CH.	Sect.	Pg.	December 2008 Revision
NA	Title Page	NA	Change the revised date to December 2008
CH 2	2.5	2-27	In the asterisk note below the table, delete the phrase, "or transfers to another facility" in the first sentence. Delete the third sentence, "~~Otherwise, the days will be paid at the default rate~~." *If a resident expires ~~or transfers to another facility~~ before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. ~~Otherwise, the days will be paid at the default rate.~~ The Assessment Reference Date must also be adjusted to no later than the date of discharge.
CH 2	2.5	2-29	In the table, "Medicare MDS Assessment Schedule for SNFs", remove the words "transfer or" from the first row on 5DAY AA8b = 1 AND Readmission/Return AA8b = 5 under Special Comment. • See Section 2.9 for instructions involving beneficiaries who ~~transfer or~~ expire.
CH 2	2.5	2-29	In the table, "Medicare MDS Assessment Schedule for SNFs", remove the words, "is completed" from the Significant Change in Status Assessment (SCSA), Special Comment. • Could establish a new RUG Classification and remains effective until the next assessment ~~is completed~~ as long as the resident continues to require a SNF level of care.
CH 2	2.6	2-31	In subsection # 8, insert the word "all" in the first sentence before "therapy." 8. Other Medicare-Required Assessment – The OMRA is completed only if the resident was in a RUG Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of all therapy.
CH 2	2.9	2-37	In the first subsection title, remove "~~or Transfers~~" and replace with "or is Discharged". Remove the two paragraphs below and replace with the following text: "If the beneficiary dies or is discharged before the eighth day of covered SNF care following the initial admission from the qualifying three-day hospital stay, a SNF must prepare an RAI as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no RAI is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code. A stay of less than eight days

CH.	Sect.	Pg.	December 2008 Revision
			that does not meet these requirements requires the completion of an MDS to receive payment; the SNF cannot bill the default code." Resident Expires ~~or Transfers~~ or is Discharged ~~If the SNF transfers a beneficiary or the beneficiary expires before the eighth day of covered SNF care within a benefit period a SNF must prepare a Medicare assessment as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no Medicare assessment is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code.~~ ~~In instances where the beneficiary is transferred and then returns to a SNF to continue receiving covered SNF services within the same benefit period, and the total number of covered days used by the beneficiary is less than 8 days out of the potential 100 (including the covered days previously utilized), the SNF may choose not to complete a Medicare assessment and instead submit a claim using the HIPPS default rate code. However, if the covered stay upon admission/readmission exceeds 8 days within the same benefit period the SNF shall not bill the default rate code, but shall complete a Medicare assessment to be paid. In these situations, if no Medicare assessment is completed, no payment will be made.~~ "If the beneficiary dies or is discharged before the eighth day of covered SNF care following the initial admission from the qualifying three-day hospital stay, a SNF must prepare an RAI as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no RAI is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code. A stay of less than eight days that does not meet these requirements requires the completion of an MDS to receive payment; the SNF cannot bill the default code."
CH 2	2.9	2-39	In subsection, "Non-Compliance with the Assessment Schedule", insert "that have an ARD prior to the date of discharge" in the first sentence preceding the word "will". According to the Part 42 of the Federal Regulation (CFR) section 413.343, assessments that fail to comply with the

CH.	Sect.	Pg.	December 2008 Revision
			assessment schedule that have an ARD prior to the date of discharge will be paid at the default rate.
CH 3	I2j	3-136	Into the first paragraph following the third sentence, insert, "The attending physician should determine the level of 'significant laboratory findings' and whether or not a culture should be obtained." Urinary Tract Infection – Includes chronic and acute symptomatic infection(s) in the last 30 days. "Symptomatic" refers to both chronic and acute infections; if symptoms are not present, do not code this item. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. The attending physician should determine the level of 'significant laboratory findings' and whether or not a culture should be obtained. For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the ITI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.
CH 3	O1	3-177	Add to the bullet points under Clarifications the following: ♦ In the event that information on IV medication additive(s) is not available, do not count as a medication in Section O1, and code P1ac with a dash.
CH 3	P1ac	3-182	Add to the bullet points under Clarifications the following: ♦ In the event that information on IV medication additive(s) is not available, P1ac should be coded with a dash.
CH 3	P1b	3-185	In the first paragraph of the section, add the following to the end of the sentence, "following an initial evaluation upon admission or readmission." Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision) following an initial evaluation upon admission or readmission.

