

- **What's new ?**
- **Video Information on MDS 3.0**
- **Transition Implementation of FY 2012 SNF New PPS Policies**
- **Revised MDS PPS Schedule**
- **Change of Therapy (COT) Other Medicare Required (OMRA)**
- **Q & A's**



What's New ?

2012 arrived with great fanfare for many people. For those of us who deal with the MDS 3.0 it brought to a close a year of learning and implementing a new assessment instrument. There are some updates and changes that have happened since the October 2010 roll out of the 3.0.

MDS 3.0 was designed to do several things:

- Improve the reliability, accuracy, and usefulness of resident assessments,
- Increase resident participation in the assessment process, and
- Make use of standard protocols common in other healthcare settings.

The RAI process includes powerful tools for implementing a standardized assessment and for facilitating care management in nursing homes and swing bed hospitals.

The Nursing Home Quality Initiative (NHQI) website at:

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.

provides information regarding the quality of care in nursing homes. Anyone can access the MDS 3.0 for Nursing Homes and Swing Beds Technical Information as well as MDS 3.0 training information and materials.

There are also related links inside the CMS website that provide additional information regarding nursing home comparisons, quality improvement organizations, survey and certification information, and frequently asked questions (FAQ's). You will also find the MDS 3.0 updates, forms, study findings; SNF PPS Payment information, updates, schedules,; and the SNF Open Door Forum (ODF) information.

According to CMS, Quality Measures will once again be released in April 2012. The CASPER reports will draw on this information and will include Short Stay and Long Stay Measures.

The measure descriptions are just like in the MDS 2.0. These include: Pain, Pressure Ulcers, Physical Restraints, Falls, Psychoactive Medications, Antianxiety Medications, Behavioral Symptoms, Depressive Symptoms, UTI, Catheter Use, Low Risk Resident, Excessive Weight loss, and increased help with ADL's.

Nursing Home Quality Measures have four intended purposes:

1. To give information about the quality of care at nursing homes to help individuals choose a nursing home for themselves or others.
2. To give information about the care at nursing homes where individuals or family members already live;
3. To get a chance to talk to the nursing home staff about the quality of care; and
4. To give data to the nursing home to help them with their quality improvement efforts.

Visit the NHQI website for MDS 3.0 training materials and information;

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.

Every now and then CMS holds National Provider calls in order to keep providers informed. You should attend the calls or access the archives of the calls. The National Provider's Call transcripts and slides are archived at :

http://www.cms.gov/SNFPSS/03_RUGIVEDu12.asp

The SNF PPS FY 2012 Final Rule outlined several policy changes in the SNF PPS effective in Fiscal Year 2012.

These changes include:

- ◇ A revised MDS assessment Schedule
- ◇ The Change of Therapy (COT) Other Medicare Required Assessment (OMRA)
- ◇ A Resumption of therapy option for End-of-Therapy (EOT) OMRA
- ◇ The allocation of group therapy time and a revised student supervision policy.

These can all be found in the download section at;

http://www.cms.gov/SNFPPS/03_RUGIVEDu12.asp#TopOfPage — or directly at:
<http://www.cms.gov/SNFPPS/Downloads/fy12transpolicymemo.pdf>

The CMS “**Open Door Forum**” (ODF) provides an opportunity for live dialogue between CMS and the provider community in order to understand and help find solutions to program access. ODF participants learn from each other’s discussions, and obtain clarification of different rules and instructions related to coverage, coding, and payments. The forum is proactively engaged to improve medical outcomes, lowering costs and improving quality within the programs.

Visit the ODF website at: <http://www.cms.gov/OpenDoorForums/>

The next Open Door Forum call is scheduled on *March 1st, 2012, Thursday*

Appendix H MDS 3.0 Item Set was updated and is now Version 1.00.6. This new version became effective October 1, 2011 and can be found within the MDS 3.0 RAI Manual at:

https://www.cms.gov/NursingHomeQualityInits/30_NHQImds30TechnicalInformation.asp

Previous files are not completely accurate and should be replaced with these immediately.

MDS 3.0 RAI Manual V1.07 (August 31,2011)

- These updates will be effective as of October 1, 2011
- The zip file labeled MDS 3.0 RAI Manual (V1.07) [ZIP 23 MB] contains the complete RAI manual.
- Change-table files are included only for sections of the manual that have changes that will be effective October 1, 2011. Sections that have been updated include; Title Page, Table of Contents, Chapter 1, Chapter 2, Chapter 3 (Introduction, Section C, I, K, M, N, and O), Chapter 4, Chapter 6 and Appendices (A, B, C, and E).

