EngageConsulting

Defending Your Medicare Margin:
Practical PDPM Protection Strategies

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Defending Your Medicare Margin

LEARNING OBJECTIVES:

- Identify the primary reimbursement risks associated with PDPM coding, documentation, and interdisciplinary communication.
- Evaluate documentation practices that support accurate clinical classification and defensible Medicare reimbursement.
- Implement operational strategies to reduce denials, audits, and payment recoupments while maintaining regulatory compliance.

Audits, TPEs, and ADRs

CMS definition of Medical Review :

Collection of information and clinical review of medical records by Medicare Contractors to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements.

Goal of Medical Review

Reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

Multiple types of ADRs:

Traditional Medicare A or B, or insurance reviews

Audits, TPEs, and ADRs

An ADR may be sent by:

- Medicare Administrative Contractor (Michigan utilizes WPS and NGS)
- Unified Program Integrity Contractor (UPIC)
- Recovery Audit (RA) contractors
- Supplemental Medical Review Contractors (SMRCs)
- CERT Contractor

Skilled Review:

- Did resident meet a skilled level of care for dates of service billed?
- Does resident have accurate Physician Certification?
- Did resident have a 3-day qualifying hospital stay? (unless waived)
- Is the entire HIPPS code supported by documentation?
  - **Must be reproducible in audit!**

Understanding HIPPS Code

Generates a "score" that identifies the complexity of the patient:

- 1st digit: PT/OT component
- 2nd digit: SLP component
- 3rd digit: Nursing component
- 4th digit: NTA component
- 5th digit: type of assessment completed

PDPM
PHYSICAL & OCCUPATIONAL THERAPY

4 PT/OT Clinical Categories	10 PDPM Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery and Acute Neurologic	Non-Orthopedic Surgery Acute Neurologic
Other Orthopedic	Non-Surgical Orthopedic/Musculoskeletal Orthopedic Surgery
Medical Management	Medical Management Acute Infections Cancer Pulmonary Cardiovascular and Coagulations

MDS Section GG Item	Score Range
Self-Care: Eating	0-4
Self-Care: Oral Hygiene	0-4
Self-Care: Toileting Hygiene	0-4
Mobility: Sit to lying Mobility: Lying to sitting on side of bed	0-4 (average of 2 items)
Mobility: Sit to stand Mobility: Chair/bed-to-chair transfer Mobility: Toilet transfer	0-4 (average of 3 items)
Mobility: Walk 50 feet with 2 turns Mobility: Walk 150 feet	0-4 (average of 2 items)
TOTAL PT/OT FUNCTION SCORE:	0-24

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

PDPM
SPEECH THERAPY

None, Any 1, Any 2, or All 3 of the following:
- **Acute Neurological Condition** – ICD-10 coded in I0020B, maps to Acute Neurologic Clinical Category
- **Speech Comorbidity** – One of the 12 ST related conditions from the table below.
- **Cognitive Impairment** – Score of 12 or less on the BIMS, or if unable to complete the BIMS, cognitive status is based on the Staff Assessment for Mental Status.

Acute Neurological Condition

I0020B. ICD Code

Speech Comorbidity

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia
I8000	Dysphagia
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits
O0110E1b	Tracheostomy Care While a Resident
O0110F1b	Ventilator or Respirator While a Resident

Cognitive Impairment

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

Neither, Either, or Both of the following:
- **Swallowing Disorder** – Signs and symptoms of a swallowing disorder checked on Section K0100.
- **Mechanically Altered Diet** – change in texture of food or liquids checked in Section K0510C.

