

MDS 3.0 RAI User's Manual (v1.12R) Errata (v1)

Effective February 5, 2015

Issue ID	Issue	Resolution
1	In Chapter 2, page 2-7, under 2.5 Assessment Types and Definitions, the admission situations that require completion of an OBRA Admission assessment no longer include “when the resident has been in this facility previously and was discharged prior to completion of the OBRA Admission assessment.”	<p>In Chapter 2, page 2-7, under 2.5 Assessment Types and Definitions, the second bullet has been deleted as follows:</p> <p>Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:</p> <ul style="list-style-type: none">• when the resident has never been admitted to this facility before; OR• when the resident has been in this facility previously and was discharged prior to completion of the OBRA Admission assessment; OR• when the resident has been in this facility previously and was discharged return not anticipated; OR• when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

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2	In Chapter 2, page 2-13, under 2.5 Assessment Types and Definitions, the definition of <i>reentry</i> has changed.	<p>In Chapter 2, page 2-13, the definition of reentry has been amended as follows:</p> <p>Reentry refers to the situation when all three of the following occurred prior to this entry: a the resident was previously in this facility nursing home and had an OBRA Admission assessment completed and was discharged return anticipated and returned within 30 days of discharge. Upon the resident’s return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 days” requirement.</p>
3	In Chapter 2, page 2-14, page length changed.	The replacement page is provided in this file.
4	In Chapter 2, page 2-19, the situations that require completion of an Admission assessment no longer include “the resident had been in this facility previously and was discharged prior to completion of the OBRA Admission assessment.”	<p>In Chapter 2, at the top of page 2-19, the second bullet has been deleted as follows (note that the header 01. Admission Assessment (A0310A=01) and introductory sentence are on page 2-18 which did not change):</p> <p>01. Admission Assessment (A0310A=01)</p> <p>The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:</p> <ul style="list-style-type: none"> • this is the resident’s first time in this facility, OR • the resident had been in this facility previously and was discharged prior to completion of the OBRA Admission assessment, OR • the resident has been admitted to this facility and was discharged return not anticipated, OR • the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

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5	In Chapter 2, page 2-19, under <i>Assessment Management Requirements and Tips for Admission Assessments</i> , there is a formatting error in the bulleted list. The third sentence in the seventh bullet should be a separate bullet.	<p>In Chapter 2, page 2-19, under <i>Assessment Management Requirements and Tips for Admission Assessments</i>, the formatting of the second bullet below has been corrected as follows:</p> <ul style="list-style-type: none"> • For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. • The nursing home may combine the Admission assessment with the Discharge assessment when applicable.
6	In Chapter 2, page 2-33, under <i>Example (Reentry)</i> , the example does not state the date of discharge.	<p>In Chapter 2, page 2-33, under <i>Example (Reentry)</i>, the date of discharge has been added to the example to clarify that the resident returned to the facility within 30 days of discharge.</p> <ol style="list-style-type: none"> 1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, Mr. W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows: <ul style="list-style-type: none"> A0310F = 01 A1600 = 05-18-2011 A1700 = 2

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7	In Chapter 2, page 2-38, the <i>Entry, Discharge, and Reentry Algorithms</i> figure requires clarification.	<p>In Chapter 2, page 2-38, the <i>Entry, Discharge, and Reentry Algorithms</i> figure has been updated to reflect the change in the situations that require an Admission assessment and the revised definition of “reentry.”</p> <p>OLD:</p> <p>NEW:</p> <p>Footnote: ¹A0310A = 99 A0310B = 99 A0310C = 0 A0310D = 0 or blank A0310E = 0 A0310F = 01 ²A0310B = E = appropriate code ³A0310B = F = appropriate code When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.</p>