For further information please visit website at;

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

SPOTLIGHTS

June 2011, A draft MDS 3.0 Technical User's manual was released.

RUG IV Grouper posted in July 2011.

August 2011, version 1.02 of the data submission specs was posted.

September 2011, effective 10/01/2011 Version 1.00.6 of the MDS 3.0 Item sets replaced the previous version.

October 1, 2011, changes of MDS PPS schedule and implementation.

For technical information

Visit this website at;

http://www.cms.gov/NursingHomeQuality/Inits/30_NHQImds30TechnicalInformation.asp

2012 March National Provider Conference is a 2-day conference that will be held twice on March 6-7 and then on March 8-9, 2012, at the Hyatt Regency St. Louis at the Arch in St. Louis, MO.

Web site at:

<http://totalsolutions-inc.com/nationalconference/>



Videos on MDS 3.0

CMS has created learning videos for clinicians & MDS Coordinators. There are CMS videos on YouTube which will help those who can't get to courses. The videos are also great refreshers.

Here are some of the MDS 3.0 videos available on You-Tube :

MDS 3 – Facility Leadership
MDS 3 – Interdisciplinary Introduction to MDS 3.0
MDS 3.0 Evening Expert Panel
MDS 3.0 Gold Standards Nurses
MDS 3.0 Section A
MDS 3.0 Sections B and C
MDS 3.0 Section C
MDS 3.0 Section D Mood
MDS 3.0 Section E
MDS 3.0 Section F
MDS 3.0 Section G Functional Status

MDS 3.0 Section I
MDS 3.0 Section J
MDS 3.0 Section K Swallowing and Nutritional Status
MDS 3.0 Section M: Skin Conditions
MDS 3.0 Section O: Special Treatments
MDS 3.0 Section P Restraints
MDS 3.0 Section Q – Informing Long Term Care Choice (Five Videos)
MDS 3.0 Sections X and Z
MDS 3.0 Oral Assessment
RACs and Medicare
There is also a series of “Videos on Interviewing Vulnerable Elders”. These include;
VIVE-Video on Interviewing Vulnerable Elders
VIVE Interview Techniques
VIVE – Cognition
VIVE – Preferences

VIVE –Pain
VIVE – Mood
VIVE – Mood Self Harm (Two videos with different scenarios), 1 and 2).
Section V Area Assessment (You Tube Video)
Section XZ (You Tube. Please review the RAI Manual for updated requirements for completing an inactivation request)
Process of Care Planning for Residents in Skilled Nursing Facilities (You Tube video)

PASRR (You Tube video)

Take the time to view these videos

They are available at the website below:

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp



Change of Therapy (COT) Other Medicare Required Assessment (OMRA)

For all Medicare Part A SNF residents, a COT OMRA is required if the therapy services a resident receives during the COT observation period do not reflect the RUG-IV classification level given on the patient's most recent PPS assessment used for payment and would instead cause the patient to be classified into a different RUG category. The term "COT observation period" refers to a successive 7-day window beginning the day following the Assessment Reference Date (ARD) of the resident's last PPS assessment used for payment. This is effective for all assessments with an ARD on or after October 1, 2011.

Allocation of Group Therapy

Effective for FY 2012, group therapy is defined as therapy provided simultaneously to four patients (regardless of payer source) who are performing the same or similar activities.

All group therapy time reported on the MDS will be divided by four when determining each resident's appropriate RUG classification.

End of therapy with Resumption (EOT-R)

Beginning in FY 2012, SNF's may

choose to complete items O0450A and O0450B on the EOT OMRA, which allows a resident to be reclassified back into the Rehabilitation plus Extensive Services or rehabilitation RUG group that he/she had been in prior to the discontinuation of therapy services that prompted the EOT OMRA and resume the original therapy program. This option is only available to resume therapy at the same therapy level as prior to the discontinuation of therapy services and must resume no more than five calendar days after the discontinuation occurred.

Effective for all EOT OMRA assessments with an ARD on or after October 1, 2011

Beginning in FY 2012, facilities must use the updated MDS Assessment schedule for setting the Assessment Reference Date (ARD) for scheduled PPS assessments.

