

**Centers for Medicare &
Medicaid Services**



**Long-Term Care
Facility Resident
Assessment
Instrument
User's Manual**

Version 3.0

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CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being.

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations¹.

Persons generally enter a nursing home because of problems with functional status caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. Sometimes, the individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment, and/or rehabilitation is needed for the resident to maintain and/or restore function or to live safely from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). This is true for both long-term residents and residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice.

1.2 Content of the RAI for Nursing Homes

The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the

¹ Healthcentric Advisors: [The Holistic Approach to Transformational Change](http://healthcentricadvisors.org/images/stories/documents/inhc.pdf) (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from <http://healthcentricadvisors.org/images/stories/documents/inhc.pdf>.

three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment-once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data items for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, Discharge, Tracking, PPS item sets) can be found in Appendix H.
- **Care Area Assessment (CAA) Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include:
 - **Care Area Triggers (CATs)** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
 - **Care Area Assessment** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The **CAA** resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources is not mandatory and the list of Web links is neither all-inclusive nor government endorsed.
 - **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning.
- **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_r.pdf).

1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose is an assessment tool is used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents.

The MDS instrument has also been adapted for use by non-critical access hospitals with a swing bed agreement. They are required to complete the MDS for reimbursement under SNF PPS.

- **Medicare and Medicaid Payment Systems.** The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at <http://www.cms.gov/Manuals/IOM/list.asp> for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.
- **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs) were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QMs, which may be modified in the future to enhance their effectiveness.
- **Consumer Access to Nursing Home Information.** Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Nursing Home Compare tool (www.medicare.gov/nursinghomecompare/) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

- (1) the assessment accurately reflects the resident's status
- (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

- (1) who should participate in the assessment process
- (2) how the assessment process is completed

- a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident’s family, and/or guardian or other legally authorized representative).
- b. **Decision Making**—Determining with the resident (resident’s family and/or guardian or other legally authorized representative), the resident’s physician and the interdisciplinary team, the severity, functional impact, and scope of a resident’s clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident’s diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident’s clinical issues and needs and discovering the “whats” and “whys” of the resident’s clinical issues and needs; finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.
- c. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident’s active participation in the process.
- d. **Care Planning**—Establishing a course of action with input from the resident (resident’s family and/or guardian or other legally authorized representative), resident’s physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the “how” of resident care.
- e. **Implementation**—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident’s care goals and approaches; carrying out the “how” and “when” of resident care.
- f. **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident’s status, goals, or improvement or decline.

The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, care plan development, care plan implementation, and finally to evaluation. This manual will refer to this process throughout several chapter discussions.



If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident’s quality of care and quality of life. The RAI offers a clear path toward using

all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another “layer” of labor.

The key to successfully using the RAI process is to understand that its structure is designed to enhance resident care, increase a resident’s active participation in care, and promote the quality of a resident’s life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its “hands on” approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident’s quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents’ families (and/or guardian or other legally authorized representative), and the interdisciplinary team, residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases.
- **Staff Communication Has Become More Effective.** When staff members are involved in a resident’s ongoing assessment and have input into the determination and development of a resident’s care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing the CAAs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is accommodated in the care plan.
- **Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident goals, needs, interests, strengths, problems, preferences, and lifestyle choices. When considering all of this information, staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.
- **Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Disease Diagnosis	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments, Procedures and Programs	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

- 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' 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).
- All comprehensive RAIs authorized by States must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-approved State's RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI).

Additional information about State specification of the RAI, variations in format and CMS approval of a State's RAI can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual (SOM). For more information about your State's assessment requirements, contact your State RAI coordinator (see Appendix B).

2.3 Responsibilities of Nursing Homes for Completing Assessments

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.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice Residents:** When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
 - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The 15-month requirement for maintenance of the RAI data must be adhered to.
 - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
 - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- 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.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.

Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.
- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have a SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.
- Early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.13).

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.

Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDSs include Admission, Annual, Significant Change in Status Assessment (SCSA), and Significant Correction to Prior Comprehensive Assessment (SCPA).

Death In Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. A Discharge assessment is not required.