Signs/Symptoms of Swallowing Disorder

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder
Check all that apply
- A. Loss of liquids/solids from mouth when eating or drinking
- B. Holding food in mouth/cheeks or residual food in mouth after meals
- C. Coughing or choking during meals or when swallowing medications
- D. Complaints of difficulty or pain with swallowing
- Z. None of the above

Mechanically Altered Diet

K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last 7 days
- C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)

Understanding HIPPS Code

PDPM
NURSING COMPONENT

Extensive Services	Nursing PDPM CMG	Conditions / Services	Nursing Function Score	Case-Mix Index
Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident	ES3 ES2 ES1	Trach and Vent Trach or Vent Isolation	0-14 0-14 0-14	3.84 2.90 2.77
Special Care High				
Comatose; septicemia; diabetes w/ daily inj. & order changes on 2+ days; quadriplegia with Nursing Function score <=11; COPD and SOB while lying flat; fever with pneumonia, vomiting, tube feed, or weight loss; parenteral/IV feedings; respiratory therapy for 7 days	HDE2 HDE1 HBC2 HBC1	Depression No Depression Depression No depression	0-5 0-5 6-14 6-14	2.27 1.88 2.12 1.76
Special Care Low				
Cerebral palsy, multiple sclerosis, or Parkinson's disease with Nursing Function score <=11; respiratory failure and oxygen while a resident; feeding tube (calories >= 51% or calories =26-50% and fluid >=501cc); ulcers (2 or more stage II pressure ulcers, or stage 3, stage 4, or unstageable due to slough or eschar, 2 or more venous ulcers or stage 2 pressure with 1 venous/arterial) with 2 or more skin care treatments; foot infection/diabetic foot ulcer/open lesion of foot with dressings to feet; radiation treatment or dialysis while a resident	LDE2 LDE1 LBC2 LBC1	Depression No Depression Depression No Depression	0-5 0-5 6-14 6-14	1.97 1.64 1.63 1.35
Clinically Complex				
Extensive Services, Special Care High, or Special Care Low qualifier and Nursing function score of 15-16; pneumonia; hemiplegia with Nursing function score <=11; open lesions with treatment or surgical wounds; burns; chemotherapy, oxygen, IV medications or transfusions while a resident Depression Qualifier: PHQ2-9 score of >= 10	CDE2 CDE1 CBC2 CBC1 CA2 CA1	Depression No Depression Depression No Depression Depression No Depression	0-5 0-5 6-14 6-14 15-16 15-16	1.77 1.53 1.47 1.27 1.03 0.89
Behavioral Cognitive Symptoms				
Cognitive impairment BIMS <= 9 or CPS >=3, hallucinations, delusions, physical or verbal behavioral symptoms towards others, behavioral symptoms, rejection of care, wandering and Nursing Function score 11-16	BAB2 BAB1	Restorative 2+ Restorative 0-1	11-16 11-16	0.98 0.94
Reduced Physical Function				
No clinical variables of previous categories Restorative Nursing: 2 or more programs 6+ days a week, for 15 minutes minimum Urinary and/or bowel training program • Passive and/or active range of motion • Amputation/prosthesis • Dressing or grooming • Eating or swallowing • Transfer • Splint or brace • Bed mobility and/or walking • Communication	PDE2 PDE1 PBC2 PBC1 PA2 PA1	Restorative 2+ Restorative 0-1 Restorative 2+ Restorative 0-1 Restorative 2+ Restorative 0-1	0-5 0-5 6-14 6-14 15-16 15-16	1.48 1.39 1.15 1.07 0.67 0.62

Understanding HIPPS Code

PDPM

NON-THERAPY ANCILIARY (NTA)

