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Please stand by for realtime captions.

We are going to get started. For those who have not heard by multiple instructions we need to be sure that we put our phones on mute. We are enabled to mute -- unable to mute all the lines. Never put us on hold. Thank you for joining our webinar today. I will be hosting today's program along with Lori from the office of health licensing survey. We are pleased to bring our program entitled MDS 3.0 scheduling for OBRA and PPS. If you have not received the handout you can download them on the web at page -- WebEx page. I have downloaded -- but these instructions in the chat box. You can also download them from the office of healthcare licensing and survey website or contact the representative in your state. To enhance our learning experience for all participants you must mute your telephone. Either hit the mute button on your phone or star for -- *4 on your keypad. We do have polling questions today.

Please participate in those polling questions when they arise. Following the end of the program there will be in evaluation pulp. -- Call -- poll. I would like to introduce wore Ruth -- wore Ruth -- Lori Ruth who were introduced the present to for today.

Jennifer Pettis is a nurse researcher associate in the health policy at the 7. She participate and -- and quality improvement in quality initiative including nursing home compare and nursing home quality assurance and quality improvement. [Indiscernible - multiple speakers] having began her career as a nursing assistants she has 20 years of experience. Welcome and we look forward to hearing more about the MDS 3.0 scheduling.

Good afternoon, everyone. Just a reminder to please rent -- mute your phone. Do not use the whole button so we do not have to hear the great services and -- at your facility and hold music. In 2010 I was there in Miami talking about scheduling. We have not talked about scheduling scripts -- cents. -- since. I have a ton of material here. We're going to move through it relatively quickly. We will slow down and expand on concepts as we go along. Scheduling is an art. As you learn to effectively schedule your MDS you are developing a skill that will take you far in our long-term care. It is not in easy task. There are a lot of rules. Many roles have evolved over time. Let's get started.

I should mention before we go further there was an update to the user's manual that came out mid-September. I did quickly go through it and was thankful that there were no changes that impacted the scheduling. We're going to start with talking about the assessment reference date and look back period. We will talk about the assessments required for Omnibus Budget Reconciliation Act (OBRA) and Prospective Payment System (PPS) purposes, those assessments are for Medicaid part a residence. I want to throw out a disclaimer that many of you will complete these assessment -- scheduled assessments for residents who are having their state paid by a Medicare advantage plan. I want to remind you how you complete those or the schedule is an agreement between you and that program. CMS does not provide oversight on what you do with this assessment. Other than what is discussed in chapter 5. Those assessments completed

solely for purpose put -- payment purposes other than over assessment should not be completed. We will talk about assessments required for Omnibus Budget Reconciliation Act (OBRA) and Prospective Payment System (PPS) purposes.

The RAI users manual is online. Use it. Follow this link on your screen to access the new manual along with the change tables for the pages. Before we began to talk about scheduling I think it is important that we talk about key definitions. There are some definitions that are critical to understand in order to effectively schedule. Hopefully you will gain an understanding of this as we go along. The first is The ARD is the last day of the observation (or look back period. this is the last day. It begins at 12:00 a.m. and ends at 11:59 p.m. It is going to cover the entire period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. The PPS assessments will be clear when that ARD needs to be set. It will be set when you are doing that assessment. Think about the assessment with this ARD because it is included in that period. Think of The observation or look back period is the time period over which the resident condition or status is captured by the MDS assessment. this will reflect how the president will acted -- looked, acted, behavior etc. Almost all of the MDS items utilize this idea of a putback period. The look back ends at 11:59 on the ARD Unless otherwise stated, the look back period is seven days. Regardless, Only those occurrences during the look back period will be captured on the MDS.

Pat mentioned that we will have time for questions and answers at the end. I welcome you to type questions in the chat as we go along. If I can address your question and it is pertinent to scheduling and is something unique clarification on before we move forward I will certainly do that if it is helpful to you.