Discharge refers to the date a resident leaves the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are two types of discharges – return anticipated and return not anticipated. A Discharge assessment is required with both types of discharges. Section 2.6 provides detailed instructions regarding both discharge types. Any of the following

situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- 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.

Discharge Assessment refers to an assessment required on resident discharge. This assessment includes clinical items for quality monitoring as well as discharge tracking information.

Entry is a term used for both an admission and a reentry, and requires completion of an Entry tracking record.

Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter or leave a nursing home. Entry/Discharge reporting includes Entry tracking record, Discharge assessments, and Death in Facility tracking record.

Interdisciplinary Team (IDT¹) is a group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident.

Item Set refers to the MDS items that are active on a particular assessment type or tracking form. There are 10 different item subsets for nursing homes and 8 for swing bed providers as follows:

- Nursing Home
 - **Comprehensive (NC²) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment).
 - **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-alone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment

¹ 42 CFR 483.20(k)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative;"

² The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

- **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 PPS assessment or a scheduled PPS assessment combined with a PPS OMRA assessment and/or a Discharge assessment.
- **OMRA - Start of Therapy (NS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
- **OMRA - Start of Therapy and Discharge (NSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
- **OMRA (NO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and a change of therapy OMRA assessment. The code used is “NO” since this was the only type of OMRA when the code was initially assigned.
- **OMRA - Discharge (NOD) Item Subset.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
- **Discharge (ND) Item Set.** This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).
- **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
- **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.
- **Swing Beds**
 - **PPS (SP) 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) or a Swing Bed Clinical Change assessment. This item set is used for a scheduled PPS assessment that is standalone or in any combination with other swing bed assessments (Swing Bed Clinical Change assessment, OMRA assessment, and/or Discharge assessment). This item set is also used for a Swing Bed Clinical Change assessment that is standalone or in any combination with other swing bed assessments (scheduled PPS assessment, OMRA assessment, and/or Discharge assessment).
 - **OMRA – Start of Therapy (SS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
 - **OMRA – Start of Therapy and Discharge Assessment (SSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
 - **OMRA (SO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and change of therapy OMRA assessment.
 - **OMRA - Discharge Assessment (SOD) Item Set.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).

- **Discharge (SD) Item Set.** This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).
- **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
- **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, and A0310F). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2-15 of this chapter provides manual lookup tables for determining the item set, when automated software is unavailable.

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the patient.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.

MDS Assessment Codes are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Medicare-Required PPS Assessments provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA). They include:

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)

must be maintained in the resident's medical record.³ In closing the record, the nursing home should note why the RAI was not completed.

- If a resident dies prior to the completion deadline for the assessment, 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.⁴ In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- The nursing home may combine a comprehensive assessment with a Discharge assessment.
- 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.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

OBRA-required comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (Item A0310A).

01. Admission Assessment (A0310A=01)

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:

³ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

⁴ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

- 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 clinical record.
- A SCSA is appropriate when:
 - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
 - The resident's condition is not expected to return to baseline within two weeks.
 - For a resident who goes in and out of the facility on a relatively frequent basis and reentry 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. However, if the IDT determines that the resident would benefit from a Significant Change in Status Assessment during the intervening period, the staff must complete a SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- A SCSA may **not** be completed prior to an OBRA Admission assessment.
- A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- 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.
- A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice

election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- 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. 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 less than or equal to 14 days after the IDT's determination that the criteria for a SCSA are met (determination date + 14 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When a SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- 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).

Guidelines for Determining a Significant Change in a Resident's Status:

Note: this is not an exhaustive list

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.

Some Guidelines to Assist in Deciding if a Change is Significant or Not:

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a SCSA. This timeframe may vary depending on clinical judgment and resident needs. For

example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, a SCSA may be warranted.

- **If there is only one change**, staff may still decide that the resident would benefit from a SCSA. It is important to remember that each resident's situation is unique and the IDT must make the decision as to whether or not the resident will benefit from a SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.
- A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- A SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning;
- **Decline in two or more of the following:**
 - Resident's decision-making changes;
 - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9[®]), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
 - Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
 - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
 - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
 - Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status;
 - Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or

- Overall deterioration of resident's condition.

