Nursing Facility Forum Call

Case Mix Team / Office of MaineCare Services
November 2019

NF Forum Call 11/7/19

Agenda

- Welcome
- HIPAA reminders
- Resources
- Review of MDS 3.0 questions and answers
- Snippet training: MDS: The Mini-Series
- Announcements
- Upcoming training

NF Forum Call 11/7/19: HIPAA

HIPAA Reminder:

When sending email, please do not include **any** identifying information. This table was developed by the federal Department of Health and Human Services gives definitions of 18 examples of identifying information.

(A) Names	
(B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000	
(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older	
(D) Telephone numbers	(L) Vehicle identifiers and serial numbers, including license plate numbers
(E) Fax numbers	(M) Device identifiers and serial numbers
(F) Email addresses	(N) Web Universal Resource Locators (URLs)
(G) Social security numbers	(O) Internet Protocol (IP) addresses
(H) Medical record numbers	(P) Biometric identifiers, including finger and voice prints
(I) Health plan beneficiary numbers	(Q) Full-face photographs and any comparable images
(J) Account numbers	(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and
(K) Certificate/license numbers	

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If you need to send a portion of an MDS record:

- Fax is preferred over email.
- If you must email, send via encrypted email and password protected document.

OR

- Black out all identifying information such as name, social security number, DOB, etc. It is acceptable to refer to a resident as #1, #2, according to a list of residents left during a case mix review.
- If you mail information, please label as confidential and identify the person to whom it is being sent.

For more information see the full guidance at the link below:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html

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This is a link to gain access to SNF QRP Training materials:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html

There is a link for CMS YouTube video on GG0130A. This 6-minute video demonstrates how to distinguish between Code 05, set-up or clean-up assistance and Code 04, supervision or touching assistance when coding GG0130A. Eating.

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This is a link to a FREE PDPM diagnosis tool that may help you decide what ICD-10 code to enter: https://www.simpleltc.com/free-pdpm-diagnosis-tool/

Instructions (from website): Type part of a diagnosis code into the search box and press Enter. Explore the color-coded tags for billable status and comorbidities. Use the buttons to specify NTA/SLP Comorbidities or Surgical Eligibility. Mouse over diagnoses to explore diagnosis synonyms.

Use this link above to access a YouTube play list of all the video presentations from the SNF QRP Training in August 2019: https://www.youtube.com/playlist?list=PLaV7m2-zFKpjqsEJsU2ymyvQUcx6ehKoN

The link is on the SNF QRP Training page.

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This link is a free PDPM calculator using in the current CMS base rates for each payment category: https://www.broadriverrehab.com/pdpm-calc

It might be useful in determining if you should complete an IPA.

Here is a link to another free PDPM calculator: https://sas.ltcwebware.com/billingsystemv2.0/pdpm_worksheet.php

Here is a link to a free PDPM rate calculator using in the current CMS base rates for each payment category: https://pdpm-calc.com/patients/1/state

It might be useful in determining if you should complete an IPA.

Note: There is another rate calculator in the downloadable files in the lower right hand corner.

NF Forum Call 11/7/19: Questions and Answers

Questions, Questions, Questions …
and Answers

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Section S

Question:

For a Section S6200 hospital stay, can we use the initial hospital stay that brings them to our building? We usually put a 0 in S6200, but other coordinators code the qualifying hospitalization.

If a resident goes to the hospital after admission to our building and then returns, we count that as a hospital stay. What is correct?

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Answer:

The initial hospital stay that lead to the SNF/NF stay is not counted in Section S. Only hospital admissions after the resident has been admitted to your facility would be coded at S6200.

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Section A

Question:

One of our NF residents was hospitalized on October 5, 2019, had qualifying stay until October 9, 2019, and returned to us for Medicare skilled care. Before his hospitalization, his 180 day, 2nd quarterly, (ARD October 6, 2019) had been opened and initiated, but not completed after it was determined he would be in the hospital for a while. He returned to receive skilled care and was D/C from Medicare Part A on October 25, 2019 to continue receiving LTC services again. What appropriate subsequent quarterly assessment was expected (180 day or 270?) and on what date do I base this quarterly ARD?