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8	In Chapter 2, pages 2-57, 2-58, and 2-59, the “= 06” option in coding instructions for A0310B should have been deleted since the Medicare PPS Readmission/Return assessment no longer exists.	<p>In Chapter 2, pages 2-57, 2-58, and 2-59, the “= 06” option has been deleted for A0310B.</p> <ul style="list-style-type: none"> Code the Item A0310 of the MDS 3.0 as follows: A0310A = 99 A0310B = 01, 02, 03, 04, or 05, or 06 as appropriate A0310C = 1 A0310D = 0 (Swing Beds only) 																																																																								
9	In Chapter 2, page 2-80, the column header <i>PPS 5-day or readmission/return</i> is incorrect since the Medicare PPS Readmission/Return assessment no longer exists.	<p>In Chapter 2, page 2-80, in the Expected Order of MDS Records table, the column header PPS 5-day or readmission/return has been changed to PPS 5-day as follows:</p> <p>OLD:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="9" style="text-align: center;">Expected Order of MDS Records</th> </tr> <tr> <th colspan="8"></th> <th style="text-align: right;">Prior Record</th> </tr> <tr> <th style="text-align: left;">Next Record</th> <th style="text-align: center;">Entry</th> <th style="text-align: center;">OBRA Admission</th> <th style="text-align: center;">OBRA annual</th> <th style="text-align: center;">OBRA quarterly</th> <th style="text-align: center;">PPS 5-day or readmission /return</th> <th style="text-align: center;">PPS 14-day</th> <th style="text-align: center;">PPS 30-day</th> <th style="text-align: center;">PPS 60-day</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">Entry</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> </tr> </tbody> </table> <p>NEW:</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="9" style="text-align: center;">Expected Order of MDS Records</th> </tr> <tr> <th colspan="8"></th> <th style="text-align: right;">Prior Record</th> </tr> <tr> <th style="text-align: left;">Next Record</th> <th style="text-align: center;">Entry</th> <th style="text-align: center;">OBRA Admission</th> <th style="text-align: center;">OBRA annual</th> <th style="text-align: center;">OBRA quarterly</th> <th style="text-align: center;">PPS 5-day</th> <th style="text-align: center;">PPS 14-day</th> <th style="text-align: center;">PPS 30-day</th> <th style="text-align: center;">PPS 60-day</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">Entry</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> </tr> </tbody> </table>	Expected Order of MDS Records																	Prior Record	Next Record	Entry	OBRA Admission	OBRA annual	OBRA quarterly	PPS 5-day or readmission /return	PPS 14-day	PPS 30-day	PPS 60-day	Entry	no	no	no	no	no	no	no	no	Expected Order of MDS Records																	Prior Record	Next Record	Entry	OBRA Admission	OBRA annual	OBRA quarterly	PPS 5-day	PPS 14-day	PPS 30-day	PPS 60-day	Entry	no	no	no	no	no	no	no	no
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10	In Chapter 3, Section A, page A-21, Most Recent Admission/Entry or Reentry into this Facility header requires clarification.	<p>In Chapter 3, Section A, page A-21, the text “A1600–A1800” has been added to identify the items included in this new grouping as follows:</p> <p>A1600–A1800: Most Recent Admission/Entry or Reentry into this Facility</p>
11	In Chapter 3, Section A, page A-22, under Item Rationale, there is a formatting error.	<p>In Chapter 3, Section A, page A-22, under Item Rationale, a space has been added between “the” and “facility” as follows:</p> <ul style="list-style-type: none"> • To document the date of admission/entry or reentry into the facility.
12	In Chapter 3, Section A, page A-22, the language in the coding instructions does not match the language in the item set.	<p>In Chapter 3, Section A, page A-22, under Coding Instructions, the word “entry” has been deleted as follows:</p> <ul style="list-style-type: none"> • Code 1, admission/entry: when one of the following occurs:
13	In Chapter 3, Section A, page A-22, Coding Tips and Special Populations contains information that pertains to more than just item A1700.	<p>The two bullets below have been moved from Chapter 3, Section A, page A-22 to page A-26, after item A1900.</p> <p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Both swing bed facilities and nursing homes must apply the above rules when determining whether a patient or resident is an admission/entry or reentry. • In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 day” requirement.

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14	In Chapter 3, Section A, page A-25, the header requires punctuation.	<p>In Chapter 3, Section A, page A-24, the colon has been added after A1900 in the header as follows:</p> <p>A1900: Admission Date (Date this episode of care in this facility began)</p>
15	In Chapter 3, Section A, page A-25, A1900, the coding of the grouped items A1600–A1800 and A1900 requires clarification.	<p>In Chapter 3, Section A, page A-25, under A1900, four examples have been added to illustrate coding for items A1600, A1700, A1800, and A1900 as follows:</p> <p>Examples</p> <ol style="list-style-type: none"> 1. Mrs. H was admitted to the facility from an acute care hospital on 09/14/2013 for rehabilitation after a hip replacement. In completing her Admission assessment, the facility entered 09/14/2013 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 09/14/2013 in item A1900, Admission Date. 2. The facility received communication from an acute care hospital discharge planner stating that Mrs. H, a former resident of the facility who was discharged home return not anticipated on 11/02/2013 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/2014 and wished to return to the facility for rehabilitation after hospital discharge. Mrs. H returned to the facility on 2/15/2014. Although Mrs. H was a resident of the facility in September of 2013, she was discharged home return not anticipated; therefore, the facility rightly considered Mrs. H as a new admission. In completing her Admission assessment, the facility entered 02/15/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 02/15/2014 in item A1900, Admission Date. 3. Mr. K was admitted to the facility on 10/05/2013 and was discharged to the hospital, return anticipated, on 10/20/2013. He returned to the facility on 10/26/2013. Since Mr. K was a resident of the facility, was discharged return