Examples (SCSA):

Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change, and a SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Mr. T's behavioral symptoms could have many causes, and a SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

1. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.
 - Improvement in two or more of the following:
 - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
 - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
 - Resident's decision making changes for the better;
 - Resident's incontinence pattern changes for the better;
 - Overall improvement of resident's condition.
2. Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. A SCSA will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status is not Significant:

Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a SCSA)
- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.

- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:

Note: this is not an exhaustive list

The key in determining if a SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

Examples (SCSA):

1. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia, diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.
2. Mrs. K came into the nursing home with identifiable problems and has steadily responded to treatment. Her condition has improved over time and has recently hit a plateau. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if Mrs. K is

discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if she is not discharged, an assessment is required by the end of the allotted 14-day period.

3. Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring a SCSA at this time. However, if her condition was to stabilize and her discharge was not imminent, a SCSA would be in order.

Guidelines for Determining When A Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:

- 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 State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/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.⁵
- PASRR is not a requirement of the resident assessment process, but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at <http://www.cms.gov/>.
- The nursing facility must provide the SMH/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/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

⁵ The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

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

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident’s plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- A resident whose condition or treatment is or will be significantly different than described in the resident’s most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with a SCSA.)

Example (PASRR & SCSA):

1. Mr. L has a diagnosis of serious mental illness, but his primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and he becomes ambulatory, even if other conditions exist for which Mr. L receives medical care, he should be referred for a PASRR evaluation to determine whether a change in his placement or services is needed.

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

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A=05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- A SCPA is appropriate when:
 - the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- 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).

Non-Comprehensive Assessments and Entry and Discharge Reporting

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:

- Quarterly Assessment
- Significant Correction to Prior Quarterly Assessment
- Discharge Assessment – Return not Anticipated
- Discharge Assessment – Return Anticipated

The Quarterly and Significant Correction to Prior Quarterly assessments are not required for Swing Bed residents. However, Swing Bed providers are required to complete the Discharge assessments.

Tracking records include a select number of MDS items and are required for **all** residents in the nursing home and swing bed facility. They include:

- Entry Tracking Record
- Death in Facility Tracking Record

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

- The ARD is considered the last day of the observation/look back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA.

For example:

- 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).
- Resident B also has a Quarterly assessment with an ARD of March 20th. She goes to the hospital on March 20th and returns March 30th. While there is no significant

change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.⁶ In closing the record, the nursing home should note why the RAI was not completed.
- 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 When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and a SCPA, if it is identified that a significant error occurred in a previous comprehensive 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 comprehensive 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.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- 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.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

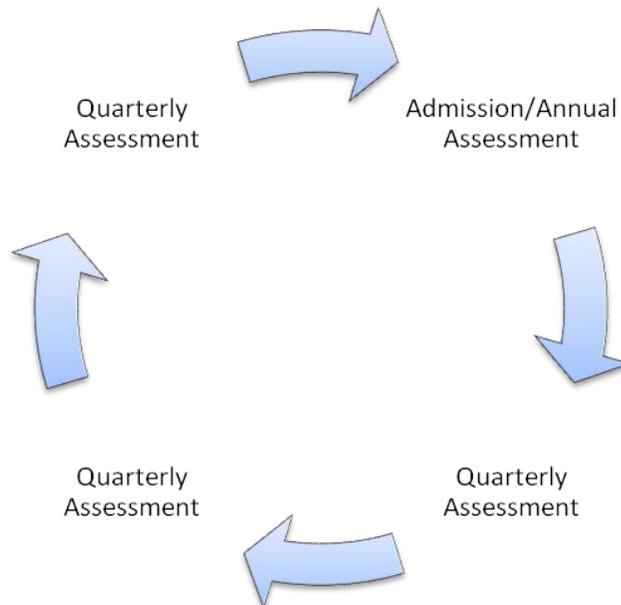
⁶ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

05. Quarterly Assessment (A0310A=02)

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

Assessment Management Requirements and Tips:

- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period. Assuming the resident does not have a SCSA or SCPA completed and was not discharged from the nursing home, a typical 12-month OBRA schedule would look like this:



- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions.
- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, or Annual assessment + 92 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).

06. Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A=06)

The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (Item A2300) and completion dates (Item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- A SCQA is appropriate when:
 - the erroneous Quarterly assessment has been completed (MDS completion date, Item Z0500B) and transmitted/submitted into the MDS system; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be less than or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred (determination date + 14 calendar days). The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

Tracking Records and Discharge Assessments (A0310F)

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry and discharge reporting **is** required for Swing Bed residents and respite residents.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit Discharge assessments and Entry records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

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 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

Assessment Management Requirements and Tips for Entry Tracking Records:

- The Entry tracking record is the first item set completed for all residents.
- Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility).
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a stand-alone tracking record.
- May **not** be combined with an assessment.

08. Death in Facility Tracking Record (A0310F=12)

- Must be completed when the resident dies in the facility or when on LOA
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any type of assessment.

Example (Death in Facility):

1. Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

A0310F = 12
A2000 = 11-13-2011
A2100 = 08

Discharge Assessments (A0310F)

Discharge assessments consist of discharge return anticipated and discharge return not anticipated. These are OBRA required assessments.

09. Discharge Assessment–Return Not Anticipated (A0310F=10)

- Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.

- Must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.

If the resident returns, the Entry tracking record will be coded A1700=1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the PPS schedule starts with a Medicare-required 5-day scheduled assessment or combination of the Admission and 5-day PPS assessment.

Examples (Discharge-return not anticipated):

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 Discharge assessment as follows:

A0310F = 10
A2000 = 03-29-2011
A2100 = 01

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

10. Discharge Assessment–Return Anticipated (A0310F=11)

- Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
- For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. 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.
- Must be completed (Item Z0500B) within 14 days after the discharge date (Item A2000) (i.e., discharge date (A2000) + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.

- When the resident returns to the nursing home, the IDT must determine if criteria are met for a SCSA (only when the OBRA Admission assessment was completed prior to discharge).
 - If criteria are met, complete a Significant Change in Status assessment.
 - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior Discharge assessment completed indicating that the resident was expected to return (A0310E=11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

Example (Discharge-return anticipated):

1. Ms. C. was admitted to the nursing home on May 22, 2011. She tripped while at a restaurant with her daughter. She was discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 Discharge assessment as follows:

A0310F = 11
 A2000 = 05-31-2011
 A2100 = 03

Assessment Management Requirements and Tips for Discharge Assessments:

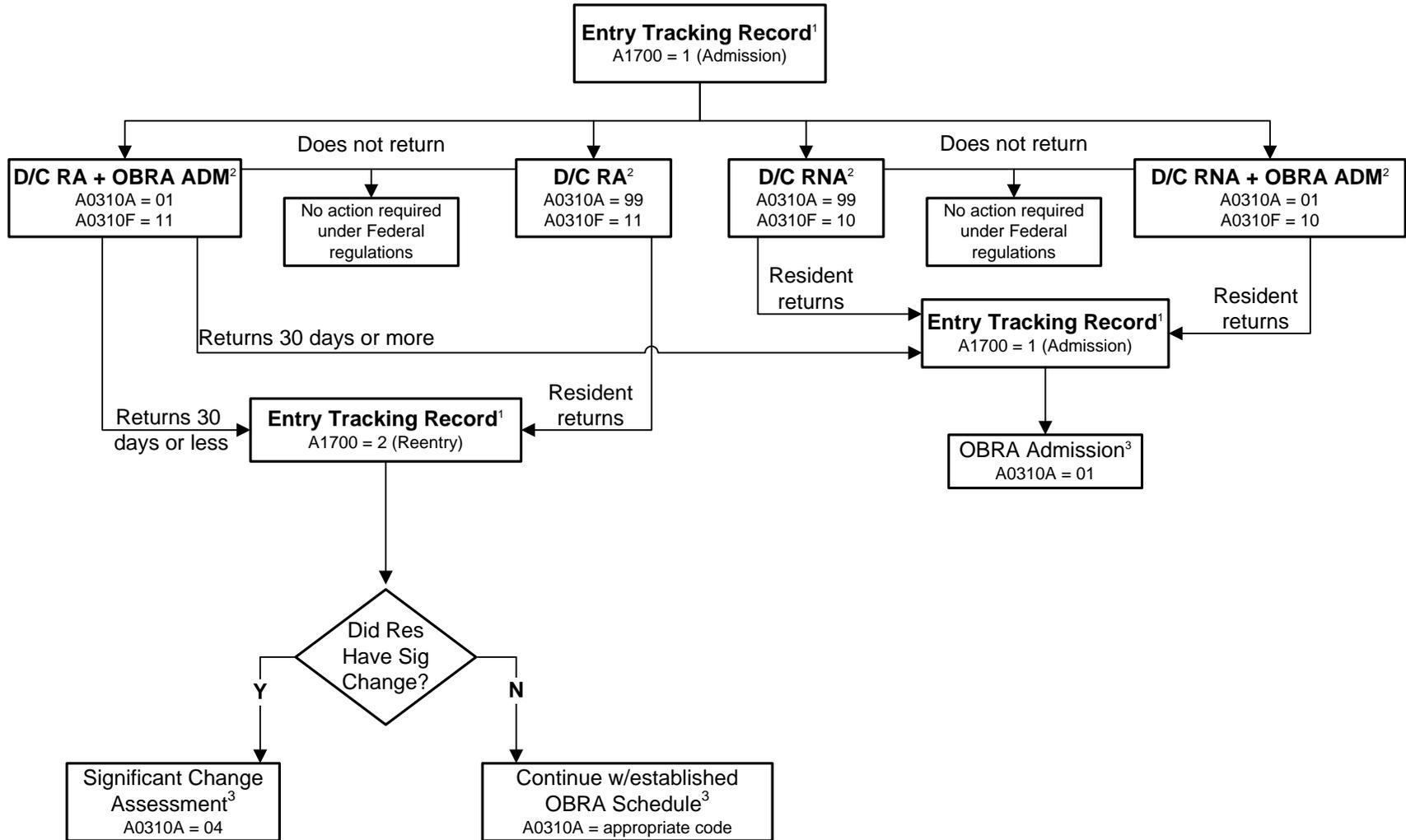
- Must be completed when the resident is discharged from the facility (see definition of Discharge on page 2-10).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA required assessment when requirements for all assessments are met.
- May be combined with a PPS Medicare required assessment 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.
 - An unplanned discharge includes, for example:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
 - Resident unexpectedly leaving the facility against medical advice; or
 - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

The following chart details the sequencing and coding of Tracking records and Discharge assessments.

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.

ADM	Admission
D/C	Discharge
RA	Return Anticipated
RNA	Return Not Anticipated

2.7 The Care Area Assessment (CAA) Process and Care Plan Completion

Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.

CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (Item V0200B2) must be either later than or the same date as the MDS completion date (Item Z0500B). In no event can either date be later than the established timeframes as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/problems. In many cases, interventions will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a preliminary care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

Care Plan Completion

- 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.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (Item V0200C2) must be either later than or the same date as the CAA completion date (Item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (Item Z0500B) must be earlier than or the same date as the care plan completion date. In no event can either date be later than the established timeframes as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- 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.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

Skilled nursing facilities (SNFs) must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF PPS. In addition to the Medicare-required assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the Medicare-required assessments, such as completion and submission time frames.

Assessment Window

Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 8. Timeliness of the PPS assessment is defined by

selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS Assessments chart below for the allowed ARDs for each of the Medicare-required assessments and other assessment information.

When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may do so no more than two days after the window has passed.

The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes. In most cases, the first day of Medicare Part A coverage is the date of admission or reentry. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date. See Chapter 6, Section 6.7, for more detailed information.

Grace Days

There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. For example, the Medicare-required 5-Day ARD can be extended 1 to 3 grace days (i.e., days 6 to 8). The use of grace days allows clinical flexibility in setting ARDs. See chart below for the allowed grace days for each of the scheduled Medicare-required assessments. Grace days are not applied to unscheduled Medicare PPS Assessments.

Scheduled Medicare PPS Assessments

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 SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Applicable Standard Medicare Payment Days^
5-day	01	Days 1-5	6-8	1 through 14
14-day	02	Days 13-14	15-18	15 through 30
30-day	03	Days 27-29	30-33	31 through 60
60-day	04	Days 57-59	60-63	61 through 90
90-day	05	Days 87-89	90-93	91 through 100

+Grace Days: a specific number of days that can be added to the ARD window without penalty.