The next definition is admission. The definition for admission changed in 2014. Previously it was required that the resident had to have in a mission assessment during a previous day in order to be considered a readmission. That is no longer a requirement. In order to be an admission, when the resident is considered new for MDS purposes , is when a president has never been admitted to your facility or they have been discharged and returned non-anticipated. Maybe they were in your facility for rehab and four months later they come back. They will be considered a review admission from MDS standpoint. Been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge. The 30 day period will consider the day of discharge but not the day of readmission. Is the resident went out on August 1 they would need to be back on August 31. It is the day of discharge +30 days. This would be a resident that was may be sent to the hospital and they did not improve rapidly or they had a long recovery. That resident was in the hospital for six weeks. They will come back to you as a new admission. Very often they are different resident that you left your facility.

Reentry refers to when the resident When they previously lived in that facility. If the president was discharged return anticipated and discharge within 30 days. They had to have been in your nursing home discharge with return anticipated and come back within the 30 day period. And entry can be an entry or a readmission -- An entry describes either an admission or a reentry. Completion of an Entry Tracking record is required with each entry. You can think of it as demographic information. Let's talk about a discharge. Discharge is the date a resident leaves the facility. Remember our dates are from midnight from 11:59 PM. The day they roll out your door

is the date of discharge There are two types of discharges return anticipated and return not anticipated. a discharge assessment will be done with both types of discharges. The assessments will differ a little bit. They will differ whether it was a planned or unplanned discharge. We will talk about discharges -- discharge requirements in a bit.

For leave of absence. This is Temporary home visit of at least one night, Therapeutic leave of at least one night and Hospital observation stay less than 24 hours and the hospital does not admit the patient considered the hospital observation status. The resident leaves your facility at noon today and come back to you at 6 AM tomorrow. That resident hasn't been -- they have been gone 18 hours. They have not been admitted. They have been on observation status the entire time. That resident does not need a discharge assessment. They do not need a reentry tracking form, you do not consider them new admission. You do not have any impact on your OBRA assessment schedule unless there are significant changes.

Is that resident is on Medicare they are not in the bed at midnight you will not bill for that day. Keep in mind that some of these admission discharge leave about some roles do not necessarily go hand in hand with Medicare benefit policies. That does it for the definitions I want to mention to you. I would like to move on and talk about over required tracking records and assessments. These are federally mandated. They will be performed on all residents regardless of their payer source as long as they are Medicare or Medicaid certified that. These are the assessments that will be coded in A0310A where it says federal OBRA reason for assessment and they will be included in A0310F under entry and discharge reporting. These include the tracking orders and in your assessments they include the omission, quarterly annually significant change in status cost significant correction to prior assessment, significant correction to prior quarterly assessment and the discharge assessment. Let's look at them. As a reminder please mute your phone.

For the comprehensive MDS assessment they include four types of assessment. These require that the care area assessments are done and they required care planning. There are for type -- types of these. [Indiscernible - multiple speakers] delivered just said you don't like it and we don't do that when we can hear you.

[Indiscernible - multiple speakers] the next type of assessment is the admission assessment. This is done the first time the resident is in your facility or if the resident has been admitted to this facility and was discharged return not anticipated, or if the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. . -- Let's look at the requirements for these. Item 8 2300 needs to be sent no later than the 14 calendar day. You will count the admission day as day one and add no more than 13 calendar days. Remember that regardless of the maximum time you can take to complete this MDS assessment that federal statute and regulations that require residents be promptly assessed and that the assessments is used to ensure you are providing appropriate care for that resident. Although we are doing this comprehensive MDS assessment we are assessing the resident along the way in order to start the care plan. We will complete the MDS assessment no later than the 14 calendar day. Because will also be completed on or after the MDS completion date and no later than the 14 calendar day of the residents admission. After their complete it you have seven days to complete your care plan. The care plan completion date is the date that drives the