NTA Conditions & Extensive Services

Points	Condition/Service	MDS 3.0	Points	Condition/Service	MDS 3.0
8	HIV/AIDS	SNF Claim	1	Morbid Obesity	I8000
7	Parenteral IV Feeding: Level High	K0520A3 K0710A2	1	Radiation Post-Admit	O0110M1b
5	IV Meds Post-Admit	O0110H1b	1	Stage 4 Unhealed Pressure Ulcer	M0300D1
4	Ventilator Post-Admit	O0110F1b	1	Psoriatic Arthropathy and Systemic Sclerosis	I8000
3	Parenteral IV Feeding: Level Low	K0520A3 K0710A2 K0710B2	1	Chronic Pancreatitis	I8000
3	Lung Transplant Status	I8000	1	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000
2	Transfusion Post-Admit	O0110I1b	1	Foot Infection, Diabetic Foot Ulcer, Other Open Lesion on Foot	M1040A M1040B M1040C
2	Major Organ Transplant Status (Except Lung)	I8000	1	Complications of Specified Implanted Device or Graft	I8000
2	Multiple Sclerosis	I5200	1	Intermittent Catheterization	H0100D
2	Opportunistic Infections	I8000	1	Inflammatory Bowel Disease	I1300
2	Asthma, COPD, Chronic Lung Diseases	I6200	1	Aseptic Necrosis of Bone	I8000
2	Bone/Joint/Muscle Infections/ Necrosis	I8000	1	Suctioning Post-Admit	O0110D1b
2	Chronic Myeloid Leukemia	I8000	1	Cardio-Respiratory Failure and Shock	I8000
2	Wound Infection	I2500	1	Myelodysplastic Syndromes and Myelofibrosis	I8000
2	Diabetes Mellitus	I2900	1	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, & Inflammatory Spondylopathies	I8000
1	Endocarditis	I8000	1	Diabetic Retinopathy	I8000
1	Immune Disorders	I8000	1	Feeding Tube While a Resident	K0520B3
1	End-Stage Liver Disease	I8000	1	Severe Skin Burn or Condition	I8000
1	Narcolepsy and Cataplexy	I8000	1	Intractable Epilepsy	I8000
1	Cystic Fibrosis	I8000	1	Malnutrition	I5600
1	Tracheostomy Care Post-Admit	O0110E1b	1	Disorders of Immunity	I8000
1	Multi-Drug Resistant Organism (MDRO)	I1700	1	Cirrhosis of Liver	I8000
1	Isolation Post-Admit	O0110M1b	1	Ostomy	H0100C
1	Specified Hereditary Metabolic/Immune Disorders	I8000	1	Respiratory Arrest	I8000
			1	Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000

Historic Denial Trends

- Physician Certification
- Incomplete documentation submitted
  - No physician orders included
  - No signed therapy evaluations included
- Signature of the certifying physician was not included
- Physician Signature requirement not met- Not dated
- Physician Signature requirement not met- Untimely
- No documentation received
- GG coding not supported (Usual performance decision form)
- Medical Necessity
- Incorrect Coding

PDPM Denial Trends (Skilled)

- Primary Diagnosis Not Supported
- Coded on MDS in section I0020B:
  - Primary reason or the Medicare Part A Stay
  - Two sources: RAI Manual and Medicare Benefit Policy Manual Chapter 8

Steps for Assessment

1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

Complete only if A0310B = 01 or 08

- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
- When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.

To be covered…treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay

PDPM Denial Trends (Skilled)

Diagnosis Coding not supported as "active"

- Signed by a physician in the last 60 days
- Active in the last 7 days
- Considerations for diagnoses that don't have medications/treatments
- Impacts Nursing and NTA categories

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

Hard to prove diagnoses:

- Diabetes with no medication or monitoring
- COPD with no medication or monitoring
- History of CVAs with no active treatment
- At risk of malnutrition with no interventions in 7 day look back

PDPM Denial Trends (Skilled)

Mechanically altered diet not delivered	If orders not present to support, dietary slips can be printed and submitted
IV fluids provided for a hydration need	
No proof of oxygen delivery	
No proof of qualifying 3-day hospital stay	
No proof of BIMS/PHQ2-9 interview conducted in 7-day look back	

PDPM Denial Trends (Skilled)

Section GG Considerations:

- Assess the resident's self-care performance based on direct observation, incorporating resident self reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.

- Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.

USUAL PERFORMANCE

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

PDPM Denial Trends (Skilled)

Section GG Considerations:

- Code based on the resident's need for assistance to perform the activity safely(for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling)..
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- Documentation to support MDS being reproducible usual performance as an IDT decision during 3-day window

Documentation to support GG:

- PT/OT evaluations completed in first 3 days of the stay
- Nursing documentation
- Nursing assistant task documentation
- NEED: GG IDT decision form to submit to "prove" usual performance determination

Supporting Documentation in Audits

Physician Orders
- Need signed and dated

Diagnoses
- Need signed within last 60 days, active in the last 7 days

Isolation Orders
- Example: Single room isolation - droplet precautions due to COVID-19 x 10 days. All services brought to resident in room.

