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Frequently Asked Questions

[On-demand webinar] What you need to know about the MDS 3.0 for October 1, 2020

On Tuesday, August 25, 2020, SimpleLTC and Briggs Healthcare hosted a live webinar with industry expert Mary Madison, RN, RAC-CT, CDP, covering updates to the MDS 3.0 Item Sets that will be used in LTC facilities beginning October 1, 2020. This document contains answers to specific questions asked during the webinar.

1. **How long do we keep the COVID diagnosis as an active diagnosis?**

   According to current CMS guidance in the RAI Manual:

   SECTION I: ACTIVE DIAGNOSES

   Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

   It is good practice to periodically review a resident's list of diagnoses with the Attending/Primary Care Physician. Resolve the diagnoses that are no active, according to the CMS definition. In addition, diagnoses come and go – for example, pneumonia and UTI. We provide treatment and medication and the pneumonia or UTI is resolved. Resolve such diagnoses on that "master" list. You may need to reactivate the diagnosis later but perhaps not. I recommend dating the resolution of any diagnosis as it provides for clear communication. The resolved diagnosis is history. COVID would be treated the same. I will also add that it would be prudent for the Attending/PCP to document/provide confirmation that COVID-19 disease is resolved for any given resident.

2. **What if your state is not a Case Mix state?**

   If your state is not a Case Mix state, you will not be required to complete GG0130, GG0170, I0020 and J2100 for your LTC/not skilled residents.

3. **Patient has Acute Respiratory Failure with Hypoxia during his/her Acute Care Stay. Patient is then transferred to Swing Bed (following the PDPM RAI manual), this diagnosis is RESOLVED and would no longer be coded on the Swing Bed stay, correct? Patient transferred from Acute Care to Swing Bed secondary to weakness from the CHF exacerbation and lung metastasis from pancreas malignant neoplasm.**

   Correct, if the acute respiratory failure w/hypoxia is no longer an active diagnosis (you indicate the diagnosis is resolved), then it would not be included in your coding for Section I.

4. **The resident who come back from hospital and due to CMS/IDPH recommendation keeping those residents in 14 days isolation, possible exposer for COVID. Do we code isolation in section S? We are not coding in section O.**

   Section S is specific to the state that requires completion of this additional section. Here is the link to the Section S items currently being utilized: https://qtso.cms.gov/system/files/qtso/Oct%202020_SectionS_Items_AmendedforCM02734.pdf. My best advice is to contact your State RAI Coordinator for answers to this Section S question as I do not know the State you're practicing in.

5. **Mass is not listed here. Any word on what MA will do?**

   I have not heard back yet from the state of MA; hopefully will soon. To the best of my knowledge, MA nursing facility payments are prospective rates based on reported costs for a prior base year. They are not currently based on the MDS.

6. **I thought Wyoming was also a case mix state. Is that changing for FY 2021 or were they not a case mix state to being with?**

   I don't believe that Wyoming is a Medicaid case-mix state. I will certainly reach out to those state folks to see if that has changed.

7. **So, the PDPM will be used to calculate the Z250A alternate state code - correct?**

   You've asked a great question – one that gave me a bit of pause and thus will need to research further! This is from the RAI Manual for Z0200A & B (I believe this is the appropriate item); below that for Z0250A&B:

Z0200: State Medicaid Billing (if required by the state)

Z0200. State Medicaid Billing (if required by the state)	
	A. Case Mix group:
	B. Version code:
Enter Code	C. Is this a Short Stay assessment? 0. No 1. Yes

Item Rationale

- Used to capture the payment code in states that employ the MDS for Medicaid case-mix reimbursement.

Coding Instructions for Z0200A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0200B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0200A.

Z0250: Alternate State Medicaid Billing (if required by state)

Z0250. Alternate State Medicaid Billing (if required by the state)	
	A. Case Mix group:
	B. Version code:

Item Rationale

- Used to capture an alternate payment group in states that employ the MDS for Medicaid case-mix reimbursement. States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model or to allow blended payment between two models during a transition period.