Issue ID	Issue	Resolution
		<p>anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record on return from the hospital, they entered 10/26/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.</p> <p>Approximately a month after his return, Mr. K was again sent to the hospital, return anticipated on 11/05/2013. He returned to the facility on 11/22/2013. Again, since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record, they entered 11/22/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.</p> <p>4. Ms. S was admitted to the facility on 8/26/2014 for rehabilitation after a total knee replacement. Three days after admission, Ms. S spiked a fever and her surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent Ms. S to the emergency room and completed her Discharge assessment as return anticipated. The hospital called the facility to inform them Ms. S was admitted. A week into her hospitalization, Ms. S developed a blood clot in her affected leg, further complicating her recovery. The facility was contacted to readmit Ms. S for rehabilitative services following discharge from the hospital on 10/10/2014. Even though Ms. S was a former patient in the facility's rehabilitation unit and was discharged return anticipated, she did not return within 30 days of discharge to the hospital. Therefore, Ms. S is considered a new admission to the facility. On her return, when the facility completed Ms. S's Admission assessment, they entered 10/10/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 10/10/2014 in item A1900, Admission Date.</p>

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16	In Chapter 3, Section A, page A-26, the coding of the grouped items A1600–A1800 and A1900 requires clarification.	<p>In Chapter 3, Section A, page A-26, under A1900, Coding Tips and Special Populations, the first two bullets have been amended and information has been added to clarify coding for items A1600, A1700, A1800, and A1900 as follows:</p> <p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Both swing bed facilities and nursing homes must apply the above rules instructions for coding items A1600 through A1900 when determining to determine whether a patient or resident is an admission/entry or reentry. • In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 days” requirement. • If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same. • If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900. • Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1800 (Entered From). It is also tied to the concepts of a “stay” and an “episode.” A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident’s time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility. • A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start

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		<p>a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.</p> <ul style="list-style-type: none"> When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1800 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1800 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began his or her first stay in the episode).
17	In Chapter 3, Section A, page A-27, under Coding Instructions, there is a formatting error.	<p>In Chapter 3, Section A, page A-28, under Coding Instructions, a bullet has been added before the text as follows:</p> <ul style="list-style-type: none"> Code 09, long term care hospital (LTCH): if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

Issue ID	Issue	Resolution
18	In Chapter 3, Section A, file length change and text shifts required page number changes from page A-23 to the end of the document.	Replacement pages are provided in this file.

the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident.

- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a hand written **or** a computer-generated copy be maintained in the clinical record. Either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR
- when the resident has been in this facility previously and was discharged return not anticipated; OR
- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

Assessment Combination refers to the use of one assessment to satisfy both OBRA and Medicare PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. Sections 2.11 and 2.12 provide more detailed information on combining Medicare and OBRA assessments. In

- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA
- Change of Therapy (COT) OMRA

Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.

Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS.

OBRA-Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

Tracking records

- Entry
- Death in facility

Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is

discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 days” requirement.

Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in Items A0310A and A0310F (Discharge Assessment). Medicare reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 am or 11:59 pm, is considered day "1" of admission.
- The ARD (Item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (Item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (Item V0200B2) must be no later than day 14.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (CAA(s) completion date + 7 calendar days).
- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry tracking record **each time** the resident returns to the facility and a Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with the Discharge assessment when applicable.

02. Annual Assessment (A0310A=03)

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

OBRA-required Tracking Records and Discharge Assessments include the following types (Item A0310F):

07. Entry Tracking Record (Item A0310F=01)

There are two types of entries – admission and reentry.

Admission (Item A1700=1)

- Entry tracking record is coded an Admission every time a resident:
 - is admitted for the first time to this facility; or
 - is readmitted after a discharge return not anticipated; or
 - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

Example (Admission):

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

A0310F = 01
A1600 = 08-27-2011
A1700 = 1

Reentry (Item A1700=2)