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Answer:

Continue with the OBRA schedule that had been established. If the resident was due for a quarterly, it would be combined with a 5-day PPS for Medicare Part A. Instead of a quarterly, would a significant change (comprehensive) be a more appropriate OBRA assessment? When the PPS stay ends, the Part A PPS discharge would be completed, but not an OBRA discharge as the resident is staying in the facility.

Complete the scheduled 2nd quarter OBRA that was due as soon as possible. Documentation in the clinical record will indicate the reason for a late assessment. When the PPS services end, the RUG III group from the most recent OBRA assessment will be used for MaineCare billing.

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Section P0100

Question:

I need some clarification on this. If a resident uses two bed siderails (1/4 rails only) and the care plan clearly documents the siderails are used solely to optimize bed mobility and is NOT used as a restraint, would I code this section as a 0 vs a 2?

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Answer: Coding Instructions

After determining whether or not an item listed in (P0100) is a physical restraint and if it was used during the 7-day look-back period, code the frequency of use as follows:

- **Code 0, not used**: If the item was not used during the 7-day look-back or it was used but did not meet the definition.
- **Code 1, used less than daily**: If the item met the definition and was used less than daily.
- **Code 2, used daily**: If the item met the definition and was used on a daily basis during the look-back period.

There is additional clarifying information at the bottom of page P-3 through page P-8 that will assist you in determining if the use of a device is considered to be a restraint. It could vary from resident to resident.

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Section O – Chemotherapy

Question:

I am coding chemotherapy for a resident. The medication is Anastrozole and I understand it is a non-steroidal aromatase inhibitor. It suppresses estrogen biosynthesis in peripheral tissues and **in cancer cells,** according to mechanism of action per PDR.NET online. So, I understand it is slowing the cancer growth by inhibiting estrogen, but it is also suppressing the biosynthesis of the cancer cells. How should I code this medication on the MDS.

Answer:

The brand name for Anastrozole is Arimidex. This drug cannot be coded on the MDS. It does not kill cancer cells, is suppresses growth of cancer cells

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Section I - Diagnosis

Question:

A resident was admitted with left shoulder pain. There is a doctor's note from the orthopedic, not dated, that states "Likely minimally displaced clavicle fracture." with no x-ray, and "suggestive of proximal humerus fracture," side not specified. Can I capture a "likely" fracture or a "suggestive of" fracture with unspecified side as an ICD-10 code?

Answer:

Use caution when coding a "possible" fracture that has not been confirmed as a primary admitting diagnosis. Unless it is confirmed, it is an unspecified injury. Try to get more information from the hospital records or from the physician. Find out if the injury is related to a fall. If you check on the ICD-10 mapping tool, it may indicate "return to provider" rather than a code related to a fall or other injury.

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Section E

Question:

Is it required to have behavior sheets for anyone on an anti-psychotic agent? If so, is a daily nurse's note or every shift nurse's note required or acceptable?

Answer:

RAI Manual, page 1-8: While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

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PDPM

Question:

With the new PDPM and managed care, can we combine the admission with the five day?

Answer:

The OBRA admission is a federal requirement. If managed care is the primary payer, NOT Medicare A, then the assessments would not be combined. The OBRA would be submitted via ASAP and the 5-day would be submitted to the payer. Check with the payer to determine what assessments are required to receive payment.

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Section O

Question:

Resident is coded for IV medications, which is the baclofen pump. We have an order for Baclofen via pump and it is on the care plan. The actual filling of the pump is done periodically off-site. Is this sufficient documentation?

Answer:

Per the Documentation Requirements, a physician's order for the pump documents the medication is administered via epidural pump and not a subcutaneous pump that is being managed by nursing. There needs to be documentation that the medication was administered, i.e. MAR documentation and documentation of effects/side effects.