COPD and Shortness of Breath While Lying Flat:
- Intervention: Elevate HOB to prevent resident reported shortness of breath while lying flat due to COPD.
- Monitoring: Does resident have shortness of breath or trouble breathing while lying flat due to COPD? Yes or No, Q shift

Orders to support conditions that don't have active treatment
- Example: Fasting FSBS Q Monday, once a week.
- Example: Resident requires additional ADL assistance to hemiparesis of left side. Sign off Q shift

Supporting Documentation in Audits

GG: Functional Abilities

- Look-back Period: Admission (1st 3 days of stay), OBRA/Interim/DC (ARD plus 2 previous days)
- CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
- If using narrative notes to support Section GG, each occurrence must include the specific activity. Wording must be equivalent to MDS key definitions for example “The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident
- The IDT should determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record.

PHQ 2-9 and BIMS Interviews

- Need signed on/before ARD in Z0400 (train staff to code and sign on MDS at time of interview, or ensure they are editing collection date if signing after the ARD)
- Staff interview proof of completion on all shifts

Interpretations: RAI Manual vs. Auditing entity

- Best practice recommendations come from experience in audits/appeals

- **Example:** No where in the RAI manual does it give instructions there needs to be a formal document identifying “usual performance”


Department of Health and Human Services

Office of Inspector General

Office of Audit Services

November 2025 | A-02-22-01017

Nearly All Skilled Nursing Services Provided by Pinnacle Multicare Nursing and Rehabilitation Center Did Not Meet Medicare Payment Requirements

https://oig.hhs.gov/documents/audit/11270/A-02-22-01017.pdf

Case Study: PDPM OIG Audit – Pinnacle NY

- 99 out of 100 sampled claims not supported, overpayments of $1.1 million in 2020-2021
- Estimates overpayment of at least $31.2 million

1. Nursing Case Mix Group Error
   - 88 claims unsupported
     - Example given: depression was not supported, because "no support that the SNF investigated the causes/contributing factors for the individual's mood distress level or if any interventions were put into place to maintain her safety"

2. Speech Language Pathology Group Error
   - 63 claims unsupported
     - Example: aphasia "no speech therapy intervention is indicated at this time"

3. PT/OT Case Mix Group Error
   - 38 claims unsupported
     - Incorrect PT/OT group based on diagnosis of osteoarthritis as primary when it should have been major depressive disorder

4. NTA Classification Group Error
   - 31 claims unsupported
     - IV medication not supported – individual diagnosed with MDRO, for which treatment did not require the admin of IV medication.

Leading an Efficient Audit Process

1. Designate an audit and appeal champion

Assign a single individual to oversee all audits and appeals from receipt through final determination. This person may be from medical records, reimbursement, business office, or compliance, but should be responsible for coordinating the process and monitoring deadlines.

2. Establish Immediate Escalation Procedures:

Audit requests are time sensitive. Administrators should ensure that ADRs, TPE requests, managed care audits, and denials are immediately routed to the appropriate team members upon receipt. Delays of even a few days can significantly reduce the time available for packet development and review.

Leading an Efficient Audit Process

3. Create a Standardized Documentation Collection Process

- Consider using a checklist
- Each department needs to understand its responsibility for gathering documentation
- Make it as easy as possible for the audit reviewer to validate critical elements within packet

Consider a TPE checklist to ensure that all needed material has been gathered

Consider a cover letter which indicates:

- Date of service
- Reason the resident required skilled services
- 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

4. Final review by MDS expert to validate MDS coding and “reproducible”

Leading an Efficient Appeal Process

1. Conduct a Root Cause Review of Every Denial

Before filing an appeal, administrators should ensure the team understands exactly why the denial occurred.

