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2	2.2	2-2	• ~~CMS's~~ CMS' approval of a State's RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI. • ~~CMS's~~ CMS' approval of a State's RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
2	2.3	2-2	The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. ~~A list of RAI Coordinators can be found in Appendix B.~~
2	2.4	2-6	After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.
2	2.5	2-9	**Assessment Transmission** refers to the electronic transmission of submission files to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.
2	2.5	2-10	• ~~r~~Resident is discharged from the facility to a private residence (as opposed to going on an LOA); • ~~r~~Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record); • ~~r~~Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident. • Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed.
2	2.5	2-10 & 2-11	• **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarter Assessment). This item set is used for a stand-

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			alone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment **PPS (NP) Item Set.** This is the set of items active on a scheduled PPS assessment (5- day, 14-day, 30-day, 60-day, or 90-day). This item set is used for a ~~standalone. scheduled~~ standalone scheduled PPS assessment or a scheduled PPS assessment combined with a PPS OMRA assessment and/or a Discharge assessment.
2	2.5	2-12	Printed layouts for the item sets are available in Appendix H of this manual. ~~on the CMS website at: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage~~
2	2.5	2-12	~~• Readmission/Return~~
2	2.6	2-18	• In the process of completing any OBRA Comprehensive assessment except an Admission and a SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the MDS system, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and chapter 5 for detailed information on processing corrections.
2	2.6	2-21	• After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the ~~progress notes~~clinical record.
2	2.6	2-21	• If a resident is admitted on the hospice benefit (i.e. the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by a SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
2	2.6	2-22	• If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by a SCSA is not required.

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			Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required. • The ARD must be ~~within~~less than or equal to 14 days after the IDT's determination that the criteria for a SCSA are met ~~for a SCSA~~ (determination date + 14 calendar days) ~~but no later than day 14 after the IDT's determination is made that the criteria for a SCSA are met~~.
2	2.6	2-23	Page length change.
2	2.6	2-24	Page length change.
2	2.6	2-25	~~*Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions: Note: this is not an exhaustive list*~~ *Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:* *Note: this is not an exhaustive list*
2	2.6	2-26	• If a SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability ("mental retardation" in the regulation), or related condition (as defined by 42 CFR 483.102), a referral to the S~~s~~state M~~m~~ental H~~h~~ealth or Intellectual Disability/Developmental Disabilities Administration~~ID/DD~~ authority (SMH/ID~~MR~~/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act. • Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the ~~state~~ SMH/~~MR~~ID/DDA authorities and the S~~s~~state Medicaid A~~a~~gency is available at ~~http://www.cms. gov/~~ http://www.cms.gov/. • The nursing facility must provide the SMH/~~MR~~ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/~~MR~~ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
2	2.6	2-27	*Referral for Level II Resident Review Evaluations are Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:* *Note: this is not an exhaustive list*

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2	2.6	2-27	*Examples (PASRR & SCSAs):*
2	2.6	2-27	~~2. Ms. K has intellectual disability. She is normally cooperative, but after she had a fall and sustained a leg injury, she becomes agitated and combative with the physical therapist and with staff who try to assess her status. She does not understand why her normal routine has changed and why staff are touching a painful area of her body.~~
2	2.6	2-27	*Referral for Level II Resident Review Evaluations are Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:* *Note: this is not an exhaustive list*
2	2.6	2-28	• Nursing homes should document the initial identification of a significant error in an assessment in the ~~progress notes~~clinical record.
2	2.6	2-29	• Resident A has a Quarterly assessment with an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3rd (which is day 14 after the ARD).
2	2.6	2-30	• If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[5] ~~In~~ When closing the record, the nursing home should document ~~note~~ why the RAI was not completed.
2	2.6	2-30	• The ARD of an assessment drives the due date of the next assessment. The next non- comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days). • While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, determine if a revision to the resident's care plan is necessary, and make the applicable revision.
2	2.6	2-31	Page length change.
2	2.6	2-32	• Nursing homes should document the initial identification of a