For assessments with an ARD set for on or after October 1, 2011, the ARD must be in compliance with the revised MDS assessment schedule, otherwise early or late assessment penalties may apply.

Unscheduled Medicare PPS Assessments

When indicated, a provider must complete the following unscheduled assessments and in situations like this the provider must complete an assessment outside of the standard schedule Medicare required assess-

ments, this is known as "Unscheduled Assessments"

For example;

A significant Correction to Prior Comprehensive Assessment completed when a significant error was made in the prior comprehensive assessment (see section 2-9 of RAI Manual, version 3.0).

SOT (Start of Therapy) OMRA is used to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. This is an optional assessment (see section 2-9 of the RAI Manual, version 3.0).

(EOT) End of Therapy OMRA

If the EOT OMRA is performed because three or more consecutive days of therapy were missed, and it is determined that therapy will resume, there are **three options** for completion:

1. Complete only the EOT OMRA and keep the resident in a non-Rehabilitation RUG category until the next scheduled PPS assessment is completed.
2. In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or therapy services will not resume at the same RUG IV therapy classification level that have been in effect prior to the EOT OMRA, and SOT OMRA is required to

(continue on page 6)

(continued from page 5)

classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well.

3. In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an EOT-R may be completed.

COT (Change of Therapy) OMRA

COT OMRA is required if the therapy received during the COT observation period does not reflect the RUG-IV classification level on patient’s most recent PPS assessment used for payment.

A successive 7-day window beginning the day following the ARD of the resident’s last PPS assessment used for payment is the COT observation period.

NOTE: *In cases where the last assessment was an EOT-R, then the COT observation period begins on the resumption date listed in O0450B.*

In order to determine if a COT OMRA is required, providers should perform

an informal **change of therapy evaluation** that considers the intensity of the therapy the patient received during the COT observation period.

The facility must consider the:

- Total Reimbursement Minutes (RTM),
- Number of Therapy Disciplines
- Number of Therapy Days
- Restorative Nursing (for patients in a Rehab Low category)

A COT OMRA retroactively establishes a new RUG beginning the day following the ARD of the resident’s last PPS assessment until the next scheduled or unscheduled Medicare PPS assessment.

If a new assessment for Medicare payment has occurred, the COT observation period will restart beginning on the day following the ARD of the most recent assessment used for Medicare payment.

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window, the two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment be modified until the next unscheduled or scheduled assessment. **See Chapter 6 of the RAI Manual for**

details.

General Clarifications on the follow up information released in October 2011

Q. Other clinician have asked regarding circumstances in which a COT OMRA can be combined with other assessments.

A. A COT OMRA can be combined with a scheduled PPS assessment. Moreover, when the ARD of A COT OMRA (that is Day 7 of the COT observation period) falls within the ARD window (including grace days) of a scheduled PPS assessment and the ARD for the scheduled assessment is not set for a day that is Day 7 or earlier in the COT observation period, then the COT OMRA and scheduled assessment must be combined.

Q. Clarification regarding the type of patients for whom a COT OMRA should be considered.

A. A COT OMRA is only necessary in cases when the patient’s RUG classification used for billing would change as a result of changes in therapy.

Q. Clarification regarding the consideration of ADLs as part of the COT evaluation process.

A. Changes in ADLs do not constitute in and of themselves a change in therapy category and should not be considered **(continue on page 8)**

MDS Assessment Schedule

Old Schedule

Medicare MDS Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date Window	Assessment Reference Date Grace Days	Applicable Medicare Payment Days
5 day*	01	Days 1 –5	6 -8	1 through 14
14 day	02	Days 11 -14	15 –19	15 through 30
30 day	03	Days 21 –29	30 –34	31 through 60
60 day	04	Days 50 –59	60 –64	61 through 90
90 day	05	Days 80 –89	90 –94	91 through 100

New Schedule

Medicare MDS Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date Window	Assessment Reference Date Grace Days	Applicable Medicare Payment Days
5 day*	01	Days 1 –5	6 -8	1 through 14
14 day	02	Days 13 -14	15 –18	15 through 30
30 day	03	Days 27 –29	30 -33	31 through 60
60 day	04	Days 57 -59	60 –63	61 through 90
90 day	05	Days 87 –89	90 –93	91 through 100

Revised MDS Assessment Schedule Policy Summary

In order to reduce overlap between assessment look-back periods, effective for FY 2012, facilities will utilize the revised MDS assessment schedule in Table 10B in the FY 2012 SNF PPS proposed rule (76 FR 26389), which was finalized in the FY 2012 SNF PPS final rule (76 FR 48517).