- Understanding the denial is essential to building an appeal strategy

2. Appeal each denial that warrants an appeal

3. Monitor denial trends and educate staff:

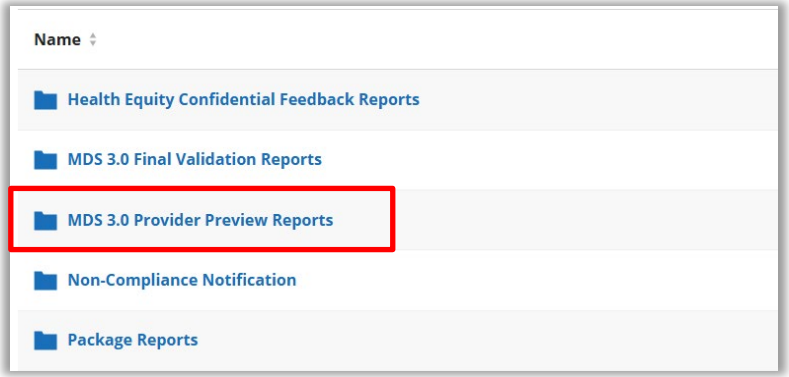
- Denial patterns
- Frequently missing documents
- Diagnosis coding issues
- Section GG discrepancies
- Physician documentation concerns

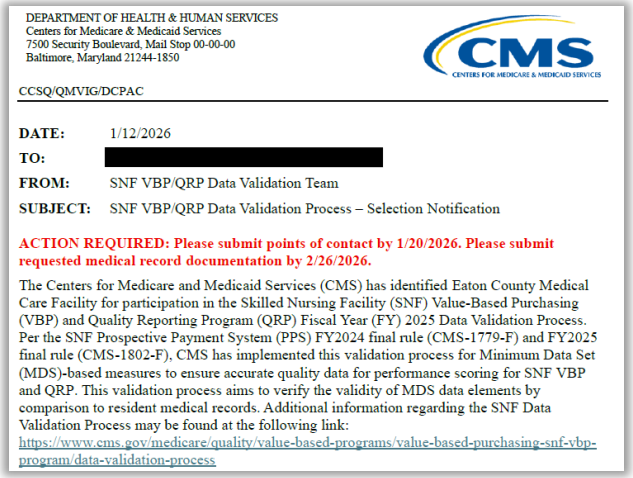
Recurring problems should be incorporated into staff education and internal auditing effort

Additional Reimbursement Trends and Risks

SNF Validation Audits:

- January 12, 2026 – Date first round of facilities found notifications in iQIES
- Healthcare Management Solutions , LLC (HMS)
- Respond to survey form of main and secondary point-of-contact (POC) within 5 business days
- Records must be submitted within 45 calendar days
- Noncompliance may result in 2% reduction in APU
- Very specific directions for responding and preparing files
- At conclusion will receiving a Summary Scoring Report





DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CCSQ/QMVIG/DCPAC

DATE: 1/12/2026
TO: [redacted]
FROM: SNF VBP/QRP Data Validation Team
SUBJECT: SNF VBP/QRP Data Validation Process – Selection Notification

ACTION REQUIRED: Please submit points of contact by 1/20/2026. Please submit requested medical record documentation by 2/26/2026.

The Centers for Medicare and Medicaid Services (CMS) has identified Eaton County Medical Care Facility for participation in the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) and Quality Reporting Program (QRP) Fiscal Year (FY) 2025 Data Validation Process. Per the SNF Prospective Payment System (PPS) FY2024 final rule (CMS-1779-F) and FY2025 final rule (CMS-1802-F), CMS has implemented this validation process for Minimum Data Set (MDS)-based measures to ensure accurate quality data for performance scoring for SNF VBP and QRP. This validation process aims to verify the validity of MDS data elements by comparison to resident medical records. Additional information regarding the SNF Data Validation Process may be found at the following link:
https://www.cms.gov/medicare/quality/value-based-programs/value-based-purchasing-snf-vbp-program/data-validation-process