submission or transmission. That is no more than 14 days after the care plan completion date. Any resident who has not experienced a significant change in status assessment or had a significant correction of prior assessment is going to have an annual assessment completed every 366 days. Every resident needs to have at least one assessment every 366 days. That is going to drive -- what is going to drive the annual assessment is the ARD previously OBRA assessment. It is no more than that date +366 days. You also need to keep an idea -- I on the previously quarter MDS assessment and make sure it is no more than 90 today's. As you are scheduling your annual not only back to the prior comprehensive but Pratt -- back to the prior [Indiscernible]. It will be completed no more than 14 calendar days after the ARD. It is your completion the charger care complete -- care plan completion and that's no more than seven days. The care plan completion will drive the submission of your MDS within 14 days. We also have a couple of comprehensive -- comprehensive assessments. One that is dependent on the status of the resident. The other is if there is an error made in MDS . A significant change is a decline or improvement in a resident status that Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not elf-limiting (for declines only), For instance a you to lie -- UTI is considered [Indiscernible]. It would normally resolve itself. If a resident has a cold we will expect that it will resolve itself. The significant change needs to Impacts more than one area of the resident health status, and Requires interdisciplinary review and/or revision of the care plan. I would argue that if it met the first two bullets you would have a hard time with why did meet the third.

When a resident status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met. I would encourage you that when you began to engage in this decision-making about whether or not the resident is a significant change, encourage -- I would encourage you to document the decision-making. The users manuals -- manual provides more than -- Decline in two or more of the following Resident decision-making changes, Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (, Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases, Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment, Emergence of unplanned weight loss (5% change in 30 days or 10% change in 180 days) Resident begins to use trunk restraint or a chair that prevents rising when it was not used before or Overall deterioration of resident condition. Improvement in two or more areas is a potential trigger for significant change.

You will identified those residents have is having met the significant change in status for improvement. It's exactly the opposite of what I just mentioned. Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment. Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases. Resident decision making changes for the better. Overall improvement of resident condition.

Discrete and easily reversible cause(s) are evident. Short-term acute illness. This can be residents with bipolar disease. I do think you may often get through a significant change or two before you really have well established the pattern. Documentation and your team will identify that.

Continued progress under the current course of care. These are often rehab residents continuing to make progress. When that resident stabilizes and are expected to be discharged in the immediate future -- Condition has stabilized but the resident is expected to be discharged in the immediate future. You will not proceed to significant change. If it were me and I were making that decision I would acknowledge that they meet the criteria and note that the discharge is planned a week from now. If the resident is still within the 14 day period you do need to move to significant change. With significant change in terminate -- terminally ill residents. We have had some changes. Particularly those on hospitals. A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home (ARD within 14 days from the effective date of the hospice election). A significant change needs to be performed regardless of an assessment was recently conducted. If the resident is admitted and hospice is initiated prior to the ARD of the admission assessment there is no reason to complete the admission and follow it with a significant change. If they came in on the first of the month and hospice was elected the fifth and the eighth is your ARD hospice services are intent -- place during that time period.

Completing an Admission assessment followed by a SCSA is not required if the resident elects hospice prior to the ARD of the Admission assessment. SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (ARD within 14 days of the event signaling the end of hospice services). I have a question that says if you do not have a hospice program and place your resident on comfort care does the assessment need to be completed? There is nothing in the user's manual that addresses comfort care. I think you need to go back and determined does my resident meet the criteria for a significant change? Is there a general condition change such that their entire click -- plan of care has changed. You are no longer wait -- worried about hydration status but comfort foods and making sure they do not complain of thirst. That is a clinically significant change in that resident. To answer the question do you do this assessment if they are placed on comfort care it really is goes back to the status of the individual resident. Making your decision based on an understanding of their criteria and moving along and documenting that decision-making process. If a resident is terminally ill -- When determining if an SCSA is required for a terminally ill resident, determine whether or not the decline is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.. Once you get the comprehensive that identifies the resident is terminally ill and they have some additional declines ask yourself and colleagues is this decline part of what we expect for this course of this disease? Or is it something that has nothing to do with their illness. [Indiscernible] likely to be dependent on oxygen or having declines of strength and endurance and the ability to do ADLs. Is of course you would expect with terminally ill one cancer. -- Long cancer. With the fall of the bed and break a hip that is not inclined associated with lung cancer. In that case there is a significant change.

The assessment reference state can no longer -- be no longer than the 14 day the significant change occurred. That's the date of termination +14 days. The care area MDS will be completed no later than the determination of the significant change +14 days and the cost will be completed on or after the MDS not before. Those would be done in the termination date +14 calendar days. Once they are completed that will drive your care plan completion. Your care plan won't drive your submission or transmission of the MDS. With your term for a question.

Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks. Should a Significant Change in Status Assessment (SCSA) be conducted? Determining a significant change is 18 decision. There's nothing better when making that decision than to document the team thought in your record. You know your residence best. The majority said yes and that is correct. We think she will return to her baseline of 4 to 6 white weeks -- weeks so we move ahead to significant change. We do that significant change for decline then chances are six week later we would do a significant change for improvement. Think about how different the care plan would be.

Whoever just mentioned there is no reason for either one of those you should mute your phone. We can all hear you. A significant error is an error in an assessment where: The error has not been corrected via submission of a more recent assessment. A significant error differs from a significant change because it reflects incorrect coding of the MDS and not an actual significant change in the resident health status. Nursing homes need to document the initial identification of a significant error in the assessment in the clinical record. With this the timing of this is identical to the significant change. It is the termination date of the significant correction of the need of the significant correction +14 days. MDS completion is wrong later than deterrent -- completion date will also be no later than the determination date +14 days on or after MDS. Your care plan is what drives your submission. It will be submitted within 14 days of the completion of the plan of care.

That is it for comprehensive assessments. Let's move on to non-comprehensive assessments required for OBRA purposes and tracking records. They are all listed here. They are found in A0310A and A0310F. Must be completed at least every 92 days following the previous OBRA assessment of any type. It Tracks a resident status between comprehensive assessments to ensure critical indicators of gradual change in a resident status are monitored. Not all assessment items will appear on the quarterly assessment it is a subset of the comprehensive assessment. Your timing needs to be your A2300 no more than 90 days after the ARD. Your completion date is ARD +14 calendar days. There are no CAAs but there is the expectation that the care plan is reviewed in conjunction with each assessment including quarterly and that your documentation and facility supports the that have been. Then you MDS completion date +14 days is what drives your submission. A significant correction of a prior quarterly is done for exactly the same reason we would do the significant correction of the prior agreements of assessment. This is where the quarterly contains the error. It can be performed any time after the completion of the quarterly that contains the error. Once you determine the air to be made we will move to do this no more than the determination date +14 days. We will accept the ARD by then. Complete the ARS by them. There's no cause required to ensure that the care plan accurately reflects a resident. You are going to submit this with your MDS completion date no more than 14 calendar days. I want to mention quickly the federal regulations that they dictate three quarterly assessments are going to be completed in each 12 month period. Usually we would have an admission three quarterly's and an annual or use this round cycle on the right of your screen where we have a comprehensive three quarterly's and and other comprehensive. Keep in mind that -- keep in mind that your significant change cost significant correction of at par conference of assessment or an annual can service conference of. Let's take a look at another question.

Mrs. J. had an Annual assessment completed in January and a Significant Change in Status Assessment (SCSA) in April. When is her next Annual assessment due? ARD of the Annual assessment (in January) + 366 calendar days and ARD of previous OBRA Quarterly assessment + 92 calendar days Or ARD of the SCSA (in April) + 366 calendar days and ARD of previous OBRA Quarterly assessment + 92 calendar days.

While we are waiting for the result I will address a comment or question that is and updated quarterly. It has to be updated with the quarterly not a date that is reported on the MDS. Your paperwork will show that your care plan is reviewed and revised in conjunction with each assessment. Most of you got it right it will be the significant changes of status in April that drives your care plan for your next annual assessment. Your comprehensive assessment goes from whatever the most recent comprehensive is +366 days. Let's move on to discharge assessments.

They are required when the resident is discharged to go to a private residents hospital where the care sending -- setting when they've had a stay of over 24 hours. Or transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed. if your resident news from the Medicare certified bed to a private pay bed to do the discharge assessment. Discharge assessment return on anticipated Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days If the resident returns, the Entry tracking record will be coded A1700=1, Admission. .

Discharge return anticipated Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. If the resident returns, the Entry tracking record will be coded A1700=1, Admission. the team would come together to see if they experienced a significant change or did not. If there was no significant change continue on with that OBRA schedule. If a significant change is not indicated you have 13 days after reentry to complete it. Get a quarterly or in all do while the rest of was in the hospital and they are not a significant change they come back then you would have that day of reentry +13 days to get that assessment done.