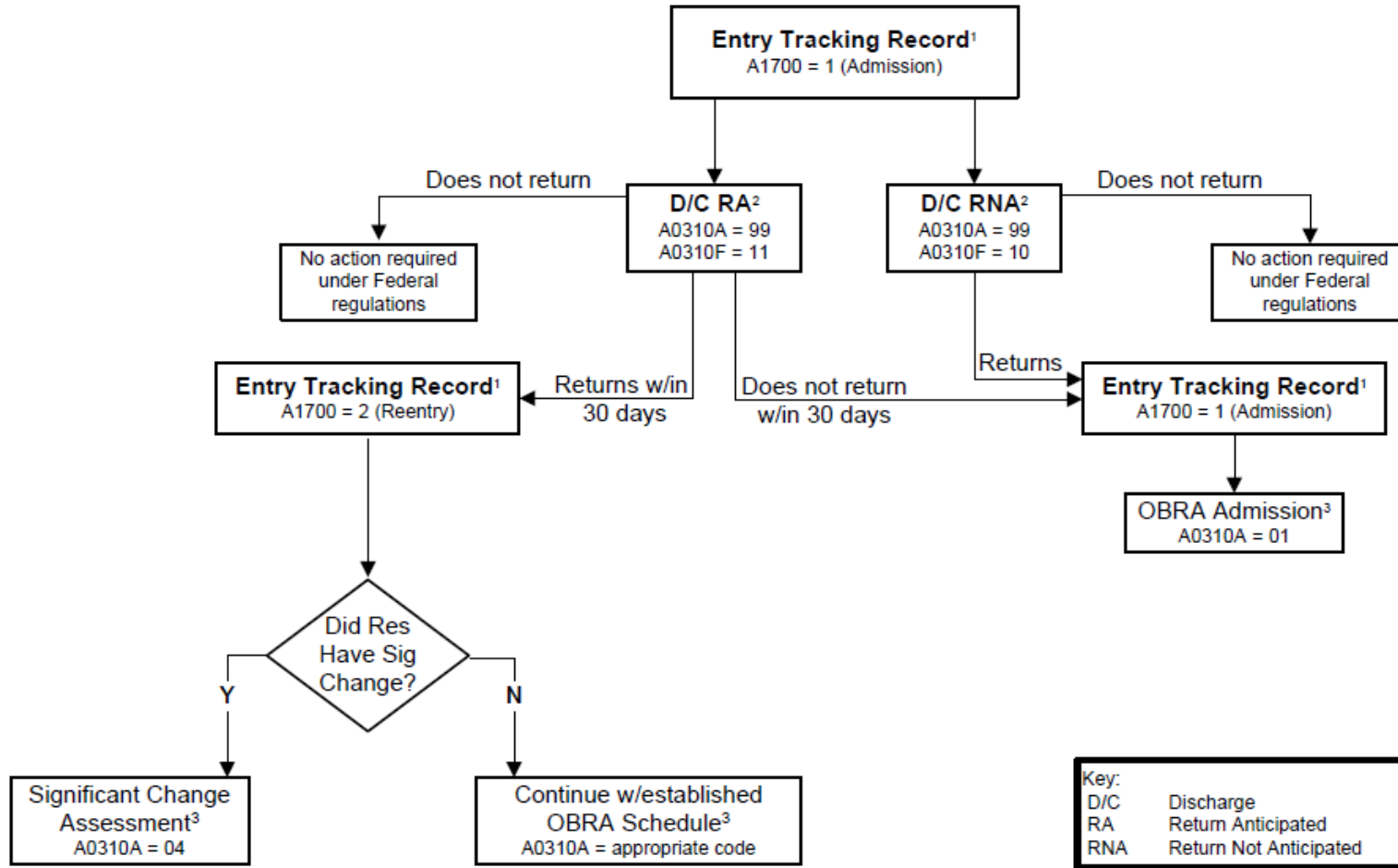
- Entry tracking record is coded Reentry every time a person:
 - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

Example (Reentry):

1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, Mr. W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

A0310F = 01
A1600 = 05-18-2011
A1700 = 2

Entry, Discharge, and Reentry Algorithms



¹A0310A = 99 A0310B = 99 A0310C = 0 A0310D = 0 or blank A0310E = 0 A0310F = 01

²A0310B – E = appropriate code

³A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

example: if the ARD of an EOT OMRA is set for Day 14 and the ARD of a 14-day assessment is set for Day 15, this would violate the combined assessment policy. Consequently, the EOT OMRA would control the payment. The EOT would begin payment on Day 12, and continue paying into the 14-day payment window until the next scheduled or unscheduled assessment used for payment.

PPS Scheduled Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within the ARD window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 01, 02, 03, 04, or 05 as appropriate
A0310C = 1
A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare scheduled assessment **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). If both ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 01, 02, 03, 04, or 05 as appropriate
A0310C = 2
A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished

(Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.