Coding Instructions for Z0250A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0250B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0250A.

8. **Is California not a case mix state for Medicaid?**

   I don't believe California is a Medicaid case-mix state.

9. **Just to clarify on the page list of the states... if the "x" is in the box for our state for the PDPM column, has it already been decided that my state will use the PDPM payment codes?**

   Correct. The X in that column reflects that your state has opted to use PDPM for Medicaid case-mix reimbursement calculation.

10. **Will V1.17.2 still report RUG in Z0200 as they do now? Z0200 - State Medicaid Billing (if required by the state).**

    Please reference my answer to Question #7 above. I believe it is Z0200 but am going to check.

11. **Will this replace doing a 5-day for PDPM?**

    If you are asking about replacing a 5-day assessment for Medicare reimbursement, it will not. You will still need that assessment to establish reimbursement. There are some Managed Medicaid entities that utilize the 5-day now – I am not aware of what their plans might be as of October 1, 2020. I am not entirely certain what you are asking, so if my answer is not an answer for you, please contact your state RAI Coordinator.

12. **Any guidance on what will happen with the Return to Provider codes in I0020B? We have many LTC residents that have a primary diagnosis of something that is considered Return to Provider for PDPM.**

    That is one of the questions I have submitted to CMS as well as a couple of RAI Coordinators in a Medicaid case-mix state. I have not received an answer yet. I would be very surprised if the allowed RTPs to be coded here but I believe there will be instances, for LTC residents, where there is not an applicable code that is not an RTP. I am hoping to hear back shortly! This is what I found in the Errata document, but I am not certain it answers our questions on RTP:

Issue ID	Problem	Resolution	Status
12	PDPM calculations for OBRA assessments will utilize two lookup tables for I0020B: the existing lookup table and a secondary lookup table, which will direct the PDPM to utilize the Medical Management category if the code is found. A new WARNING edit will be issued if the submitted value for I0020B is not present in either lookup table.	A new WARNING edit, -3967, will be created and read as follows: If A0310B=[99] and STATE_PDPM_OBRA_CD is active and STATE_PDPM_OBRA_CD=[1] and I0020B cannot be found in either data spec dictionary table pdpm_icd_codes_FYxxxx or pdpm_icd_codes_2_FYxxxx (where FYxxxx is the fiscal year matching the target date of the assessment), then the PDPM cannot be determined for this assessment. NOTE: ASAP will use the DMS value for the state where the assessment was performed instead of STATE_PDPM_OBRA_CD to determine whether this warning is applicable. This edit will only apply for assessments with target date on or after October 1, 2020.	This change will be made in the next version of the MDS 3.0 Data Submission Specs. It will be implemented in production on October 1, 2020.

13. Regarding Section I Primary Diagnosis, what should we be coding in this item for OBRA? Since the resident is no longer under skilled level of care, should we use the Admission diagnosis?

This is another question that I have posed to CMS and a couple of RAI Coordinators in a Medicaid case-mix state. I have written but have not received an answer yet. As a clinician, I would think that for an OBRA assessment, it would be the diagnosis that reflects the reason for the stay in the LTCF and at the time the OBRA is completed. I am not regulatory though and thus the reason for my asking regulators what they expect for LTC residents.

14. Will GG in Comprehensive and Quarterly be coded the same as "most usual" like in Admission or code as "most dependent" in regular G now?

Section GG for the OBRA Medicaid case-mix states will function just as it has for SNF PPS – usual during the observation period. Section G will retain the most dependent, following the Rule of 3 as it has for over 20 years.

15. What does it mean for PA " no earlier than 1/1/21"?

PA is not wanting OBRAs coded for GG0130, GG0170, I0020 and J2100 for LTC/non-skilled residents until January 1, 2121.

16. Do you have an on-demand webinar for section G? I like the one for section GG.

Thank you for that suggestion! I will certainly give it some thought.