How you handle a resident on readmission from a MDS standpoint is totally driven by where they discharged and return anticipated or not. It has nothing to do with that hold, payer status, new medical records because they are in a different room any of that. All I have to do with his did they come back after return anticipated. If it is your facility policy to choke --) chart and start a new chart that is fine. That is not what happens with the MDS. It needs to follow this rule. You will -- continue on with the OBRA assessment was they require a significant change.

Discharge date +14 days is the completion period. At any time you can document that ARD in that assessment or software. Submitted MDS completion date plus no more than 14 calendar days.

A resident went from a Medicare certified bed to a noncertified bed and remained long-term in the facility. He is going to have a discharge assessment return not anticipated. Consider that a resident moving to a noncertified add on a distinct part of your facility or part of a complex it is essentially being discharged from that Medicare bed. They will have discharge return not anticipated.

Entry tracking the residents need to have a entry tracker. It is the first item set done for each resident. It needs to be done every time they are admitted as an admission or readmitted and considered a reentry. And needs to be completed by the entry date +7 calendar days after that admission reentry. Needs to be transmitted no later than the 14 calendar day after the reentry. This is largely demographic information. A cannot be combined with any other assessment. It is a standalone tracking record. If your resident is considered an admission that entry tracker is going to be coded as such when they are admitted for the first time. The resident will be considered a reentry when the that -- that resident was discharged and return anticipated from that facility and returned within 30 days. Do remember you are counting -- the day of discharge will not be counting the day of admission. If they leave on the first they need to be back by the 31st. Then there is another standalone tracking record. That is the facility tracker. This will be completed when the resident dies in the facility or LOA. Don't forget when a resident is in the ER or observation stay and has not been there long enough to have a discharge assessment and they pass away. This would be the right assessment to do. If the resident left your facility at noon today and received a call at 9 PM they expired in the ER than they would have a death and facility tracker. You would not do that discharge assessment. It needs to be completed within seven days after death. Date of death is going to be recorded in the discharge date. It is going to be submitted within 14 days after the resident’s death. This is standalone and cannot be combined.

I want to mention causing and care planning. The completion date with the care planning remember that CAAs has to come on our after the admission date. The care plan is going to be driven by the completion. Sometimes you will hear a care plan for a new president is due no later than date 21. That is only do -- true if it is done on day 14. If it is done on day 12 then the care plan is due by Dave 19. The MDS completion date is always going to be earlier than the same date as the care plan completion. Remember they are not required for comprehensive assessment. Nursing home teams do need to be sure to evaluate the appropriateness of the care plan after each quarterly and significant correction to a quarterly assessment. The care plan should always reflect the current status of the resident.

We're going to spend the next 30 minutes talking about Medicare required or PPS assessments. Last year they took away the return readmission assessment. We also have unscheduled assessments we will detail. Each of the Medicare-required scheduled assessments has defined days within which the ARD must be set. The facility is required to set the ARD within the appropriate timeframe of the assessment type being completed. When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may do so no more than two days after the window has passed. The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes. Your compliance and payment implications rely heavily on how you set that ARD .

When coding standalone or other Medicare required assessment you do have flexibility of when you set that ARD. You need to set it for a day in the allowable window. You have that one day plus the next two days to set that ARD. Once you are three or four days beyond that ARD you

have Mr. window of opportunity to go back and set it. Encourage you to review the guidance in the user's manual.

We have grace days. Years ago we were told not to use them often. Will we hear now is that they are available to you and use them when you need them in order to capture the full complement of services you are providing to that resident. Grace days allow for flexibility in scheduling PPS assessments (e.g., to more fully capture therapy provided or if there are operational reasons that the assessments may be delayed).

Let's look at the scheduled assessments. These will be assessments recorded in A0310B they are the PPS assessments. The ARD ranges for the five days assessment is a 135. We have grace days up to date -- one through five -- through five. All of these are setting payment rates for these periods of time unless there is an unscheduled assessment thrown in there. We will talk about their impact on the payment. Any of the PPS assessments need to be completed within 14 days after the ARD. That is the ARD plus that is the ARD +14 days. For a 30 day assessment we have date 27 through day 29. Grace days are there -- days 3333 and ARD when there is 27 to 33. Except payment from day 31 through 60.