Transition Policy For assessments with an ARD set for on or after October 1, 2011, the ARD must be in compliance with the revised MDS assessment schedule.

http://www.cms.gov/SNFPPS/03_RUGivedu12.asp#TopOfPage.

(continued from page 6)

as a part of the COT evaluation process. Although ADLs are not considered when determining whether a COT OMRA is required, they will be included in the calculation of the RUG score if a COT OMRA is performed.

Q. Clarification regarding the number of minutes outside the current RUG category a patient's therapy must be to require a COT OMRA.

A. Any amount of minutes which would constitute a change in the therapy category could necessitate a COT OMRA. For example, if a patient classified into Ultra High Rehabilitation receives 719 minutes of therapy during the COT observation period, then this would constitute a change in the resident's therapy RUG category.

Q. Clarification regarding the situation when the last assessment before the COT OMRA occurred only 7 days prior to the COT OMRA, and whether facilities can choose to either use a different item set for the COT OMRA or to ignore certain items on the COT OMRA item set (e.g., patient interview questions, in some situations).

A. In order to capture accurately all of the necessary information on the COT OMRA that would be required to provide the appropriate RUG group, providers must complete the full COT OMRA (which as a standalone assessment uses the EOT OMRA item set) and may not skip the interview questions or any

other areas necessary to complete the assessment.

Q. Clarification regarding whether a COT OMRA is necessary when a resident misses 3 consecutive days of therapy and Day 7 of the COT observation period falls on one of the 3 missed days. (Example: A resident misses therapy Days 36-38 and Day 7 of the COT observation period is Day 37.)

A. The necessity of a COT OMRA will depend on what day is used for the ARD of the EOT OMRA. In this example, if the ARD of the EOT OMRA is set for either Day 36 or Day 37, then a COT OMRA would not be necessary. If the ARD of the EOT OMRA is set for Day 38, then in addition to the EOT OMRA, the COT OMRA would need to be completed, assuming there has been a sufficient change in the intensity of therapy.

Q. Clarification regarding when the COT OMRA must be completed and submitted.

A. If deemed necessary, a COT OMRA should be completed no more than 14 days after the ARD for the COT OMRA. It must be submitted no more than 14 days after the date of completion. This is consistent with completion and submission requirements for all scheduled and unscheduled PPS assessments.

Q. Clarification regarding the relationship between holidays (e.g. Christmas, New Year, etc.) and the COT OMRA.

A. In cases where **holidays** fall within a COT observation period, **holidays**

are considered as part of the 7-day COT observation period. Facilities should plan the therapy schedule accordingly to ensure that the resident receives the requisite therapy.

Q. Clarification regarding how claims that include a COT OMRA will be identified.

A. The COT OMRA will be identified through the appropriate HIPPS code on the claim. The AI codes associated with the COT OMRA and all other PPS assessments are listed in the RAI manual.



Q. Clarification regarding details of the COT evaluation process that facilities should use to determine the need for a COT OMRA.

A. Each facility should determine for itself an appropriate COT evaluation process that may be used to determine if a COT OMRA is necessary.

Q. Clarification regarding circumstances in which a COT OMRA can be combined with other assessments.

A. A COT OMRA can be combined with a scheduled PPS assessment. Moreover, when the ARD of a COT OMRA (that is a Day 7 of the COT observation period) falls within the ARD window (including grace days) of a scheduled PPS assessment and the ARD for the scheduled assessment is not set for a day that is Day 7 or earlier in the COT observation period, then the COT OMRA and scheduled assessment must be combined.

Q. Clarification regarding existence of a “Medicare week”.

A. The 7 day look back period used for a COT observation period is determined based on the ARD of the patient’s other assessments, not on a standardized weekly schedule.

Q. Clarification regarding the term “therapy category”.

A. The term “therapy category” refers to the ten major therapy divisions, which are;

- Ultra High Plus Extensive

- Very High rehab Plus Extensive
- High Rehab Plus Extensive
- Medium Rehab Plus Extensive
- Low Rehab Plus Extensive
- Ultra High Rehab
- Very High Rehab
- High Rehab
- Medium Rehab



Low Rehab

Q. Clarification regarding the situation when a patient’s therapy category changes, but the patient index maximizes into the same non-therapy RUG.