17. Will we have to go through and recode LTC residents to fit a PDPM category?

You will not/I have not heard that any state is requiring such an action. We'll begin using MDS 3.0 v1.17.2 on October 1st for states that have opted to use the PDPM version for calculation of Medicaid case-mix reimbursement (with the exception of the state of PA (see my answer to Question #15 above). The next OBRA assessment you do will be coded according to your state's decision to use GG0130, GG0170, I0020 and J2100.

18. As we continue to see an increase of beneficiaries enrolling into Medicare Advantage plans, some SNFs admit just as many FFS for MA plans as MCR Part A. Does Simple have any plans to be able to collect data for MDS' for those FFS on an MA plan since these MDS' are being completed as non-CMS since Medicare does not allow for those to be submitted? There seems to be a lot of data not getting included.

Yes, SimpleLTC has plans to start accepting Medicare Advantage and Managed Care assessments soon. Availability, however, will be dependent on which EHR you are using to complete your MDS assessments.

19. For OBRA, will the second column be dashed?

I am thinking that the EMR vendors will not make the second column (Discharge Goal) available for data entry (it will be greyed-out) as we are not required to complete that second column on OBRA reviews.

20. When we switched to PDPM last October, the MDS for existing Medicare had to be adjusted and resubmitted. With the change from RUG to PDPM for case mix, will we have to perform similar changes to the MDS for our existing LTC?

I do not believe that will be required this year – I certainly have not heard anything about it. We had to do that readjustment last October because we were moving from RUGS to PDPM, both "spoke different languages" for reimbursement calculation. That action also allowed for PDPM payment, based on the resident's condition to start October 1st through the resident's discharge from skilled care. Prior to October 1st, your facility was reimbursed using the RUG classification.

21. With Managed Medicaid, we must provide PDPM scores as 5 day completed assessment. Does this run along lines of case mix Medicaid?

Please check with/confirm this with your Managed Medicaid insurer. Are you in a Medicaid case-mix state? Managed Medicaid is not always the same as Medicaid case-mix.

22. When a state chooses their option does it apply to both Medicaid and Medicare?

Only Medicaid for the case-mix states. Medicare is Federal – states have no "say" in that.

23. Is section "G" going away completely?

Not for a couple of years anyway! That was the plan with the draft MDS 3.0 v1.18 Item Set however it did not allow the Medicaid case-mix states to calculate reimbursement. With all of us working feverishly with COVID, CMS pulled back v1.18. We will not see an updated MDS 3.0 version (the middle number, if you will in the version identification) for 2 full fiscal years after the end of the declared PHE. Section G will be around for a bit longer.

24. If I am not a Case Mix State, should I expect no changes coming October 1st? I live in MI.

Beyond the version identification of the MDS Item Set you are completing/submitting being v1.17.2, you will not have any changes to manage.

25. For supportive documentation for GG for OBRA, will we need to have GG Huddle notes?

Huddle notes will help the MDS Coordinator or clinician completing Section GG to properly encode those items, but they are not usually part of the permanent resident record as they tend to include notes for multiple residents. Do you use flowsheets?

26. What do you recommend if CNAs charting on GG or G is not accurate during your lookback period?

The first thing you will want to do is interview and coach the CNA on accurate recording of assistance/interaction with the resident to ensure future, accurate charting. Work with the CNA to model the activity and how it would be coded. Do not allow caregivers to copy from previous documentation as that skews the actual identification of resident functioning. Audit periodically to ensure accurate representation of assistance.

27. Section G still has no impact on Medicare Part A PDPM, correct?

You are correct.

28. Is Florida moving to OBRA or PDPM? I did not see that one on your list.

Florida, to my current knowledge, is not a Medicaid case-mix reimbursement state.

29. Can extra quarterlies be done for case mix purposes?

I have no reason to believe that they cannot still be done going forward from October, especially if your state allows that now. If in doubt, check with your state RAI Coordinator.