Then we have unscheduled PPS assessments. These are used in situations where the provider needs use complete these outside of a standard assessment. These are -- there are two OBRA assessments that will potentially impact your payment. Those are the significant change in status assessment and Significant Correction to Prior Comprehensive Assessment either one of them whether or not they are combined with a PPS assessment they will potentially impact your payment. We also have three assessments that are specifically designed to impact your payment those are Start of Therapy Other Medicare Required Assessment (SOT-OMRA) , End of Therapy Other Medicare Required Assessment (EOT- OMRA), or Change of Therapy Other Medicare Required Assessment (COT-OMRA).

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window. Date 27 through 33 is our window of opportunity. On day 27 we do a in the therapy and we cannot turn around today's letters on the 29th and scheduled the 30 day assessment. Those would have to be combined. You could have done a scheduled assessment on day 27 and on day 31 turn around and do a OMRA.

Let's take a look at start of therapy. It is a optional assessment. This is completed to classify a resident into a rehab less extensive or rehab group. If the classification is not rehab or rehab plus extensive the assessment will not be accepted into the database that CMS uses to collect your MDS. And it cannot be used for billing. This will only be completed if the president has already classified -- not been classified into the rugged group. If my evaluation is Monday Friday is day five and Sunday is day seven. I need to set the ARD between day five and day seven. This does modify payment on the first therapy day. You will complete this assessment within 14 days after the ARD. Submit it within 14 days after completion. Start of therapy is cut and dry. I do not get a lot of questions. The other two Jan -- tend to generate more questions. A end of therapy OMRA is not optional. This is required -- Required when the resident was in a RUG-IV Rehab Plus Extensive or Rehab group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days. for

purposes of determining what must be completed a treatment day is defined exactly the way it is in chapter 3 section oh -- O. These MDS can be combined with other ARD -- PPS assessments or other OBRA assessments. You are going to complete this assessment within 14 days after the ARD and submit it within 14 days after it is completed. This will modify your payment the day after your latest therapy day. If the resident had their last therapy treatment on Monday you would need to complete the MDS with a ARD scheduled Tuesday Wednesday or Thursday. Your payment rate will still change on the Tuesday. The last rehab payment will be Monday and whatever nursing rug was obtained from this will change and the therapy OMRA will not be required if a resident is discharged from the SNF on or prior to the third consecutive day of missed therapy services, the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services car and the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services. In this case you can combined the EOT with a discharge if it is a benefit to you. It is not required. The end of therapy OMRA has three options.

That is, that it is Complete only the EOT OMRA and wait until the next scheduled PPS assessment. I do not think that is the option most people choose. In cases where therapy resumes -- Complete the EOT OMRA. If therapy resumes more than five consecutive calendar days since the last day of therapy or therapy will not resume at the same level, complete an SOT OMRA upon resumption.. -- In cases where therapy resumes 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 and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. A end of therapy resumption is essentially your option if no more than five days while between therapy and it wasn't really a therapy thing that led them to having that time off. Maybe they had a illness. This is the opportunity to use the end of therapy Omagh -- OMRA. Keep in mind that while they are not getting therapy you are not getting paid. You will get the EOT payment. It is important to be sure that when you do the end of therapy with resumption you are using the correct therapy*and end dates. When this assessment is completed the therapy start date on the next assessment is the same -- PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

Please reference the scenarios in the manual. Particularly with and of therapy assessments. The change of therapy assessment is one that changes how nursing and there became together to schedule MDS to talk about resident status. It causes to reload at how things were working for the residents. This is required when they are receiving a sufficient level of rehab therapy to qualify for any one of the rehab levels and the intensity of therapy is indicated by total reimbursable therapy minutes and other therapy qualifiers. Changes to a degree that would no longer effect the RUG for classes and payment assignment for the resident based on the most recent assessments used for Medicare payment. Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days). If my ARD is on the first ongoing to the eighth and looking back to say what happened or not seven days. Does it reflect the same therapy status same therapy minutes days and disciplined that the prior MDS dead? If you establish a new

payment with these required assessment payment weekend on day one of the COT observation period. It will continue until the next schedule assessment or and other change of therapy or other assessment changes that again.