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Eligibility

Question:

In the MaineCare Benefits Manual, Chapter II, Section 67.02-3, Medical Requirements, A. Number 8, (page number 8) it states, physical, speech/language, occupational, or respiratory therapy provided at least 5 days per week as part of a planned program provided by, and requires the professional skills of a licensed therapist could meet the medical eligibility criteria as long as there is an order, an evaluation and periodic assessment. On the Maximus assessment, the question of therapies only addresses physical, speech and/or occupational therapies, not Respiratory therapy. Can a MaineCare member medically qualify for long term care if they have 5-7 days per week of respiratory therapy for an unstable respiratory condition, even if they don't meet the ADL/cognitive requirements for MaineCare LTC?

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Answer:

MaineCare Benefits Manual
67.02.3 Medical Requirements

In order to receive services under this Section applicants must meet the eligibility requirements as set forth in this Section and as documented on the MED form. An applicant for services or a resident under this Section meets the medical eligibility requirements for admission to a nursing facility if he or she requires the services specified in 67.02-3(A) OR (B) OR (C), as determined or otherwise verified by the Department or its Authorized Entity and documented on the approved MED form. The timeframes used to determine medical eligibility are incorporated in the MED form.

A. A person meets the medical eligibility requirements for NF services if he or she needs at least one (1) of the following services seven (7) days per week (unless otherwise specified) that are or otherwise would be performed by or under the supervision of a registered professional nurse:.

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8. physical, speech/language, occupational, or respiratory therapy provided at least five (5) says per week as part of a planned program that is designed, established by, and provided by, and *requires the professional skills of, a licensed or registered therapist*. Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.

The findings of an initial evaluation and periodic reassessments must be documented in the person's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. With the exception of speech/language criteria outlined under 67.05-13 (E), maintenance or preventative therapy does not meet the requirements of this Section. A Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) system or the wearing of an airway clearance system vest does not meet the requirements of this Section.

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Sections A0310G1 and A2400
Question:

We have several questions surrounding MDS items A0310G1 and A2400, related to the new Interrupted Stay Policy. When a patient discharges from a facility on 10/7 and *returns* on 10/9 – on the OBRA Discharge (ARD 10/7), we code A0310G1 as (1), yes. Normally, we would answer any question on the assessment related to the resident status as of the ARD, and at the time of discharge it is not a known interrupted stay.

If we answer 0, no, it requires us to answer A2400A. According to the RAI Manual's algorithm, we would input an end date of 10/9 – which then we are required to complete a Part A PPS Discharge per the MDS 3.0 Technical Specifications. Should we respond with dashes? But again, as of the ARD we did not know this is an interrupted stay, and the Manual does not address this. How do we answer A0310G1 on the OBRA Discharge assessment if after the ARD an interrupted stay occurs? How do we answer A2400 on the OBRA Discharge? How about the subsequent Entry Tracking Record, as A0310G1 is not part of Tracking Records but A2400 is? Would we answer No?

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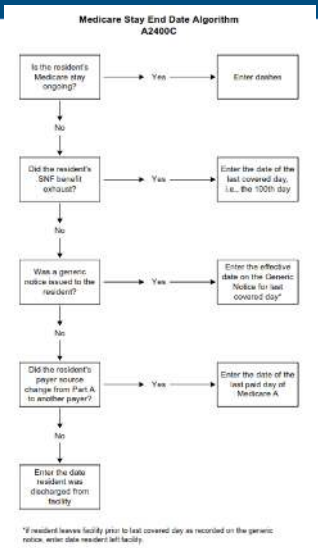

Answer:

RAI Manual, page A-40 = **Medicare Stay End Date Algorithm**

If the Medicare A stay is ending, enter (0), NO at A0310G1 and enter a response related to reason at A2400C related to the reason the stay is ending.

If the Medicare A stay is ongoing, as with an interrupted stay, code (1) yes at A0310G1 and enter dashes at A2400C.

You can open the discharge assessment on the selected ARD. You have 14 days to complete it, which would allow time to determine if there is an interrupted stay. (RAI Manual, page 2-37). Complete an entry tracking form when the resident is readmitted from the hospital.

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Question:

In reviewing Coding Instructions for A0310G1, is this a SNF Part A Interrupted Stay?

Answer:

• Code 0, no: If the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did not resume SNF care in the same SNF within the interruption window.

• Code 1, yes: If the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay), is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay), and subsequently resumes SNF care in the same SNF within the interruption window.