30. How do you recommend capturing section GG information?

If you mean capturing for documentation purposes, flowsheets with the items/functions to be evaluated work great, especially with references to what is to be evaluated – the definitions and codes. If you mean how to obtain the Section GG information, it will take a team. This is what is found on GG-10, Section 3 of the RAI Manual: "CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period." Also:

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Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

I recommend that you gather your team now – before October 1 – to review what you need to put in place to start Section GG observation. Practice now with your team – you won't actual code GG on the current MDS' but provide the experience of gathering the data for a few of the residents you currently care for. Licensed nurses should definitely be involved. If you have therapists on your staff, enlist their assistance – you're lucky. If you have contract therapists, speak to them about assisting with GG item evaluation. Remember too the coding for GG – some residents cannot or have not negotiated stairs – there is a code for those kinds of situations. 09 = not applicable, not attempted and resident did not do this before; 10 = not attempted because of environmental limitations (lack of equipment, weather issues); and 88 = not attempted due to medical condition or safety concerns. There is literally a code for every scenario for Column 1 so you should be able to code and not dash (-) those fields.

You can also view the on-demand recording for 2 great Section GG webinars – see Slide #25 for that info. There are some great tips within those resources.

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31. Where do you find CMS "expected" self-care & mobility score?

Expected scores are calculated by CMS upon acceptance of the 5-day assessment. You can find out more information about it in the SNF QRP Measure Calculations and Reporting User's Manual. The logistic regression covariates and their coefficients for calculating the expected score can be found in the appendices.

For SimpleLTC customers, your CMS expected self-care and mobility scores are automatically calculated and located under the Function Scores tab in SimpleAnalyzer™.

32. How does CMS determine the functional score? what is this based on?

That I can't answer in a concise manner! I encourage you to review this Fact Sheet: PDPM Patient Classification (ZIP). You'll find it at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM. It is a 5-page Fact Sheet that is easy to follow.

33. Which 3 days should be used in the look back for Section GG OBRA?

The ARD (Assessment Reference Date) + the 2 days immediately prior to the ARD are your observation/look-back days for OBRA assessments.

34. Our facility does not have Medicaid billing. Does that mean the annual OBRA will not require the extra GG coding?

Correct. If you do not have Medicaid beneficiaries in your facility and your state is not a Medicaid case-mix state, you will not code GG0130, GG0130, I0020 and J2100 on OBRA assessments.

35. Is the ICD PDPM mapping a zip file? I can't access it.

It is indeed a .zip file:

- FY 2021 PDPM ICD-10 Mappings (ZIP)

. Ask your IT or someone in the Business Office for assistance with accessing/unzipping that file.

36. Is pain still part of QMs?

It is. Check it out at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-USERS-MANUAL-v121.pdf.

37. If your state is undecided, does education/training need to be done just in case? Also, who do we contact to try and get a response on their decision? I've sent emails and tried calling several times but for Kansas have not been getting any responses from anyone.

I hear you – it is tough sometimes to get a response. CMS has stated that states will be notifying their facilities as to their decision on case-mix so watch for such notification. You could also contact your State RAI Coordinator or MDS Automation Coordinator (you'll find the most current Appendix B with those individuals identified at: https://www.cms.gov/files/document/appendix-b-08272020.pdf); you could also contact your state's Medicaid agency. Lastly, your EMR/EHR vendor may have that information. I would wait to do any training until you know what Kansas decides to do – to avoid confusion for your staff.

38. Can you share the two links on the I2000 page? It had to do with case mix and PDPM tracking.

I would be happy to!

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM is the landing page for PDPM. On that same page, scroll down the page to PDPM resources where you'll find this:
FY 2021 PDPM ICD-10 Mappings (ZIP)

39. I am in Washington State. Anything changing for us?

The state of Washington is a Medicaid case-mix state. WA has chosen to use PDPM for calculation of Medicaid reimbursement.

40. If the state is using PDPM or reviewing the PDPM vs CMI to decide, they would not be able to have RTP for primary, correct? Otherwise, the PDPM HIPPS will not calculate accurately... I will be very surprised if they allow RTP for primary due to this reason.

I think that as well! Please reference my answer to Question #12. Waiting for answers aren't we.

41. Can you please some of your thoughts about Generalized weakness for part B of skill?

Part B works a bit differently than does Part A Skilled. Generalized weakness was typical verbiage many years ago. Without knowing any details, there is likely a more specific diagnosis(es) to qualify therapy intervention.