A. A COT OMRA is only necessary in cases when the patient’s RUG classification used for billing would change as a result of changes in therapy.

Q. Clarification regarding COT OMRA with a non-compliant ARD.

A. As a general rule, COT OMRA which contain a non-compliant ARD, meaning that the ARD on the COT OMRA is set for something other than Day 7 of the relevant COT observation period, will be treated as if the ARD has been set late. As such, pursuant to the policy outlined in the

FY 2012 SNF final rule (76 FR 48524), in the case of a late COT OMRA, facilities should bill the default rate for all days that are not in compliance with the ARD requirement. For example, if the ARD for a COT OMRA is set for Day 9 (two days late), rather than day 7, of the COT observation period, then the facility should bill the appropriate HIPPS code from the COT OMRA beginning on the day after the ARD of the last PPS assessment used for payment (or the date of resumption of therapy) and for the following six days, which would be through the end of the COT observation period had the ARD been set for the appropriate day. Days 8 and 9 would be billed at the default rate to account for the days the COT OMRA was out of compliance and the next COT observation period would begin on Day 10.

Q. Clarification regarding completion of interview questions for a COT OMRA.

A. In relation to the interview in a COT OMRA, facilities may complete the interviews within a day or two of the ARD of the COT OMRA. If the interviews are not completed by this time, then facilities should use the staff assessment to complete that portion of the COT OMRA. We would note, however, that given the types of changes in the intensity of therapy that would prompt the need for a COT OMRA. Facilities are expected to continually evaluate the therapy intensity for a given SNF resident and anticipate the possibility that a COT OMRA may be necessary.

Revised SNF End-of-therapy (EOT) OMRA Policy

Q. Clarification regarding the days used to determine if an EOT OMRA is necessary.

A. Any three consecutive calendar days when no therapy is given to a resident classified into a Rehabilitation plus extensive Services or Rehabilitation RUG group, regardless of the reason, count toward the EOT OMRA.

Q. Clarification regarding whether the facility always required to issue the patient an Advanced Beneficiary Notice (ABN) or a Notice of Medicare Non-Coverage (NOMNC) in situations where the only skilled service that a patient is receiving is therapy-related and the patient does not receive any therapy for three consecutive calendar days.

A. A facility is only required to issue the ABN or NOMNC in cases where the facility believes the resident will enter a non-covered stay. The ABN is intended to provide the beneficiary with sufficient time and information to make an informal decision regarding their treatment. Facilities must determine if there is a reasonable expectation that the SNF stay, or part of the SNF stay, will not be covered by the resident's Medicare Part A benefit.

Q. Clarification regarding the minimum number of therapy minutes which constitute a therapy day.

A. If a patient receives 15 or more

codable minutes of therapy in one discipline in a given day, including a therapy evaluation, then this would count as a therapy day.

Q. Clarification whether an EOT is necessary when one therapy discipline is discontinued or when all therapies are discontinued.

A. An EOT OMRA is necessary when all therapies have been discontinued.

Q. Clarification whether an EOT-R can be combined with a scheduled assessment.

A. Yes, an EOT PMRA can be combined with a scheduled assessment.

Q. Clarification regarding which item set is used when the WEOT OMRA is combined with a scheduled assessment.

A. In such cases, the facility should use the item set for the scheduled assessment.

End of Therapy with Resumption (EOT-R)

Q. Clarification regarding whether the EOT-R is a new assessment type.

A. The EOT-R is not a new assessment type. It refers to a subset of items on the EOT OMRA, specifically two items (O450A and O0450B) that have been added to the existing EOT OMRA item set to permit facilities to report the resumption of a previous therapy program.

Q. clarification regarding whether a new therapy evaluation is required if facilities choose to use an EOT-R.

A. A new therapy evaluation is not required in cases when an EOT-R is used.

Q. Clarification regarding how payment is effected if an EOT-R is used.

A. In cases when an EOT-R is used, the facility should bill the non-therapy RUG given on the EOT OMRA beginning the day after the patient's last therapy session. The facility would then begin billing the therapy RUG that was in effect prior to the EOT OMRA beginning on the day that therapy resumed (O0450B).