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			significant error in an assessment in the ~~progress notes~~clinical record. • The ARD must be ~~within~~ less than or equal to 14 days after the determination that a significant error in the prior Quarterly~~assessment~~ has occurred (determination date + 14 calendar days)~~ and no later than 14 days after determining that the significant error occurred~~.
2	2.6	2-33	— is admitted for the first time to this facility; or — ~~is readmitted after a discharge prior to completion of the OBRA Admission assessment; 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. ~~— For swing bed facilities, the Entry tracking record will always be coded 1, Admission, since these providers do not complete an OBRA Admission assessment.~~
2	2.6	2-33	~~• Entry tracking record is coded Reentry every time a person is readmitted to a nursing home when the resident was previously admitted to this nursing home (i.e., an OBRA Admission was completed), **and** was discharged return anticipated from this nursing home, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.~~ • 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.
2	2.6	2-34	Page length change.
2	2.6	2-35	*Examples (Discharge-return not anticipated):*
2	2.6	2-35	2. Mr. K. was transferred from a Medicare-certified bed to a noncertified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows: A0310F=10 A2000=12-12-2013 A2100=2
2	2.6	2-36 & 2-37	~~For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days). For **unplanned discharges**, the facility should complete the Discharge assessment to the best of its~~

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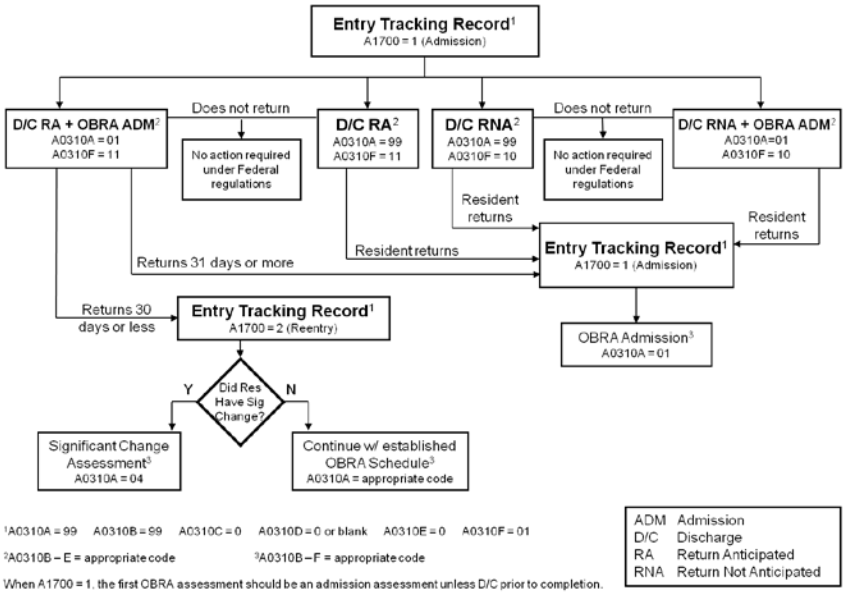
			~~abilities. The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the Discharge assessment with another assessment(s) when requirements for all assessments are met.~~ • For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days). • The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the Discharge assessment with another assessment(s) when requirements for all assessments are met. • For **unplanned discharges**, the facility should complete the Discharge assessment to the best of its abilities.
2	2.6	2-38	Replaced Entry, Discharge, and Reentry Algorithms diagram. **OLD:** 