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RAI Manual, page 2-11 (V1.17.1, Oct 2019):

Interrupted Stay is a **Medicare Part A** SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.

Interruption Window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the same SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

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Announcement:

If a resident is discharged to the hospital, discharge return anticipated: Code A0310G1 as (1), yes. In A2400A, coding (1) will result in the submission to ASAP being rejected. A dash or blank is not a valid value and will be rejected.

As of October 21, 2019, CMS says to code (0) no, until they release a fix for the coding error. There is no information available as to when a fix will be released.

Have you experienced any issues with Discharge Assessments (not related to an interrupted stay) and coding of A2400A?

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Section GG

Question:

I am seeking clarification regarding GG0130E, Shower/bathe self. Does this include a full-body bed bath? The coding tips only include this statement regarding "where" the bath/shower may occur on page GG-22: "Assessment of Shower/bathe self can take place in a shower or bath or at a sink (i.e., full body sponge bath)."

Answer:

Showering/bathing involves the **entire body, head-to-toe**, whether it occurs in the shower, tub, bed, at the sink, etc.

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Chapter 2

Question:

If a private pay long term care resident (does not have MaineCare but is private pay receiving long term care services) goes to the ER at 8:00 pm one day and returns at 3:00 am the next day, and is not back in our facility at midnight, should we do a discharge assessment and then a re-entry assessment on the morning he returns?

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Answer:

The resident is sent to an acute care facility, not in the SNF at midnight, and is not admitted to the acute care facility.

If a resident is out of the facility at midnight, but for less than 24 hours, and is not admitted to an acute care facility, a new 5-Day PPS assessment is not required, though an IPA may be completed, if deemed appropriate; however, there are payment implications. Theday preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the "midnight rule." For example, if the resident goes to the emergency room at 10:00 pm on Wednesday, day 22 of his Part A stay, and returns at 3:00 a the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes day 22 of his Part A stay. This means that this day is skipped for purposes of the variable per diem adjustment, described in Chapter 6.

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Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge in Section 2.5, Assessment Types and Definitions).
- Must be completed when the resident is *admitted* to an acute care hospital.
- Must be completed when the resident has a hospital *observation stay greater than 24 hours*.
- Must be completed if a resident in a Medicare Part A stay is discharged from the facility regardless of whether the resident resumes Part A within the 3-day interruption window (see Interrupted Stay, Section 2.5, Assessment Types and Definitions above).

OBRA rules apply to all payers, because of federal certification of the beds.

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Section M

Question:

One of our residents has a Deep Tissue Injury (DTI) on his heel. It was debrided by the wound doctor and now has dimensions as follows: 2.4 cm x 2.9 cm x 0.1 cm. The doctor didn't stage the wound so, I coded it as stage 2 and not DTI. Is that correct?

Answer:

RAI Manual, page M-24:

Steps for Assessment

2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.

3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister does not show signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do not code as a deep tissue injury.

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Section M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury

Coding Tips for M0300G (RAI Manual, page M-24)

- Once deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Staging of a pressure ulcer can be done by a registered nurse or a physician.
- DEEP TISSUE INJURY: Purple or maroon area of discolored *intact* skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

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Section M

Question:

A resident was coded for one stage-1 left middle toe and one stage-2 ulcer right ankle. The ARD was 7/8/19. There was a nurse's note dated 7/3/19 indicating the wounds were resolved. On 7/7/19, there was a nurse's note indicating "right ankle Duoderm in place, unable to visual" and "left ankle blanchable red." How should these wounds be coded?

Answer:

Are these wounds caused by pressure or impaired circulation?

PRESSURE ULCER/INJURY: A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

If caused by pressure, what is the source of the pressure?

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Section M

Arterial Ulcers

Caused by peripheral arterial disease

Most commonly occur on the tips and tops of the toes, top of the foot, or distal to the medial malleolus.

Often painful

Typically have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

Venous Ulcers

- Caused by peripheral venous disease
- Most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- May or may not be painful
- Typically shallow with irregular would edges, a red granular (bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin stating. Leg edema may also be present.