42. How about if resident LTC for hernia repair, will it count if he comes back after 3 days? Can I code it?

I am not entirely certain what your asking. I will base my reply on the assumption you are asking about major surgery. Go back and review Slides #30 and #31; also, the RAI Manual, pages J-35 through J-37. You can code the hernia repair if it meets those definitions.

43. Would states be possibly different for their opinion for surgeries?

I would not think there would be a difference of opinion between states. The Feds (aka RAI Manual) are pretty specific about what qualifies for major surgery. I cannot see an individual state changing that guidance.

44. If the BIMS or PHQ9 is completed late or signed off in Z0400 after the ARD, how is this viewed in Medicare post payment audit? Especially if it impacts the SLP and Nursing CMG.

Neither would be considered part of the PDPM calculation if it is not encoded on the target MDS and done prior to the ARD. Nothing should be coded on the MDS Item Set after the ARD.

45. When it was an unplanned discharge in the past, it would not allow staff assessment. Do we need to do it no matter what time of day or night they discharge?

That is always a tough one as unplanned discharge is just that – something usually serious happens and the resident needs to return to the hospital or leaves your facility suddenly. Also depends on the type of discharge.

If the discharge is a standalone discharge, the resident interview items will be skipped and the staff assessment for cognition will be required.

If the OBRA discharge is combined with either an OBRA or PPS MDS, the answer is different. From the instructions in the RAI Manual, if the resident interview was not completed for a resident who was not rarely/never understood, the gateway question (C0600) about whether the resident interview should be conducted should be answered Yes (1). All items would then be dashed. The staff assessment cannot be done.

46. Just clarifying, the interview must be the day of or the day before the ARD for PHQ9 and BIMS?

The RAI Manual used to say that "out loud" however in the current manual, the only reference to that is found on Section J, Page J-8 (Pain Interview): "The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period."

47. **I understand why we do the resident interviews. Unfortunately, I have noticed that residents have memorized the BIMS. I have had a resident score perfect on the actual BIMS but if I change the words they cannot remember. Has this been brought up before?**

    You bet it has!! Residents are really smart – I've had them parrot back those 3 words before I finished asking the question – sometimes when I walked in their room! That was precisely one of the reasons behind CMS reducing the frequency of such interviews with PPS assessments 2 or 3 years ago. I would encourage you to NOT change the words you use within the BIMS interview – I do not believe CMS or any surveyor would approve! Interviews must be conducted consistently.

48. **If the person interviewing is different from the staff that encodes the information on the MDS, can the staff encoding sign off the accuracy of the interview information in Z0400?**

    See my answer (1st paragraph) to Question #61.

49. **Isn't it a recommendation that we do the interview the day before or day of ARD? We do have the 7 day look back to complete, don't we?**

    Please reference my answer to Question #61.

50. **For coding isolation, if they have one day that meets all 4 of those criteria in the lookback, can I code isolation?**

    Absolutely! Code away – it counts if it is during the look-back period.

51. When talking about training others such as CNAs, I thought many of the interviews required certain training. For example, PHQ9 and BIMS requires person to be an SSD or Nurse and Pain had to be a Licensed Nurse. Is that correct?

It is not. CMS does not specify who can conduct resident interviews. The person conducting any of the interviews should review and follow the guidance provided in the RAI manual.

52. For isolation, active infection is the actual positive COVID test with s/s of infection, right?

Correct + the remaining 3 items = ability to code isolation. Reference Slide #35 for all four qualifiers.

53. If the roommate of the COVID resident was discharged during the look-back period, can you code isolation? Does the resident have to be in the room by themselves during the 14-day look-back period?

The resident must be alone in the room is one of the four qualifiers to code isolation on the MDS. If that is the case and all four qualifiers are met, you will code isolation. See Slide #35.

54. How long does the resident need to be in the single room to pick up for Isolation?

Please reference my answer to Question #53 above.

