Minimum Data Set (MDS) Overview for Providers

About the MDS:

According to the RAI Manual V1.17 Chapter 1, The MDS serves many purposes:

1. The primary purpose is to serve as an assessment tool to identify resident care problems which are addressed in an individualized care plan – **OBRA assessment process (required)**.
2. To determine the Medicare Part A SNF reimbursement level for Medicare Part A beneficiaries – **PPS assessment (required ONLY for Medicare Part A beneficiaries)**.
3. To monitor the quality of care provided to all nursing home residents by providing baseline data used in the Department of Public Health annual survey.
4. To inform consumers on the quality of Skilled Nursing Facilities, specifically the Nursing Home Compare Tool.
5. To determine the level of care needed and corresponding reimbursement rate by cross walking to many State Medicaid reimbursement systems.

The OBRA MDS Process vs. PPS MDS Process

- OBRA requires a comprehensive MDS is completed for all residents admitted to a SNF, if the SNF accepts Medicare and Medicaid Payment. This assessment process follows a predetermined schedule, as defined by CMS, in order to satisfy the intent identified in number 1 above. **All residents, regardless of payer type** are assessed following the OBRA Required Assessment process.
- The PPS Assessment Process is for the purpose of determining the **provider's per diem reimbursement rate** by CMS for **Medicare Part A beneficiaries only**. It too has its own schedule. The PPS Assessment Process does not replace the provider's obligation of following the OBRA required assessment process, however, the PPS assessment may be combined with the OBRA assessment when appropriate to do so.
- Historically, SNFs may have intentionally opted to follow the PPS assessment process for the Medicare Advantage Organization (MAO) residents admitted to their facility, for the purpose of generating a per diem reimbursement rate to submit to the Health Plan. Providers should not mis-categorize these MAO residents as Medicare Part A beneficiaries on the MDS.
- In the naviHealth model of care, the per diem reimbursement rate is determined by naviHealth, **concurrent** with the MAO resident's stay, based on clinical information submitted by the SNF. This practice **eliminates the need for the provider to follow the PPS assessment process for the naviHealth coordinated Medicare Advantage Resident**.

Completing the Appropriate Assessment

CMS expects the SNF provider to properly identify the type of assessment being completed (OBRA or PPS) as well as whether the resident being assessed is insured by Medicare Part A. For the MAO resident, it is important the SNF is identifying the member properly as **NOT** part of the Part A reimbursement program.

To do so the SNF:

- Identifies the Assessment as an OBRA Required Admission Assessment by coding **01** on section **A0310A**.
- Identifies the Assessment as not PPS related by coding **99** on section **A0310B**.
- Identifies the resident as **NOT** being in a Medicare covered stay by coding **0** on section **A2400A**.

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Applying the Appropriate HIPPS Code

- When the MDS assessment is properly coded as OBRA required **and** the resident is properly identified as NOT a Medicare Part A beneficiary, portions of the MDS are not required. The CMG levels and subsequent HIPPS codes **DO NOT** automatically transfer onto the Providers UB04 or claim (providers may wish to confirm this with their MDS software vendor).
- **Following proper CMS instruction regarding MDS completion eliminates the misalignment of a facility generated vs. a naviHealth generate per diem reimbursement rate.**
- The provider may enter the naviHealth authorized level of care in section Z0300 of the MDS.
- The provider ensures the naviHealth authorized level of care is recorded on the claim (UB04) to ensure proper and timely claims processing and payment.

Requesting a CMG Level Change

If a provider feels the CMG level/s assigned by naviHealth require an adjustment, the provider requests a reassessment of the CMG level by:

- Alerting the naviHealth Skilled Inpatient Care Coordinator (SICC) **after** the calculation of the CMG level.
- Submitting additional clinical documentation supporting the **presence of active** and relevant condition/s of the resident.
- Being available for subsequent telephonic inquiry/discussion as indicated.

NOTE: This type of request may result in a Medical Director review.

naviHealth Authorization File and the Provider Claim

- naviHealth sends an authorization file to the Health Plan that includes the first four characters of the HIPPS code—this corresponds to each of the 4 CMG levels authorized.
- The provider's claim includes the first four characters of the HIPPS code, authorized by naviHealth, plus a fifth character, which represents the Assessment Indicator (AI) or Assessment Type.
- To avoid claims processing delays, the naviHealth authorized level of care must be on the claim.