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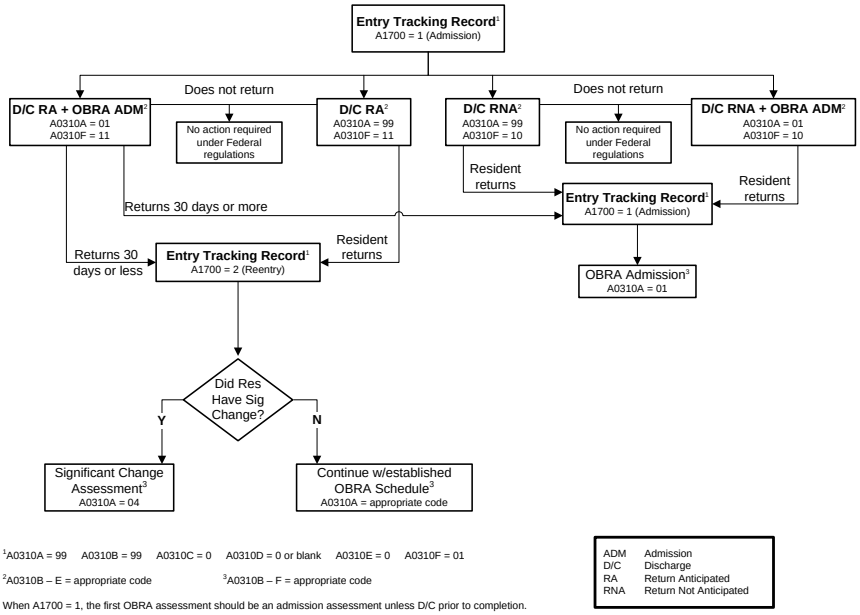
			NEW: 
2	2.7	2-39	Page number change.
2	2.7	2-40	Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records.
2	2.7	2-40	Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly and SCQA assessment and modify the care plan on an ongoing basis, if appropriate.
2	2.8	2-40	Page number change.
2	2.8	2-41	The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments, each with a predetermined time period for setting the ARD for that assessment. ~~The Readmission/Return assessment is also a scheduled assessment.~~
2	2.8	2-41	5-day 01 ~~Readmission/Return 06~~
2	2.8	2-42	1. Significant Change in Status Assessment (for swing bed providers this unscheduled assessment is called the Swing Bed Clinical Change Assessment)~~: Complete when the SNF interdisciplinary team has determined that a resident meets the significant change guidelines for either improvement or decline~~ (see S~~s~~ection 2.6). 2. Significant Correction to Prior Comprehensive Assessment~~:~~ ~~Complete because a significant error was made in the prior~~

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			~~comprehensive assessment~~ (see Ssection 2.6). 3. Start of Therapy Other Medicare Required Assessment (SOT-OMRA)~~: Complete to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. This is an optional assessment~~ (see Ssection 2.9). 4. End of Therapy Other Medicare Required Assessment (EOT-OMRA) (see Section 2.9).~~: Complete in two circumstances: (a) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group, all therapies have ended and the beneficiary continues to receive skilled services. (b) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech- language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and did not receive any therapy services for three or more consecutive calendar days. The EOT would be completed to classify the beneficiary into a non-therapy RUG group beginning on the day after the last day of therapy provided.~~ 5. Change of Therapy Other Medicare Required Assessment (COT-OMRA) (see Section 2.9).~~: Complete when the intensity of therapy, which includes the total reimbursable therapy minutes (RTM), and other therapy qualifiers such as number of therapy days and disciplines providing therapy, changes to such a degree that the beneficiary would classify into a different RUG-IV category than the RUG-IV category for which the resident is currently being billed for the 7-day COT observation period following the ARD of the most recent assessment used for Medicare payment(see section 2.9). The requirement to complete a change of therapy is reevaluated with additional 7-day COT observation periods ending on the 14th, 21st, and 28th days after the most recent Medicare payment assessment ARD and a COT OMRA is to be completed if the RUG-IV category changes. If a new assessment used for Medicare payment has occurred, the COT observation period will restart beginning on the day following the ARD of the most recent assessment used for Medicare payment.~~ A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in

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			that window—the two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has been completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. See Chapter 6 (Section 6.4) and Section 2.10 below for complete details.
2	2.8	2-43	5-day A0310B = 01 ~~and~~ ~~Readmission/return~~ ~~A0310B = 06~~
2	2.8	2-43	• See Section 2.1~~2~~3 for instructions involving beneficiaries who transfer or expire day 8 or earlier.
2	2.8	2-44	• 1-3 days after all therapy (Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP)) services are discontinued.
2	2.8 & 2.9	2-45	Page number change.
2	2.9	2-46	Page number change.
2	2.9	2-47	~~**06. Medicare-required Readmission/Return Assessment**~~ ~~• Completed when a resident whose SNF stay was being reimbursed by Medicare Part A is hospitalized, discharged return anticipated, and then returns to the SNF from the hospital within 30 days and continues to require and receive Part A SNF-level care services. Under these conditions, the entry tracking record completed upon return to the SNF will be coded as a reentry with Item A1700 = 2.~~ ~~• ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.~~ ~~• ARD may be extended up to day 8 if using the designated grace days.~~ ~~• Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).~~ ~~• Authorizes payment from days 1 through 14 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.~~ ~~• Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).~~ ~~• If combined with the OBRA Admission assessment, the assessment must be completed by the Day 14 counting the date of admission as Day 1 (admission date plus 13 calendar days).~~