- If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

A0310A = 99

A0310B = 01, 02, 03, 04, or 05 as appropriate

A0310C = 3

A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Change of Therapy OMRA

- The ARD must be set within the window for the scheduled assessment and on day 7 of the COT observation period. If both ARD requirements are not met, the assessments may not be combined.
- Must complete the scheduled PPS assessment item set.
- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current standard payment period and the next payment period appropriate to the given scheduled assessment, assuming no intervening assessments. For example:

— Based on her 14-day assessment, Mrs. T is currently classified into group RVB. Based on the ARD set for the 14-day assessment, a change of therapy evaluation for Mrs. T is necessary on Day 28. The change of therapy evaluation reveals that the therapy services Mrs. T received during that COT observation period were only sufficient to qualify Mrs. T for RHB. Therefore, a COT OMRA is required. Since the facility has not yet completed a 30-day assessment for Mrs. T, the facility must combine the 30-day assessment with the required COT OMRA. The combined assessment confirms Mrs. T's appropriate classification into RHB. The payment for the revised RUG classification will begin on Day 22 and, assuming no intervening assessments, will continue until Day 60.

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.

- If the ARD for the Swing Bed Clinical Change Assessment falls within the ARD (including grace days) of a PPS scheduled assessment that has not been completed yet, the assessments **MUST** be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99 (only value allowed for Swing Beds)
A0310B = 01, 02, 03, 04, or 05 as appropriate
A0310C = 0
A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 07
A0310C = 1
A0310D = 1

Swing Bed Clinical Change Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 07
A0310C = 2
A0310D = 1

Swing Bed Clinical Change Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14

Expected Order of MDS Records

Next Record	Prior Record												
	Entry	OBRA Admission	OBRA annual	OBRA quarterly	PPS 5-day	PPS 14-day	PPS 30-day	PPS 60-day	PPS 90-day	PPS unscheduled	Discharge	Death in facility	No prior record
Entry	no	no	no	no	no	no	no	no	no	no		no	
OBRA Admission		no	no	no			no	no	no		no	no	no
OBRA Annual		no	no								no	no	no
OBRA Quarterly, sign. change, sign correction											no	no	no
PPS 5-day					no	no	no	no	no		no	no	no
PPS 14-day	no					no	no	no	no		no	no	no
PPS 30-day	no				no		no	no	no		no	no	no
PPS 60-day	no	no			no	no		no	no		no	no	no
PPS 90-day	no	no			no	no	no		no		no	no	no
PPS unscheduled											no	no	no
Discharge											no	no	no
Death in facility											no	no	no

Note: “no” indicates that the record sequence is not expected; record order warnings will be issued for these combinations. Blank cells indicate expected record sequences; no record order warning will be issued for these combinations.

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status (cont.)

- Code E: if an ID/DD condition is present but the resident does not have any of the specific conditions listed.
- Code Z: if ID/DD condition is not present.

DEFINITION

OTHER ORGANIC CONDITION RELATED TO ID/DD

Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningoencephalocele, congenital hydrocephalus, etc.

A1600–A1800: Most Recent Admission/Entry or Reentry into this Facility

Most Recent Admission/Entry or Reentry into this Facility																					
A1600. Entry Date																					
	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td></td> <td colspan="2" style="text-align: center;">Day</td> <td></td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>			-			-					Month			Day			Year			
		-			-																
Month			Day			Year															
A1700. Type of Entry																					
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Admission 2. Reentry 																				
A1800. Entered From																					
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other 																				

A1600: Entry Date

Most Recent Admission/Entry or Reentry into this Facility			
A1600. Entry Date			
	<input type="text"/>	-	<input type="text"/>
	Month		Day
		-	<input type="text"/>
			Year

Item Rationale

- To document the date of admission/entry or reentry into the facility.

Coding Instructions

- Enter the most recent date of admission/entry or reentry to this facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

DEFINITION

ENTRY DATE

The initial date of admission to the facility, or the date the resident most recently returned to your facility after being discharged.

A1700: Type of Entry

A1700. Type of Entry	
Enter Code	<input type="checkbox"/> 1. Admission <input type="checkbox"/> 2. Reentry

Item Rationale

- Captures whether date in A1600 is an admission/entry or reentry date.

Coding Instructions

- Code 1, admission: when one of the following occurs:
 - resident has never been admitted to this facility before; OR
 - resident has been in this facility previously and was discharged return not anticipated; OR
 - resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- Code 2, reentry: when all three of the following occurred prior to this entry; the resident was:
 - admitted to this facility, AND
 - discharged return anticipated, AND
 - returned to facility within 30 days of discharge.

A1800: Entered From

A1800. Entered From	
Enter Code <input type="text"/> <input type="text"/>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other

Item Rationale

- Understanding the setting that the individual was in immediately prior to facility admission/entry or reentry informs care planning and may also inform discharge planning and discussions.
- Demographic information.

Steps for Assessment

1. Review transfer and admission records.
2. Ask the resident and/or family or significant others.

Coding Instructions

Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission/entry or reentry.

- Code 01, community (private home/apt, board/care, assisted living, group home): if the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
- Code 02, another nursing home or swing bed: if the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

DEFINITIONS

PRIVATE HOME OR APARTMENT

Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.