CH.	Sect.	Pg.	December 2008 Revision
CH 3	P1b	3-186	Remove the last sentence from the first bullet under "Coding Minutes of Therapy". Replace with, "If a resident returns from a hospital stay, count only those therapies that occurred since readmission to the facility based upon the initial evaluation performed post-readmission." • Includes only therapies that were provided once the individual is actually living/being cared for at the facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. ~~If a resident returns from a hospital stay and a readmission assessment is done, count only those therapies that occurred since readmission to the facility.~~ If a resident returns from a hospital stay, count only those therapies that occurred since readmission to the facility based upon the initial evaluation performed post-readmission.
CH 3	T1b	3-215	In the section, "Ordered Therapies", insert the following into the Intent subsection: "following the initial evaluation" in the first sentence after the bracketed language. Intent: To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] following the initial evaluation during the early days of the resident's stay.
CH 3	T1b	3-216	In the section, "Ordered Therapies", insert "based upon the initial evaluation" after the word "therapies" in second paragraph in the "Process" subsection. At the end of the last sentence of that paragraph insert, "based upon the initial evaluation and subsequent treatment plan." If the resident is scheduled to receive at least one of the therapies based upon the initial evaluation, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A based upon the initial evaluation and subsequent treatment plan.

CH.	Sect.	Pg.	December 2008 Revision
CH 3	T1c	3-216	In the section, "Estimate of Number of Days (Through day 15)" under "Coding", insert the following to the first sentence: "based upon the initial evaluation and subsequent treatment plan". At the end of the third sentence, insert "based upon the initial evaluation and subsequent treatment plan." Coding: Estimate the Number of Days – Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission based upon the initial evaluation and subsequent treatment plan. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number of days through day 15, even if the resident is discharged prior to day 15, based upon the initial evaluation and subsequent treatment plan.
CH 5	5.1	5-1	Replace the Internet address in the first paragraph with the following: http://www.cms.hhs.gov/mds20swspecs/01_overview.asp Every state agency is equipped with the standardized computer hardware and data management software system to electronically receive MDS data from all Medicare and Medicaid nursing facilities. After completion of the required assessments and/or tracking forms, each nursing facility must create an electronic transmission file that meets the requirements detailed in the current MDS Data Specifications available at ~~http://www.cms.hhs.gov/medicaid/mds20/mdssoftw.asp~~ http://www.cms.hhs.gov/mds20swspecs/01_overview.asp

	Appendix	Page	December 2008 Revision
	B	B-3	Update contact information for MDS RAI Coordinators for the following states: Alaska, Kansas, Minnesota and Pennsylvania.
	B	B-6	Update contact information for MDS RAI Automation Coordinators for the following states: Alaska, Minnesota and Oregon.

2.5 The SNF Medicare Prospective Payment System Assessment Schedule

Nursing facilities will assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care. The MDS must be completed in compliance with the Medicare schedule as shown in the chart below.

Medicare MDS Assessment Type	Reason for Assessment (AA8b code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 Day	1	Days 1-5*	6 - 8	14	1 through 14
14 Day	7	Days 11-14	15 - 19	16	15 through 30
30 Day	2	Days 21-29	30 - 34	30	31 through 60
60 Day	3	Days 50-59	60 - 64	30	61 through 90
90 Day	4	Days 80-89	90 - 94	10	91 through 100

*If a resident expires before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. The Assessment Reference Date must also be adjusted to no later than the date of discharge.

+Grace Days: A specific number of grace days (i.e., days that can be added to the Medicare assessment schedule without penalty) are allowed for setting the Assessment Reference Date (ARD) for each scheduled Medicare assessment.

The Medicare assessment schedule includes a 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessment. The first day of Medicare Part A coverage is considered Day 1. In most cases, the first day of Medicare Part A eligibility is also the date of admission. However, there are situations where the Medicare beneficiary may only become eligible for Part A services at a later date. See Section 2.9 for more detailed information.

Assessments must also be completed whenever there is a significant change in clinical status or when all therapies are discontinued for a beneficiary who is classified in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group, and that beneficiary continues to require skilled services.

A Readmission/Return assessment must be completed when a beneficiary who was receiving Part A SNF-level services is hospitalized and returns to the SNF and continues to receive Part A SNF-level services.