ARD is set for Day 7 of a COT observation period. The COT observation periods are successive 7-day windows with the first observation period beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment, except for an EOT-R assessment. In cases where the last PPS assessment was an EOT-R, the end of the first COT observation period is Day 7 after the Resumption of Therapy date (O0450B) on the EOT- R, rather than the ARD. Think of the ARD of the end of therapy resumption as day one when you are counting for those days. You can think of the ARD as day zero and this observation period begins the next day.

If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS assessment, the SNF may choose to complete the scheduled assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is on or prior to Day 7 of the COT observation period. In cases where a resident is discharged from the SNF on or prior to Day 7 of the COT observation period, then no COT OMRA is required. The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient initial RUG-IV therapy classification in a Medicare Part A SNF stay.

The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if both of the following conditions are met: Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident current Medicare Part A stay, and And -- No discontinuation of therapy services (planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group. in other words, if they have been receiving therapy all along but something happened or something else got them in a non-therapy rubbed you do not -- you can use the CRT -- COT to reclaim the therapy RUG . Under these you can complete the COT to reclassify that resident into their therapy group. It is a optional assessment. Then continue on with the COT evaluations. Do remember I mentioned significant change or sit vacant correction of prior assessment. These will act as off cycle PPS assessments. They are OBRA assessments the impact your PPS payment.

When a SCSA/SCPA is not combined with a PPS assessment (A0310A = 04 and A0310B = 99), the RUG-IV classification and associated payment rate begin on the ARD. When the SCSA/SCPA is completed with a scheduled PPS assessment and grace days are not used, the RUG-IV classification begins on the ARD. When the SCSA/SCPA is completed with a scheduled PPS assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. There are few slides of coding tips I have to share with you. When you -- When coding a standalone COT, EOT, and SOT, facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. I gave you the example earlier of day seven of the COT observation period as the only allowable date you can set that change of

therapy ARD. You have to calendar days to set that in your software or MDS form we can combined assessments you'll never find a case where you will schedule a combined to Medicare did -- Medicare scheduled assessments. Even if you had one that was late -- Two Medicare-required scheduled assessments may never be combined. it is possible to have. Medicare-required scheduled assessments and a Medicare unscheduled assessments may be combined or that two Medicare unscheduled assessments may be combined. If an unscheduled PPS assessment is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met.

We have a few minutes before questions. Does the Medicare stay have a COT them when they are taken of Medicare and remain in the building? No. If the resident is taken off for Medicare completely you do not need to do a COT or EOT. You are just ending Medicare. Whatever the last unscheduled assessment was completed based on the rules that will pay you on through their Medicare. Any other questions?

If anyone has any questions you can unmute your phone.

I realize this is a lot of information but you hate to do scheduling without mentioning PPS. I think they build on each other.

Are you getting any in the private chat?

I am not. I want to thank you all for inviting me to join you guys I hope everyone found it helpful. We always like to hear what you find it beneficial -- find an official -- beneficial.

The MDS folks have always been my hero. Any support we can give them I am supportive of that. Do have any questions before we close the program? I would like to thank you for an insightful and informative presentation. For the participants on the call I would like to thank you for joining us. I would like to thank everyone for being patient with technical difficulties. If you have any additional questions please feel free to submit those to myself and I will be happy to forward them. [Indiscernible - multiple speakers]

We had one question they are asking for PowerPoint slides.

A should have gotten them in the email but they can go back to the login page and on the left-hand side there is a box where you can put in scheduling the password and the handouts will pop in for downloading and printing.

Perfect.

I would like to remind participants to complete the program evaluation. It should be in your browser page. That gives us the information we need to determine if we are meeting your needs and if we can make your programs better. With no more questions thank you and this will conclude today's program.

We sure appreciate everything you do every day for your patients.

[Event Concluded]