NF Forum Call 11/7/19: Questions and Answers

Snippet Topics:

Respiratory Therapy documentation

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RAI Manual, page O-16

Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:

(1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan,
(2) documented in the resident's medical record, and
(3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.

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RAI Manual, page O-18

Respiratory therapy- Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

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RAI Manual, page O-20

For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:

- The physician orders the therapy;
- The physician's order includes a statement of frequency, duration, and scope of treatment;
- The services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (see Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services are required and provided by qualified personnel (see Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services must be reasonable and necessary for treatment of the resident's condition.

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Documentation Requirements

- Current physician order which "includes a statement of frequency, duration, and scope of treatment."
- O04001: Documented delivery of the total number of minute's respiratory therapy was provided during the 7-day look-back period. (this is not a payment item.
- O0400D2: Documentation of number of days respiratory therapy was administered for a total of at least 15 minutes/24hours in the 7-day look-back period.
- Evidence that services are directly and specifically related to an active written treatment plan.
- Evidence services were provided by qualified personnel (see Appendix A, page 19).

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Billing with RUG groups

Question:

When the skilled care PPS ended for a resident who was admitted for skilled care, she remained in the facility for long term care services that would be paid by MaineCare. What RUG group should be used for billing?

Answer:

The case mix adjustment to the rate is associated with the resident's *active assessment*. All OBR required assessments including admission, quarterly, annual, significant change, and significant correction are considered active assessments for specific dates of service.

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Billing with an active assessment

Question:
How do I associate an "active assessment with dates of service for billing?

Answer:
OBRA required assessments are used for MaineCare payment. A Medicare PPS assessment is not used unless it is also an OBRA required assessment (e.g. Admission assessment that is combined with a Medicare 5-day or 14-day assessment.)

The assessment reference date (ARD) is the key to linking an assessment to billing service dates. The ARD establishes the last day of the observation period for the assessment. All other items are assessed from this date. The admission assessment covers service dates from the date of admission to the day *before* the next required OBRA assessment ARD. All other OBRA assessments cover service dates from the ARD to the day before the ARD of the next required OBRA assessment or discharge date.

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The table below is an example of a resident admitted on 1/15/2018 and discharged on 8/10/2018. The admission assessment's ARD is 1/23/2018. This assessment classifies into the special care group (SC2). The SC2 group would be used to bill for dates of service 1/15/2018 until the day before the next quarterly assessment ARD date (4/24/2018). The first quarterly would cover dates of services 4/25/2018 until the day before the next quarterly ARD (7/22/2018) and the physical group (PE2) would be used for billing. The resident was discharged on 8/10/2018. The last quarterly would cover dates of service 7/23/18 until the day before the resident's discharge on 8/10/2018. For these dates of service, the physical group (PE1) would be billed.

Sample resident's dates of service covered relative to assessment reference date (ARD)			
Type of Assessment	ARD or Discharge Date	Dates of Service covered	RUG Group
Admission	1/23/2018	1/15/2018 – 4/24/2018	SC2
Quarterly	4/25/2018	4/25/2018 – 7/22/2018	PE2
Quarterly	7/23/2018	7/23/2018 – 8/9/2018	PE1
Discharge	8/10/2018		

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Questions?

NF Forum Call 11/7/19: Training

Upcoming MDS 3.0 training:

- MDS 3.0 Mini-Series (5 sessions) will begin soon if there is interest
- November 26, 2019 - Payment Items and Documentation in Lewiston

Call or email the help desk to register: MDS3.0.DHHS@maine.gov

Please let the help desk know if you are interested in MDS 3.0 2-day training, Mini-Series, Restorative Nursing training, or other type of training that is not currently scheduled. We keep a wait list and schedule when there are enough participants.

OMS website for handouts:
http://www.maine.gov/dhhs/oms/provider/case_mix_manuals.html

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Forum Calls

The next forum call will be on **February 6, 2020**.

Email the help desk to register for the call, to send questions, or with suggestions for Snippet topics at: MDS3.0.dhhs@maine.gov

Case Mix Team Contact Information

- **MDS Help Desk**: 624-4019 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
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  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

Questions?

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Case Mix Manager / State RAI Coordinator
207-287-3933