Assessments performed solely for Medicare payment purposes must be completed within 14 days of the Assessment Reference Date (ARD). The Assessment Reference Date establishes a common reference end-point for all items. The Assessment Reference Date is described in detail in Chapter 3. Nursing facility staff should make every effort to complete assessments in a timely

MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE PERIOD DAYS ARD can also be set on these days	BILLING CYCLE Used by the business office	SPECIAL COMMENT
5 DAY AA8b = 1 AND Readmission/ Return AA8b = 5	Days 1-5	6-8	Set payment rate for Days 1-14	• See Section 2.9 for instructions involving beneficiaries who expire. • RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA.
14 Day AA8b = 7	Days 11-14	15-19	Set payment rate for Days 15-30	• RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment. • Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment.
30 Day AA8b = 2	Days 21-29	30-34	Set payment rate for Days 31-60	
60 Day AA8b = 3	Days 50-59	60-64	Set payment rate for Days 61-90	
90 Day AA8b = 4	Days 80-89	90-94	Set payment rate for Days 91-100	• Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment.
Other Medicare Required Assessment (OMRA)	• 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Set payment rate effective with the ARD	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Not required if the resident is dis-charged from Medicare prior to day 8. • Not required if not previously in a RUG Rehabilitation Plus Extensive Services or Rehabilitation group
Significant Change in Status Assessment (SCSA)	Completed by the end of the 14th calendar day following determination that a significant change has occurred.	N/A	Set payment rate effective with the ARD	• Could establish a new RUG Classification and remains effective until the next assessment as long as the resident continues to require a SNF level of care.

***NOTE:** Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

4. **Medicare 90-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 80-89 of the SNF stay. The ARD (Item A3a) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). (NOTE: When combined with an OBRA Quarterly assessment, see Section 2.2).

5. **Medicare Readmission/Return Assessment** - Medicare assessment that is completed when a resident whose stay was being reimbursed by Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (Item A3a) established between days 1-8 of the return. The Readmission/Return assessment must be completed (Item R2b) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

6. **Other State-Required Assessment – This assessment is not used for Medicare purposes.** In some cases, States have established assessment requirements in addition to the OBRA and Medicare assessments. Contact your RAI Coordinator for State specific requirements.

7. **Medicare 14-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (Item R2b) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission. (NOTE: When combined with an OBRA Admission assessment, see instructions in Sections 2.2 and 2.8.)

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8. **Other Medicare-Required Assessment** - The OMRA is completed only if the resident was in a RUG Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of all therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG group and Medicare payment rate. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

assessment. The ARD must also be set within the proper window for the Medicare requirement. Then the facility must decide which form to complete.

- If the State requires only a two page or RUG-III Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, either a full MDS or MPAF would be completed. The full MDS or MPAF is the more extensive MDS form; the most stringent requirement must be met.
- If the State requires a full assessment for a Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, a full MDS form must be completed. It is the more extensive MDS form; the most stringent requirement must be met.

NOTE: It is extremely important to understand the MDS requirements established in your state. Your decision to use the MPAF may be dependent upon your State Medicaid agency's MDS assessment requirements and the State-designated Quarterly assessment.

For a resident who was already in the nursing facility but is now beginning a new Medicare Part A stay, it might be appropriate to combine a Quarterly with a Medicare 5-Day, depending on the resident's status.

A Significant Change in Status assessment might be combined with any Medicare assessment including an OMRA, presuming that the ARD is within the assigned Medicare assessment window and the assessment is completed within 14 days of the identification of the change. At all times, when the nursing facility chooses to complete one assessment to meet both an OBRA and a Medicare requirement, staff must carefully review the standards for each assessment to assure that the most stringent requirement is met.

2.9 Factors Impacting the SNF Medicare Assessment Schedule

Resident Expires or is Discharged

If the beneficiary dies or is discharged before the eighth day of covered SNF care following the initial admission from the qualifying three-day hospital stay a SNF must prepare an RAI as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no RAI is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code. A stay of less than eight days that does not meet these requirements requires the completion of an MDS to receive payment; the SNF cannot bill the default code.

Resident Discharges to Hospital Prior to the Admission Assessment Completion

Since the Admission assessment was not completed, the facility must complete a Discharge Tracking form with a reason for assessment A8a = 8, discharged prior to completion of admission assessment. In most cases, the facility will have completed a 5-Day Medicare assessment covering the period from the date of admission to the earlier of the Assessment Reference Date (which can be assigned up through day 8 of the Part A stay) or the actual date of discharge. This Medicare assessment will be needed to bill for Part A days.

window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as AA8a = 3 and AA8b = 8, Other Medicare Required assessment.

Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the nursing facility provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of a physician hold could occur when a resident is admitted to the nursing facility for rehabilitation services but is not ready for weight-bearing exercises. The physician will write an order to start therapy when the resident is able to do weight bearing. Once the resident is able to start the therapy, the Medicare Part A stay begins, and the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the resident is able to start therapy services.