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2	2.9	2-48	• The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day ~~or readmission/return~~ assessment).
2	2.9	2-48	• ~~If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday.~~ — If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday. • For purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.
2	2.9	2-48	• The ARD for the End of Therapy OMRA may not precede the ARD of the first scheduled PPS assessment of the Medicare stay (5-day ~~or readmission/return~~ assessment).
2	2.9	2-49	Page length change.
2	2.9	2-50	Page length change.
2	2.9	2-51	Page length change.
2	2.9	2-52 thru 2-54	• The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's ~~current~~ initial RUG-IV therapy classification in a Medicare Part A SNF stay. • Except as described below, a COT OMRA may only be completed when a resident is currently classified into a RUG-IV therapy group (regardless of whether or not the resident is classified into this group for payment), based on the resident's most recent assessment used for payment. • The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions are met*: 1. Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and 2. No discontinuation of therapy services (planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that

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			reclassified the resident into a RUG-IV therapy group. Under these circumstances, completing the COT OMRA to reclassify the resident into a therapy group may be considered optional. Additionally, the COT OMRA which classifies a resident into a non-therapy group or the COT OMRA which reclassifies the resident into a therapy group may be combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual. — Example 1: Mr. T classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount therapy provided to Mr. T. and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. T. did not qualified for a therapy RUG group. The facility completes a COT OMRA for Mr. T, with an ARD set for Day 37, on which he qualifies for LB1. Mr. T's rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 44, the facility checks the amount of therapy provided to Mr. T during the previous 7 days and finds that Mr. T again qualifies for the RUG-IV therapy group RUA.~~Mr. T. was classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount therapy provided to Mr. T. and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. T. did not qualified for a therapy RUG group. Mr. T.'s rehabilitation regimen has continued throughout this time period. The facility may complete a COT OMRA with an ARD of Day 44 to reclassify Mr. T. back into~~

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			~~RUA.~~ In example 1 above, because Mr. T had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment) and no discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group (Day 31, in this scenario) and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (Day 44, in this scenario), the facility may complete a COT OMRA with an ARD of Day 44 to reclassify Mr. T. back into the RUG-IV therapy group RUA. — Example 2: Mr. A classified into the RUG group RVA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount of therapy provided to Mr. A during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for a Very-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. A did not qualify for any RUG-IV therapy group. The facility completes a COT OMRA for Mr. A, with an ARD set for Day 37, on which he qualifies for LB1. Mr. A's rehabilitation regimen is intended to continue from that point, but Mr. A does not receive therapy on Days 36, 37 and 38. On Day 44, the facility checks the amount of therapy provided to Mr. A during the previous 7 days and finds that Mr. A again qualifies for the RUG-IV therapy group RVA. In example 2 above, while Mr. A had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment), a discontinuation of therapy services occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (i.e., the discontinuation due to Mr. A missing therapy on Days 36-38). Therefore, the facility may not complete a COT OMRA with an ARD of Day 44 to reclassify Mr. A back into the RUG-IV therapy group RVA.