Q. Clarification regarding what day facilities should start billing the therapy RUG if they choose to resume therapy.

A. The therapy RUG should be billed from the day that therapy resumed, according to item O0450B on the EOT OMRA.

Guidance for therapy student supervision is available on the SNF PPS website at ;

www.cms.gov/SNFPPS/03_RUGIVEDu12.asp#TopOfPage

Additional Q&A's

Q. EOT - We normally provide therapy Mon-Fri , if a resident has Part A which involves 3 consecutive days (Sat, Sun, Mon) and no therapist can work on those weekends and holidays then the patients are missing 3 days of therapy. Do we need to do an EOT on a skilled resident if they have missed 3 consecutive days?

A. If your facility provides therapy on the weekends and holidays then you have to consider the weekend a usual therapy day and after the weekend was missed, Mondays would be the third day missed only if your therapy department would provide services on a holiday. If the therapy is never provided on weekends and/or a holiday then no suggestion, and this is not something that the therapy department is at liberty to decide.

Q. Z0300/HMOs/Vendor:

This is in regards to how the facility codes a HMO assessment, the facility have been coding like PPS assessments to get the rugs, if the code is "99" and does not get a RUG score for the assessment . Sometimes the assessment combine a PPS and HMO assessment together and then submit these kind of assessments. The facility feels this is a problem as when coding the HMO assessment as 99 the facility do not get the RUG. The facility are using the DLL from CMS to produce the Medicare RUG score. How should we advise this client to get the Medicare RUG score?

A. For the vendor; CMS is very specific that only the MDS OBRA or Medicare PPS assessments will be allowed into the MDS QIES ASAP system. They have inserted Z0300 for the coding of HMO and/or insurance RUG score and to do that, the vendor needs to work with the facility. The facility may not combine any type of assessment with an HMO assessment. The HMO assessment has to be completed separately as it may not be transmitted to the ASAP QIES data base. If the HMO requires a RUG score for payment, then the facility can complete a PPS assessment, but it cannot be submitted.

Q. How COT OMRA affects payment?

A. Once it has been determined that a COT OMRA is necessary, the new payment rate will be effective from Day 1 of the COT observation period and will continue until modified by a future scheduled or unscheduled assessment.

Q. When will the COT observation period began?

A. The COT observation period begins on the day following the ARD of the most recent scheduled or unscheduled PPS assessment. However, in cases where the previous assessment is an EOT with resumption set in item O0450B on the EOT-R.

Q. Clarification regarding type of cases to which COT OMRA applies.

A. The COT OMRA applies in both cases where the patient's RUG classification decreases or increases.



From the previous issue; How should the interview items be handled on the discharge assessment when resident is sent out in an emergency situation?

A. On page 2-36 of updated RAI manual, October 2011...For unplanned discharges, the facility should complete the discharge assessment to the best of its abilities. The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessments and should record those responses or may be in the process of completing an assessment. The facility may combine the discharge assessment with another assessment when requirements for all assessments are met.



California Department of Public Health
Center for Health Care Quality
Licensing & Certification
PO Box 997377, MS 3201
1615 Capitol Avenue,
Sacramento, CA 95899-7377

Send your questions and ideas for this newsletter to:
Susana Belda

State RAI Educational Coordinator: (for RAI/MDS questions)

OR Roberto Toffoletti

Federal System Support Unit- ASPEN Coordinator
MDS Automation Coordinator (for Software/IT/Technical
questions)

Phone: (916) 324-2362 or
(800)-236-0747

Fax: (916)552-8965

E-mail: mdsoasis@cdph.ca.gov

References:

- * RAI User Manual 2011
- * MDS Version 3.0 National Providers Call August 23, 2011/ Slides & Clarification
- * CMS All State RAI Teleconference July 2011 to December 2011 agenda
- * CMS & State Q & A's
- * CMS Open Door Forum

To access Newsletter go to;

[www@cdph.ca.gov](http://www.cdph.ca.gov).

Under Licensing & Certification,
MDS 3.0 CA Nuggets



Follow-up information from August 23, 2011 Provider's Training and September 1, 2011 from CMS Open Door Forum: *(copied from the follow up information released by CMS in October 2011).*

Information are available on CMS website at:

<http://www.cms.gov/>

<http://www.cms.gov/SNFPPS>

<http://www.cms.gov/>

[NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp)

There are general clarifications that was posted on CMS website at;

http://www.cms.gov/SNFPPS/03_RUGIVEDu12.asp#TopOfPage