Combining Assessments

Significant Change in Status Assessment (SCSA) or the Other Medicare Required Assessment (OMRA) may be combined with the regularly scheduled Medicare assessments. If the Medicare assessment window coincides with the SCSA assessment, a single assessment may be coded as both a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and an SCSA. If the Assessment Reference Date of an OMRA coincides with a regularly scheduled Medicare assessment, it is coded only as the OMRA. For billing purposes, it is identified as an OMRA replacing a 14-Day, 30-Day, 60-Day or 90-Day.

Currently there is no way to code that a SCSA performed outside the assessment window is a Medicare assessment. Until this problem can be corrected, code AA8a = 3 to show the SCSA and AA8b = 8 to indicate that the record is a Medicare assessment.

Non-Compliance with the Assessment Schedule

According to the Part 42 Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule that have an ARD prior to the date of discharge will be paid at the default rate. Frequent early or late assessment scheduling practices may result in onsite review. The default code takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level or BC1, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early Assessment

An assessment should be completed according to the designated Medicare assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

j. Urinary Tract Infection - Includes chronic and acute symptomatic infection(s) in the last 30 days. "Symptomatic" refers to both chronic and acute infections; if symptoms are not present, do not code this item. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. The attending physician should determine the level of 'significant laboratory findings' and whether or not a culture should be obtained. For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

k. Viral Hepatitis - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.

l. Wound infection - Infection of any type of wound (e.g., postoperative; traumatic; pressure) on any part of the body.

m. ***NONE OF ABOVE***

Process: Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS.

Physician involvement in this part of the assessment process is crucial.

Clarifications:

- If a dietary supplement, given to a resident between meals, has a vitamin as one of its ingredients, code it as a dietary supplement, *not* as a medication.

  Coding Examples:

  - If a resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).
  - If a resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code (K5f = check) for dietary supplement between meals.
  - The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Section K., Oral Nutritional Status. Medications, such as electrolytes, vitamins, or insulin, which have been added to the TPN solution, are considered medications and should be coded in this section.

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted in this item. These substances may be coded at MDS Item K5f, provided they meet the definition of dietary supplement for this Item. Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications. More information on dietary supplements identified by the FDA can be found at the following web site: **http://www.nih.gov/health**.

- All medications used by the resident in the 7-Day assessment period need to be counted in Section O. All medications administered off-site (e.g., while receiving dialysis or chemotherapy) must be considered when completing this item. The facility is responsible for communicating with the outpatient site to identify the use of any medications received while the resident was under their care, and for monitoring the effect, including any adverse effects, of medications after the resident's return to the facility.

- Combination products such as Corzide (which contains a diuretic and a beta-blocker) are counted as one medication.

- In the event that information on IV medication additive(s) is not available, do not count as a medication in Section O1, and code P1ac with a dash.

- Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation. It should be counted at MDS Item O1 (Number of Medications), and if it was initiated during the last 90 days, it should also be indicated at MDS Item O2 (New

SECTION P.
SPECIAL TREATMENTS AND PROCEDURES

P1. Special Treatments, Procedures, and Programs

Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.**

a. SPECIAL CARE (14-day look back)

TREATMENTS - The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc.

Definition:

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

b. Dialysis - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

c. IV Medication - Includes any drug given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy. In the event that information on IV medication additive(s) is not available, P1ac should be coded with a dash.

b. THERAPIES (7-day look back)

Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision) following an initial evaluation upon admission or readmission.

The licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.

Intent: To record the **(A) number of days**, and **(B) total number of minutes** each of the following therapies was administered to residents (for at least 15 minutes a day) in the last 7 days.

Definition:

a. **Speech-Language Pathology, Audiology Services** - Services that are provided by a licensed speech-language pathologist.

b. **Occupational Therapy** - Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed occupational therapist.

c. **Physical Therapy** - Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.

d. **Respiratory Therapy** – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.") A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act.

e. Psychological Therapy - Therapy provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric Technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the State does not license a certain category of professionals working in your facility, you may not count the services of those unlicensed therapists in this item.

Process: Review the resident's clinical record and consult with each of the qualified therapists.

Coding: **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days, even if you entered "0" in Box A (e.g., less than 15 minutes of therapy provided). The time should include only the actual treatment time (not time waiting or writing reports). Enter "0" if none.

A therapist's initial evaluation time may not be counted, but subsequent evaluations, conducted as part of the treatment process, may be counted.

Clarifications: **Coding Minutes of Therapy:**

- Includes only therapies that were provided once the individual is actually living/being cared for at the facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. If a resident returns from a hospital stay count only those therapies that occurred since readmission to the facility based upon the initial evaluation performed post-readmission.