BOARD AND CARE/ ASSISTED LIVING/ GROUP HOME

A non-institutional community residential setting that includes services of the following types: home health services, homemaker/ personal care services, or meal services.

A1800: Entered From (cont.)

- Code 04, psychiatric hospital: if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility (IRF): if the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled, or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- Code 07, hospice: if the resident was admitted from a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
- Code 09, long term care hospital (LTCH): if the resident was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)((1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
- Code 99, other: if the resident was admitted from none of the above.

Coding Tips and Special Populations

- If an individual was enrolled in a home-based hospice program enter 07, Hospice, instead of 01, Community.

A1900: Admission Date (Date this episode of care in this facility began)

A1900. Admission Date (Date this episode of care in this facility began)			
	<input type="text"/> <input type="text"/>	-	<input type="text"/> <input type="text"/>
	Month		Day
		-	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			Year

Item Rationale

- To document the date this episode of care in this facility began.

Coding Instructions

- Enter the date this episode of care in this facility began. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
- The Admission Date may be the same as the Entry Date (A1600) for the entire stay (i.e., if the resident is never discharged).

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

Examples

1. Mrs. H was admitted to the facility from an acute care hospital on 09/14/2013 for rehabilitation after a hip replacement. In completing her Admission assessment, the facility entered 09/14/2013 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 09/14/2013 in item A1900, Admission Date.
2. The facility received communication from an acute care hospital discharge planner stating that Mrs. H, a former resident of the facility who was discharged home return not anticipated on 11/02/2013 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/2014 and wished to return to the facility for rehabilitation after hospital discharge. Mrs. H returned to the facility on 2/15/2014. Although Mrs. H was a resident of the facility in September of 2013, she was discharged home return not anticipated; therefore, the facility rightly considered Mrs. H as a new admission. In completing her Admission assessment, the facility entered 02/15/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 02/15/2014 in item A1900, Admission Date.
3. Mr. K was admitted to the facility on 10/05/2013 and was discharged to the hospital, return anticipated, on 10/20/2013. He returned to the facility on 10/26/2013. Since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record on return from the hospital, they entered 10/26/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

Approximately a month after his return, Mr. K was again sent to the hospital, return anticipated on 11/05/2013. He returned to the facility on 11/22/2013. Again, since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record, they entered 11/22/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

4. Ms. S was admitted to the facility on 8/26/2014 for rehabilitation after a total knee replacement. Three days after admission, Ms. S spiked a fever and her surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent Ms. S to the emergency room and completed her Discharge assessment as return anticipated. The hospital called the facility to inform them Ms. S was admitted. A week into her hospitalization, Ms. S developed a blood clot in her affected leg, further complicating her recovery. The facility was contacted to readmit Ms. S for rehabilitative services following discharge from the hospital on 10/10/2014. Even though Ms. S was a former patient in the facility's rehabilitation unit and was discharged return anticipated,

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

she did not return within 30 days of discharge to the hospital. Therefore, Ms. S is considered a new admission to the facility. On her return, when the facility completed Ms. S's Admission assessment, they entered 10/10/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 10/10/2014 in item A1900, Admission Date.

Coding Tips and Special Populations

- Both swing bed facilities and nursing homes must apply the above instructions for coding items A1600 through A1900 to determine whether a patient or resident is an admission/entry or reentry.
- In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 days” requirement.
- If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same.
- If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900.
- Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1800 (Entered From). It is also tied to the concepts of a “stay” and an “episode.” A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident’s time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.
- A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.
- When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1800 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1800 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began his or her first stay in the episode).

A2000: Discharge Date

A2000. Discharge Date			
Complete only if A0310F = 10, 11, or 12			
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Month	Day	Year

Item Rationale

- Closes case in system.

Coding Instructions

- Enter the date the resident was discharged (whether or not return is anticipated). This is the date the resident leaves the facility.
- For discharge assessments, the discharge date (A2000) and ARD (A2300) must be the same date.
- Do not include leave of absence or hospital observational stays less than 24 hours unless admitted to the hospital.
- Obtain data from the medical, admissions or transfer records.

Coding Tips and Special Populations

- If a resident was receiving services under SNF Part A PPS, the discharge date may be later than the end of Medicare stay date (A2400C).

A2100: Discharge Status

A2100. Discharge Status	
Complete only if A0310F = 10, 11, or 12	
Enter Code <input type="text"/> <input type="text"/>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 08. Deceased 09. Long Term Care Hospital (LTCH) 99. Other

A2100: Discharge Status (cont.)

Item Rationale

- Demographic and outcome information.

Steps for Assessment

1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location.

