentation.
- Stay informed of updates and changes to the Quality Measure and documentation requirements
- Incorporate Quality Measures and MDS verification processes into the facility's QAPI program.

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FAQs on Skilled Nursing Facility Data Validation Process

- The Centers for Medicare & Medicaid Services (CMS) has released a detailed Frequently Asked Questions (FAQ) document to assist skilled nursing facilities (SNFs) in understanding and complying with the new Data Validation Process. The FAQs provide essential guidance ahead of the process launch in fall 2025, which will impact the FY 2027 Skilled Nursing Facility Quality Reporting Program (QRP).
- CMS developed the FAQ to address common questions from providers about the requirements, procedures, and timelines associated with the Data Validation Process. According to CMS, this initiative is designed to ensure the accuracy of quality data reported by SNFs through the Minimum Data Set (MDS). This data supports programs that measure and improve the quality of care, including the QRP and the Value-Based Purchasing (VBP) Program.

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Topics covered in the FAQ include:

- Who is subject to the validation process and how facilities are selected
- How SNFs will be notified of their selection and how to access these notifications
- The types of medical record documentation SNFs must submit to demonstrate compliance
- Required submission formats, timelines, and naming conventions for documentation
- Security measures protecting submitted documentation
- How CMS will communicate validation results and findings
- Consequences for noncompliance and available appeal procedures
- Contact information for assistance and support throughout the process

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Compliance Perspective

- *CMS has published a detailed FAQ document to support SNFs as they prepare for the new Data Validation Process starting in fall 2025. This federally mandated process requires randomly selected SNFs to submit medical record documentation to validate MDS quality data used in the QRP and the VBP program. Facilities must understand the requirements, timelines, and compliance obligations outlined in the FAQs to avoid potential penalties, including a 2 percent reduction in Medicare reimbursement for noncompliance.*

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Data Validation Process Discussion Points

- Review and update policies and procedures to incorporate CMS's Data Validation Process requirements as detailed in the FAQs. Develop clear processes to promptly identify validation requests, collect and submit required medical documentation, and manage communications. Facilities may benefit from collaborating with external consultants who specialize in regulatory compliance and documentation management to ensure these policies are comprehensive and aligned with CMS expectations. Ensure roles and responsibilities are clearly assigned to meet submission deadlines and maintain compliance.
- Conduct audits or mock validation exercises to assess readiness for CMS's data validation requests. These audits can verify that medical record documentation aligns with MDS data and meets CMS submission requirements. An external review—such as a focused audit or mock assessment—can help identify potential gaps and strengthen submission readiness. Use audit findings to address gaps, enhance processes, and reinforce compliance practices proactively.

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Resource Links

- Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 12283; Issued: 10-05-23) https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf
- iQIES Access Instructions for Long Term Care Providers Using ePOC: Nursing Home Functionality– https://qtso.cms.gov/news-and-updates/iqies-access-instructions-long-term-care-providers-using-epoc-nursing-home
- Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Help: https://www.cms.gov/medicare/quality/snf-quality-reporting-program/help
- Skilled Nursing Facility Data Validation Process: Frequently Asked Questions (FAQs) https://www.cms.gov/files/document/data-validation-process-frequently-asked-questions.pdf
- RAI Manual October 2025 – Chapter 1 Pages 1-11 to 1-17 https://www.cms.gov/files/document/finalmds-30-rai-manual-v1201october2025.pdf-0

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Resource Links

- Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025 https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual
- Centers for Medicare & Medicaid Services: State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities. Section 483.20(b) Utilization Guidelines for Completion of the RAI. Available from https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Medicare & Medicaid Services: Patient Driven Payment Model. Available from https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facilitysnf/patient-driven-model

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