- If a whirlpool treatment is specifically ordered by a physician to be performed by or under the supervision of a physical therapist, it may be coded as therapy.

- Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded in Item P1b when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should not be coded as therapy, even when performed by therapists.

- Qualified professionals for the delivery of respiratory services include "**trained nurses**." A trained nurse refers to a nurse who received specific

Intent: To record the **(A) number of days** and **(B) total number of minutes** recreation therapy was administered (for at least 15 minutes a day) in the last 7 days.

Definition: **Recreation Therapy** - Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

Process: Review the resident's clinical record and consult with the qualified recreation therapists.

Coding: **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes recreational therapy was provided in the last seven days. The time should include only the actual treatment time (not resident time waiting for treatment or therapist time documenting a treatment). Enter "0" if none.

b. ORDERED THERAPIES (first 14 days)

Skip these items unless this is a Medicare 5-Day assessment or a Medicare Readmission/Return assessment.

Coding: **Ordered Therapies** – Code "1", Yes, if the physician has ordered any of the following therapy services to begin in the first 14 days of the stay – physical therapy, occupational therapy, or speech pathology services. If No, enter "0" and skip to T2.

Intent: To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] following the initial evaluation during the early days of the resident's stay. Often therapies are not initiated until after the end of the observation assessment period. For the Medicare 5-Day or Readmission/Return assessment, this section provides an overall picture of the amount of therapy that a resident will likely receive through the fifteenth day from admission.

Process: For Item T1b: Review the resident's clinical record to determine if the physician has ordered one or more of the medically necessary therapies to begin in the first 14 days of stay. Therapies include physical therapy (PT), occupational therapy (OT), and/or speech pathology services. If not, skip to Item T2. If orders exist, consult with the therapists involved to determine if the initial evaluation is

completed and therapy treatment(s) has been scheduled. Skip to Item T3 if the therapy evaluation is not completed, or the evaluation is completed but no treatment is scheduled.

If the resident is scheduled to receive at least one of the therapies based upon the initial evaluation, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A based upon the initial evaluation and subsequent treatment plan.

c. ESTIMATE OF NUMBER OF DAYS (Through day 15)

Coding: **Estimate of Number of Days** - Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission based upon the initial evaluation and subsequent treatment plan. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number or days through day 15, even if the resident is discharged prior to day 15, based upon the initial evaluation and subsequent treatment plan. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

Clarifications:

- ♦ Do not count the evaluation day in the estimate number of days unless treatment is rendered.
- ♦ When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered.
  For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7.

d. ESTIMATE OF NUMBER OF MINUTES (Through day 15)

Coding: **Estimate of Number of Minutes** - Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission. Include the number of minutes already provided from MDS Items P1ba(B), P1bb(B), and P1bc(B). Calculate the expected number of minutes through day 15, even if the resident is discharged prior to day 15.

Clarification:

- ◆ Do not include evaluation minutes in the estimate of number of minutes.

CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Long-term care nursing facilities are required to submit MDS records for all residents in Medicare or Medicaid certified beds regardless of the pay source. Skilled nursing facilities are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF PPS.

5.1 Transmitting MDS Data

Every State agency is equipped with the standardized computer hardware and data management software system to electronically receive MDS data from all Medicare and Medicaid nursing facilities. After completion of the required assessments and/or tracking forms, each nursing facility must create an electronic transmission file that meets the requirements detailed in the current MDS Data Specifications available at **http://www.cms.hhs.gov/mds20swspecs/01_overview.asp**.

In addition, nursing facilities must be certain they are submitting MDS assessments under the appropriate authority. There must be a Federal and/or State authority to submit MDS assessment data to the standard MDS system. The software used by nursing facilities should have a prompt for confirming the authority to submit that record.

The facility indicates the submission authority for a record in a field labeled SUB_REQ.

- **Value = 3** Indicates that the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.
- **Value = 2** Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or Medicaid requirements, to collect MDS information for residents on this unit.
- **Value = 1** Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for all residents on this unit. Note that if a record is submitted with SUB_REQ = 1, then that record will be rejected and all information concerning the record will be purged.

Nursing facilities must establish communication with the State MDS database in order to submit a file. This is accomplished by using specialized communications software and hardware and the Medicare Data Communication Network (MDCN). Details about these processes are available at the following web site: **http://www.qtso.com/mdsdownload.html**.

Once communication is established, the nursing facility can access the State's CMS MDS Welcome Page in the MDS system. This site allows nursing facilities to submit MDS assessment data, receive various reports, including the validation reports for the submitted MDS data, and access various

APPENDIX B

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RESPONSIBLE FOR ANSWERING RAI QUESTIONS

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