Coding Instructions

Select the 2-digit code that corresponds to the resident's discharge status.

- Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
- Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- Code 07, hospice: if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient hospice programs.
- Code 08, deceased: if resident is deceased.
- Code 09, long term care hospital (LTCH): if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare

A2100: Discharge Status (cont.)

payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

- Code 99, other: if discharge location is none of the above.

A2200: Previous Assessment Reference Date for Significant Correction

A2200. Previous Assessment Reference Date for Significant Correction		
Complete only if A0310A = 05 or 06		
	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	Month Day Year	

Item Rationale

- To identify the ARD of a previous comprehensive (A0310 = 01, 03, or 04) or Quarterly assessment (A0310A = 02) in which a significant error is discovered.

Coding Instructions

- Complete only if A0310A = 05 (Significant Correction to Prior Comprehensive Assessment) or A0310A = 06 (Significant Correction to Prior Quarterly Assessment).
- Enter the ARD of the prior comprehensive or Quarterly assessment in which a significant error has been identified and a correction is required.

A2300: Assessment Reference Date

A2300. Assessment Reference Date		
Observation end date:		
	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	Month Day Year	

Item Rationale

- Designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time.

As the last day of the look-back period, the ARD serves as the reference point for determining the care and services captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for a MDS item with a 7-day look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period. For an item with a 14-day look-back period, the information is collected for a 14-day period ending on and including the ARD. The look-back period includes observations and events through the end of the day (midnight) of the ARD.

A2300: Assessment Reference Date (cont.)

Steps for Assessment

1. Interdisciplinary team members should select the ARD based on the reason for the assessment and compliance with all timing and scheduling requirements outlined in Chapter 2.

Coding Instructions

- Enter the appropriate date on the lines provided. Do not leave any spaces blank. If the month or day contains only a single digit, enter a "0" in the first space. Use four digits for the year. For example, October 2, 2010, should be entered as: 10-02-2010.
- For detailed information on the timing of the assessments, see Chapter 2 on assessment schedules.
- For discharge assessments, the discharge date item (A2000) and the ARD item (A2300) must contain the same date.

Coding Tips and Special Populations

- When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the look-back period, the 2 leave days are still considered part of the look-back period.
- When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to the physician during the leave, the visit would be counted in Item O0600, **Physician Examination** (if criteria are otherwise met).
This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

DEFINITION

ASSESSMENT REFERENCE DATE (ARD)

The specific end-point for the look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, this look-back period, also called the observation or assessment period, is a 7-day period ending on the ARD. Look-back periods may cover the 7 days ending on this date, 14 days ending on this date, etc.

A2400: Medicare Stay

A2400. Medicare Stay	
Enter Code <input type="checkbox"/>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <p>0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent Medicare stay</p> <p>B. Start date of most recent Medicare stay:</p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p>

A2400: Medicare Stay (cont.)

Item Rationale

- Identifies when a resident is receiving services under the scheduled PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.

Coding Instructions for A2400A, Has the Resident Had a Medicare-covered Stay since the Most Recent Entry?

- Code 0, no: if the resident has not had a covered Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.
- Code 1, yes: if the resident has had a Medicare Part A covered stay since the most recent admission/entry or reentry. Continue to A2400B.

Coding Instructions for A2400B, Start of Most Recent Medicare Stay

- Code the date of day 1 of this Medicare stay if A2400A is coded 1, yes.

Coding Instructions for A2400C, End Date of Most Recent Medicare Stay

- Code the date of last day of this Medicare stay if A2400A is coded 1, yes.
- If the Medicare Part A stay is ongoing there will be no end date to report. Enter dashes to indicate that the stay is ongoing.
- The end of Medicare date is coded as follows, whichever occurs first:
 - Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
 - Date of last day covered as recorded on the effective date from the Generic Notice; or
 - The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
 - Date the resident was discharged from the facility (see Item A2000, Discharge Date).

DEFINITIONS

MOST RECENT MEDICARE STAY

This is a Medicare Part A covered stay that has started on or after the most recent admission/entry or reentry to the nursing facility.

MEDICARE-COVERED STAY

Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

CURRENT MEDICARE STAY

NEW ADMISSION: Day 1 of Medicare Part A stay.

READMISSION: Day 1 of Medicare Part A coverage after readmission following a discharge.

A2400: Medicare Stay (cont.)