55. I thought major surgery is 100 days not 30 as stated in the handouts. Can you please clarify?

J2000 (Prior Surgery) is 100 days:

J2000. Prior Surgery - Complete only if A0310B = 01	
Enter Code ☐	Did the resident have major surgery during the **100 days prior to admission**? 0. **No** 1. **Yes** 8. **Unknown**

J2100 – major surgery – is 30 days prior to admit to SNF:

Coding Tips

- *Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:*
  1. *the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF),* ***and***
  2. *the surgery carried some degree of risk to the resident's life or the potential for severe disability.*

56. If a resident is exposed to staff that tests positive, are you able to put on skilled for 14 days observation?

In order to skill a resident, they must be receiving a skilled service or meet presumption of care. Here's a link to review administrative presumption of care: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_AdminPresumption_v6_508.pdf.

57. What if your building is not Medicaid certified but you are in a case mix state?

I have not run into that, but I am fairly certain that you would not be encoding GG0130, GG0170, I0020 and J2100. Please contact your state RAI Coordinator or your state Medicaid agency for confirmation of that.

58. Regarding coding Isolation in section O, and 1, 2, 3, and 4 are met...however, they require Dialysis and need to go out of facility to receive Dialysis. Then Isolation may not be coded?

Correct. Check out Slide #35: The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

There is specific guidance (in the October 2019 RAI User's Manual) for coding isolation on the MDS for a dialysis patient receiving services outside the LTC facility:

> If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

If that resident is in isolation, per MDS guidelines found on page O-5 *and you're following the CDC guidelines for transport of patients with communicable disease*, you may code isolation on the MDS. Remember that this resident must have all other services (beyond dialysis) in his/her room and must not have a roommate.

59. If a resident comes in under Medicare part A, generally we would combine an Admission and 5-day MDS. Will they have to be separated starting 10/1 due to the different look back windows for GG for the 5 day and the Admission?

No, you can continue to combine the Admission with the 5-day as appropriate.

60. Will we have to go through and recode LTC primary codes to fit a PDPM category?

Good question. That is one of the questions I have posed to CMS and a couple of state RAI Coordinators. No answer yet. Hopefully, the states will provide answers pretty quickly so we're ready to hit the ground running on October 1st.

61. Our therapy department has been doing the interviews on the day of admission. Does another interview need to be completed either the day of or the day after ARD?

The interviews should never be done after the ARD. The ARD ends the observation and data collection period and thus the interview would not be valid after the ARD. The date to be entered in Z0400 to attest to the accuracy of those interviews should be the actual date the interviews were conducted.

CMS has long maintained that resident interviews should be the conducted the day before or the day of the ARD – those 2 days are the last of the general 7-day observation period (pain is 5 days). You can certainly do the interviews on the day of admission if you are opening and encoding a 5-day PPS assessment. When you get to the OBRA Admission Assessment (required by day 14 of the stay), your resident's Mood, Cognition and Pain could be very different from the day of admission. The look-back period provides for the snapshot of the resident during that period.

62. I noticed this was being recorded, may we be able to view that?

You can! Watch the recording here. Handouts are also available there as well as this FAQ document.

63. The RAI manual says on or before the ARD for BIM's and PHQ-9. This is a 7 day look back. Will there ever be a final rule to be more specific? For example, therapy (ST) does the BIM's on day 2 of the stay. However, it is in the 7 day look back. Just not on or day before ARD.

I encourage you to also review my answer to Question #61.

64. For Pennsylvania, since not beginning until after Jan 1, does that mean additional PDPM questions will not be required when completing OBRA MDS until that time?

You are correct!

66. **I am in Pennsylvania. It Is my understanding that since PA is not starting PDPM until Jan 1 at the earliest, that we won't be filling in the additional sections GG etc. that are in the update for OBRA comprehensives or quarterlies until that time. Can you please clarify?**

    Please see my answer to Question #64 above.

67. **Do you happen to know if CA will be moving forward with adding section GG to the OBRA assessments that are not combined with an admission assessment?**

    California is not a Medicaid case-mix state so they will not utilize Section GG for OBRA assessments. That is what I know to date.