Additional Reimbursement Trends + Risks

Expanding SNF Value Based Purchasing

FY 2026 Program Year Impacts:

SNF 30-Day All-Cause Readmission Measure (SNFRM)

- Historical SNF VBP Measure
- Annual risk-standardized rate of unplanned, all-cause readmissions

Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI)

- Targets infection prevention and management
- Current SNF QRP Measure

Total Nursing Hours per Resident Day

- Links staffing levels to Medicare payment
- Current Five-Star Measure Staffing reported through PBJ

Nursing Staff Turnover Measure

- Links Nursing staff turnover to Medicare payment
- Current Five-Star Measure Staffing reported through PBJ

Additional Reimbursement Trends + Risks

Expanding SNF Value Based Purchasing

FY 2027 Program Year Impacts:

Discharge to Community – Post Acute Care Measure (DTC)

- Outcome measure that assesses the rate of successful discharges to community from a SNF setting
- Current SNF QRP Measure

Discharge Function Score Measure

- Adopted as a new QRP Measure effective FY 2027
- Directly ties patient functional outcomes to Medicare A payment

Long Stay Hospitalization Measure per 1,000 Resident Days

- Links performance with long-term residents care to Medicare A reimbursement
- Current Claims-based Quality Measure in Five-Star Rating system

Percent of Residents Fall with Major Injury (Long Stay)

- Links performance with long-term residents care to Medicare A reimbursement
- Current MDS 3.0 Quality Measure

FY 2027 SNF VBP Reports are available

Table 1. Your SNF's Program Eligibility and Performance	
Is your SNF included in the SNF VBP Program? (i.e., met measure minimum?)	Yes
Your SNF's Performance Score (0 - 100; higher is better)	40.03575
Your SNF's Incentive Payment Multiplier (IPM)	0.9894392388
Interpretation of Your SNF's IPM	Your IPM is <1, meaning your SNF will earn back less than it would have in the absence of the SNF VBP Program
Your SNF's Program Percent Rank, National	Your SNF's overall performance was equal to or better than 58.4% of SNFs nationwide
Your SNF's Program Percent Rank, State	Your SNF's overall performance was equal to or better than 58.6% of SNFs in your state

Table 2. Measure Performance and Scores

Quality Measure	Your SNF's Baseline Period Measure Result	Your SNF's Performance Period Measure Result	Compared to the Baseline Period, Your SNF's Performance Period Measure Result is... [a]	Your SNF's Measure Score (0 - 10; higher is better)	Your SNF's Measure Score is...
SNFRM	18.568%	20.383%	worse	2.54658	equal to or better than 50.7% of SNFs nationwide
SNF HAI	5.782%	6.474%	worse	5.25465	equal to or better than 73.0% of SNFs nationwide
DTC PAC SNF	not enough data	44.080%	not available	0.93571	equal to or better than 21.4% of SNFs nationwide
Long Stay Hospitalization	2.570 hospitalizations	1.721 hospitalizations	better	3.63433	equal to or better than 51.7% of SNFs nationwide
Nursing Staff Turnover	58.621%	40.000%	better	5.52272	equal to or better than 64.4% of SNFs nationwide
Total Nurse Staffing	4.145 hours	4.545 hours	better	5.10902	equal to or better than 81.7% of SNFs nationwide
Discharge Function Score	48.571%	57.143%	better	4.47647	equal to or better than 49.8% of SNFs nationwide
Falls with Major Injury (Long-Stay)	4.054%	2.581%	better	4.54912	equal to or better than 53.0% of SNFs nationwide

Key Takeaways

MDS Accuracy:

- Starts with accurate MDS records
- Documentation compliance – is your MDS reproducible?
- Look at facility-wide processes – is GG reproducible in an audit?
- Consider training for MDS team

Audit Process:

- Designate an audit/appeal leader
- Implement an audit/appeal tracking system
- Ensure complete, thorough records are being gathered
- Final review of packet by MDS expert
- Don’t just gather records – be strategic

THANK YOU!

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