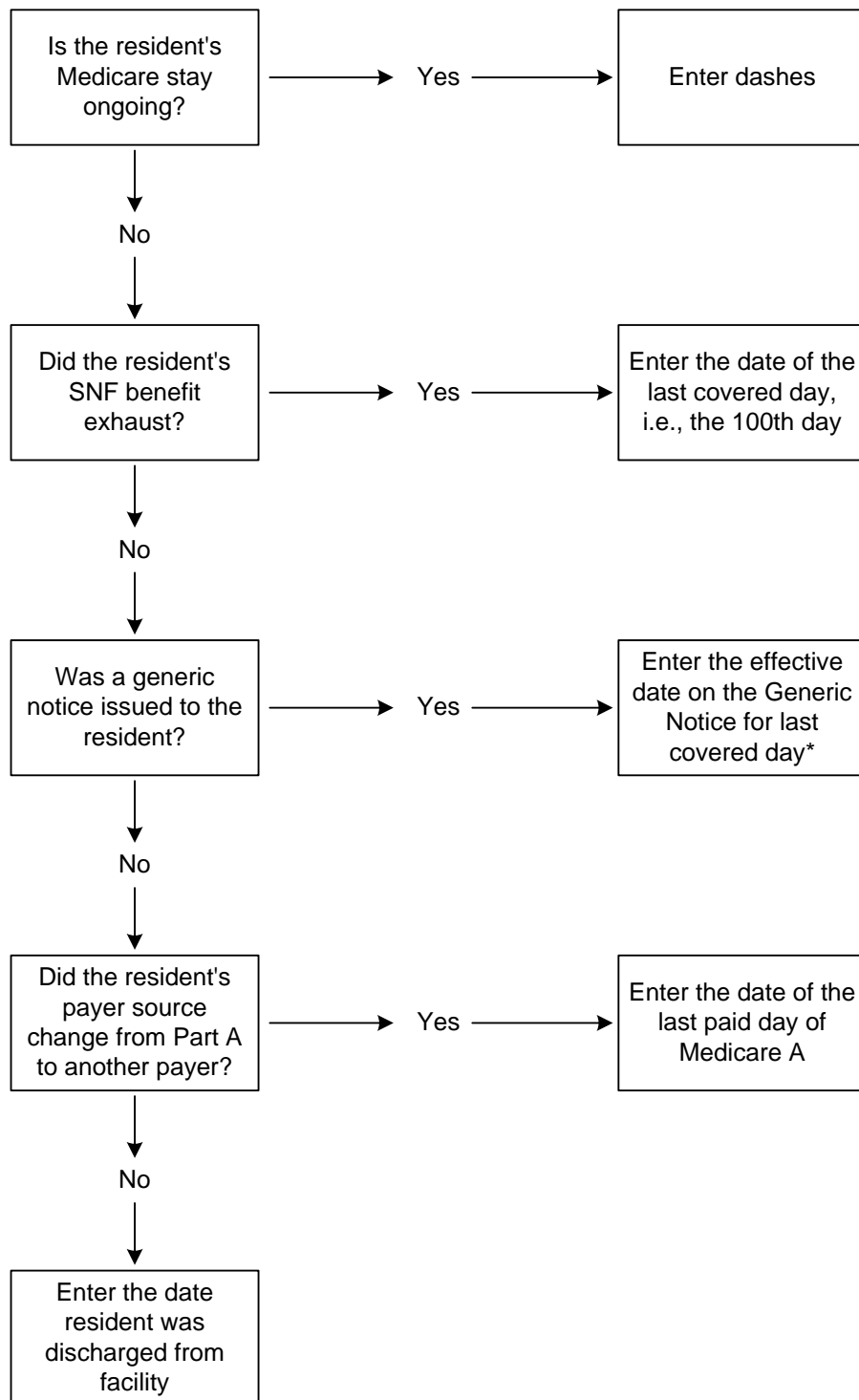
Coding Tips and Special Populations

- When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- The end date of the Medicare stay may be earlier than actual discharge date from the facility (Item A2000).

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and a Generic Notice with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her Discharge assessment:
 - A2000 = 11-24-2010
 - A2400A = 1
 - A2400B = 10-14-2010
 - A2400C = 11-23-2010

Medicare Stay End Date Algorithm A2400C



*if resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

A2400: Medicare Stay (cont.)

2. Mr. N began receiving services under Medicare Part A on December 11, 2010. He was sent to the ER on December 19, 2010 at 8:30pm and was not admitted to the hospital. He returned to the facility on December 20, 2010, at 11:00 am. The facility completed his 14-day PPS assessment with an ARD of December 23, 2010. Code the following on his 14-day PPS assessment:

- A2400A = 1
- A2400B = 12-11-2010
- A2400C = -----

3. Mr. R. began receiving services under Medicare Part A on October 15, 2010. He was discharged return anticipated on October 20, 2010, to the hospital. Code the following on his Discharge assessment:

- A2000 = 10-20-2010
- A2400A = 1
- A2400B = 10-15-2010
- A2400C = 10-20-2010