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			• A COT OMRA may be used to reclassify a resident into a RUG-IV therapy group only when the resident was classified into a RUG-IV non-therapy by a previous COT OMRA (which may have been combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual). — For example: Mr. E classified into the RUG group RUA on his 14-day assessment with an ARD set for Day 15 of his stay. No unscheduled assessments were required or completed between Mr. E's 14-day assessment and his 30-day assessment. On Day 29, the facility checked the amount of therapy provided to Mr. E during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. E did not qualify for any RUG-IV therapy group. The facility completes a 30-day assessment for Mr. E, with an ARD set for Day 29, on which he qualifies for LB1, but opts not to combine this 30-day assessment with a COT OMRA (as permitted under the COT rules outlines in Section 2.9 of the MDS 3.0 manual) Mr. E.'s rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 36, the facility checks the amount of therapy provided to Mr. E during the previous 7 days and finds that Mr. E again qualifies for the RUG-IV therapy group RUA. In the scenario above, although Mr. E had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (e.g., the 14-day assessment), the assessment which classified Mr. E into a RUG-IV non-therapy group was not a COT OMRA. Therefore, the facility may not complete a COT OMRA with an ARD of Day 36 to reclassify Mr. E back into the RUG-IV therapy group RUA. If a resident is classified into a non-therapy RUG on a COT OMRA and the facility subsequently decides to discontinue therapy services for that resident, an EOT OMRA is not required for this resident.
2	2.9	2-55	Page length change.
2	2.10	2-56	Page length change.

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2	2.10	2-57	Page length change.
2	2.10	2-58	• 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.~~If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS Assessment, and the ARD of the scheduled PPS assessment has not been set for a day that is prior to Day 7 of the COT observation period, and a COT OMRA is deemed necessary upon completion of the change of therapy evaluation, then the SNF must combine the COT OMRA and the scheduled assessment.~~
2	2.10	2-59	Page length change.
2	2.10 & 2.11	2-60	Page length change.
2	2.11	2-61	• Quarterly • Significant Correction to Prior Quarterly • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • ~~PPS Readmission/Return~~
2	2.11	2-62	• PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • ~~PPS Readmission/Return~~ • Clinical Change Assessment
2	2.12	2-62	Below are some of the allowed possible assessment combinations~~allowed~~. A provider may choose to combine more than two assessment types when all requirements are met. The coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15).
2	2.12	2-62	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-63	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-63	• See Section 2.7 and Chapter 4 for requirements for CAA

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			process and care plan completion.
2	2.12	2-63	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-64	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-64	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-65	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-65	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-65	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-66	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-67	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-67	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-68	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-68	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-69	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-70	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-70	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-71	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-72	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-72	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-73	• See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.13	2-74	If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted. ~~The type of entry on the Entry Tracking record (as described in Section 2.6) completed by the provider determines whether a Medicare-~~

Chapter	Section	Page	Change
			~~required 5-day or a Medicare Readmission/Return assessment should be completed.~~ ~~When the Medicare resident returns to the SNF and the entry type on the Entry Tracking record is a Reentry (Item A1700=2), the first required Medicare assessment is the Medicare Readmission/ Return assessment (Item A0310B = 06) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.~~ ~~When the Medicare resident returns to the SNF and the entry type on the Entry Tracking record is an Admission (Item A1700=1), the first required Medicare assessment is the Medicare-required 5-Day assessment (Item A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.~~ For all providers, including Swing bed providers, the first required Medicare assessment is always the Medicare-required 5-Day assessment (Item A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.
2	2.13	2-75 & 2-76	~~Finally, t~~There may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days. If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3). ~~***Resident Leaves the Facility and Returns During an Observation Period***~~ ~~The ARD is not altered if the beneficiary is out of the facility for a~~

Chapter	Section	Page	Change
			~~temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3) but may not extend the observation period.~~
2	2.13 & 2-14	2-77, 2-78 & 2-79	Page length change.
2	2.14	2-80	**Next Record** Entry OBRA Admission OBRA Annual OBRA Quarterly, sign. change, sign correction PPS 5-day ~~or readmission/return~~ PPS 14-day PPS 30-day PPS 60-day PPS 90-day PPS unscheduled Discharge Death in facility
2	2.15	2-81	**PPS RFA (A0310B)** 01,02,~~06,~~99 01,02,~~06,~~07 02,07 01 thru 0~~6~~6,99 01 thru 07 02 thru 05,07 01 thru 07,99 01 thru 0~~6~~5,99 01 thru 07 02 thru 05,07 01 thru 0~~6~~5 02 thru 05 07 07

Track Changes
from Chapter 2 V1.11
to Chapter 2 V1.12

Chapter	Section	Page	Change
			07 07 99 99
2	2.15	2-82	**PPS RFA (A0310B)** 01 thru 0~~6~~5 01 thru 07 02 thru 05 02 thru 05,07 07 07 07 07 99 99