^Applicable Standard Medicare Payment Days may vary when assessment types are combined. For example, when a provider combines an unscheduled assessment, such as a Significant Change in Status Assessment (SCSA), with a scheduled assessment, such as a 30-day Medicare-required assessment, the new resource utilization group (RUG) would take effect on the ARD of the assessment. If the ARD of this assessment was day 28, the new RUG would take effect on day 28 of the stay. The exception would be if the ARD fell within the grace days. In that case, the new RUG would be effective on the first day of the regular payment period. For example, if the ARD of an unscheduled assessment combined with the 60-day assessment, was day 62, the new RUG would take effect on day 61.

Unscheduled Medicare PPS Assessments

There are situations when a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments. These assessments are known as unscheduled assessments. When indicated, a provider must complete the following unscheduled assessments:

1. Significant Change in Status Assessment (for swing bed providers this unscheduled assessment is called the Swing Bed Clinical Change Assessment) (see Section 2.6).
2. Significant Correction to Prior Comprehensive Assessment (see Section 2.6).
3. Start of Therapy Other Medicare Required Assessment (SOT-OMRA) (see Section 2.9).
4. End of Therapy Other Medicare Required Assessment (EOT- OMRA) (see Section 2.9).
5. Change of Therapy Other Medicare Required Assessment (COT-OMRA) (see Section 2.9).

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in 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.

Tracking Records and Discharge Assessments Reporting

Tracking records and discharge assessments reporting are required on **all** residents in the SNF and swing bed facilities. Tracking records and standalone Discharge assessments do not impact payment.

The following chart summarizes the Medicare-required scheduled and unscheduled assessments, tracking records, and discharge assessments:

Medicare Scheduled and Unscheduled MDS Assessment, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
5-day A0310B = 01	Days 1-5	6-8	Days 1-8	Sets payment rate for days 1-14	<ul style="list-style-type: none"> See Section 2.13 for instructions involving beneficiaries who transfer or expire day 8 or earlier. CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA.
14-day A0310B = 02	Days 13-14	15-18	Days 13-18	Sets payment rate for days 15-30	<ul style="list-style-type: none"> CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.
30-day A0310B = 03	Days 27-29	30-33	Days 27-33	Sets payment rate for days 31-60	
60-day A0310B = 04	Days 57-59	60-63	Days 57-63	Sets payment rate for days 61-90	
90-day A0310B = 05	Days 87-89	90-93	Days 87-93	Sets payment rate for days 91-100	<ul style="list-style-type: none"> If combined with the OBRA Quarterly assessment the completion date requirements for the OBRA Quarterly assessment must also be met.

(continued)

Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Start of Therapy Other Medicare-required Assessment (OMRA) A0310B = 01 - 07 and A0310C = 1 or 3	<ul style="list-style-type: none"> 5-7 days after the start of therapy The day of the first therapy evaluation counts as day 1 	N/A	N/A	Modifies payment rate starting on the date of the first therapy evaluation	<ul style="list-style-type: none"> Voluntary assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG.
End of Therapy OMRA A0310B = 01-07 and A0310C = 2 or 3	<ul style="list-style-type: none"> 1-3 days after all therapy (Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP)) services are discontinued. The first non-therapy day counts as day 1. 	N/A	N/A	Modifies payment rate starting on the day after the latest therapy end date	<ul style="list-style-type: none"> Not required if the resident has been determined to no longer meet Medicare skilled level of care. Establishes a new non-therapy RUG Classification. Only required for patients who are classified into Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment. For circumstances when an End of Therapy with Resumption option would be used, See Section 2.9.
Change of Therapy OMRA A0310B = 01-07 And A0310C = 4	<ul style="list-style-type: none"> Day 7 of the COT observation period 	N/A	N/A	Modifies payment rate starting on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other scheduled or unscheduled PPS assessment	<ul style="list-style-type: none"> Required only if the intensity of therapy during the 7-day look back period would change the RUG category classification of the most recent PPS Assessment Establishes a new RUG classification

(continued)

Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Significant Change in Status Assessment (SCSA) A0310A = 04	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Swing Bed Clinical Change Assessment (CCA) A0310B = 01-07 and A0310D = 1	Completed by the end of the 14th calendar day after determination that a clinical change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Significant Correction to Prior Comprehensive Assessment (SCPA) A0310A = 05	Completed by the end of the 14th calendar day after identification of a significant, uncorrected error in prior comprehensive assessment.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Entry tracking record A0310F = 01	N/A	N/A	N/A	N/A	May not be combined with another assessment
Discharge Assessment A0310F = 10 or 11	Must be set for the day of discharge	N/A	N/A	N/A	May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment
Death in facility tracking record A0310F = 12	N/A	N/A	N/A	N/A	May not be combined with another assessment

*NOTE: When SCSA, SCPA, and CCA are combined with another assessment, payment rate may not be effective on the ARD. For example, a provider combines the 30-day Medicare-required assessment with a Significant Change in Status assessment with an ARD of day 33, a grace day, payment rate would become effective on day 31, not day 33. See Chapter 6, Section 6.4.

2.9 MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in Items A0310A and A0310B respectively. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item A0310B. The OBRA Reason for Assessment is described earlier in this section while the Medicare PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and Medicare requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Sections 2.11 and 2.12.

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

- 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 the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (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 end of day 14 of admission (admission date plus 13 calendar days).
- Is the first Medicare-required assessment to be completed when the resident is first admitted for SNF Part A stay.
- Is the first Medicare-required assessment to be completed when the Part A resident is re-admitted to the facility following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5 -day PPS assessment as the resident is now beginning a Medicare Part A stay.

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 13 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 18 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 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 end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 27 through 29 of the Part A SNF covered stay.
- ARD may be extended up to day 33 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 31 through 60 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).

04. Medicare-required 60-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 57 through 59 of the Part A SNF covered stay.
- ARD may be extended up to day 63 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 61 through 90 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).

05. Medicare-required 90-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 87 through 89 of the Part A SNF covered stay.
- ARD may be extended up to day 93 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 91 through 100 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).

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled Assessments Used for PPS

There are several unscheduled assessment types that may be required to be completed during a resident's Part A SNF covered stay.

Start of Therapy (SOT) OMRA

- Optional.
- Completed only to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Completed only if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group.
- ARD (Item A2300) must be set on days 5-7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) with the exception of the Short Stay Assessment (see Chapter 6, Section 6.4). The date of the earliest therapy evaluation is counted as day 1 when determining the ARD for the Start of Therapy OMRA, regardless if treatment is provided or not on that day.
- May be combined with scheduled PPS assessments.

- 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.
- The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day assessment).
 - For example if the 5-day assessment is performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued for any reason (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided whether therapy was scheduled or not scheduled for that day. For example:
 - If the resident was discharged from all therapy services on Tuesday, day 1 is Wednesday.
 - If the resident was discharged from all therapy services on Friday, 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.
- May be combined with any scheduled PPS assessment. In such cases, the item set for the scheduled assessment should be used.
- 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 assessment).
 - For example: if the 5-day assessment is completed on day 8 and an EOT is completed in that window, the ARD for the EOT should be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).

- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment regardless of day selected for ARD.
- Must be submitted electronically to the QIES ASAP system and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- In cases where a resident is discharged from the SNF *on or prior to* the third consecutive day of missed therapy services, then no EOT is required. More precisely, in cases where the date coded for Item A2000 is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If a SNF chooses to complete the EOT OMRA in this situation, they may combine the EOT OMRA with the discharge assessment.
- In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.
- In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.
- If the EOT OMRA is performed because three or more consecutive days of therapy were missed, and it is determined that therapy will resume, there are three options for completion:
 1. Complete only the EOT OMRA and keep the resident in a non-Rehabilitation RUG category until the next scheduled PPS assessment is completed. For example:
 - Mr. K. was discharged from all therapy services on Day 22 of his SNF stay. The EOT OMRA was performed on Day 24 of his SNF stay and classified into HD1. Payment continued at HD1 until the 30- day assessment was completed. At that point, therapy resumed (with a new therapy evaluation) and the resident was classified into RVB.
 2. In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or therapy services will not resume at the same RUG-IV therapy classification level that had been in effect prior to the EOT OMRA, an SOT OMRA is required to classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well. For example: Mr. G. who had been classified into RVX did not receive therapy on Saturday and Sunday. He also missed therapy on Monday because his family came to visit, on Tuesday he missed therapy due to a doctor's appointment and refused therapy on Wednesday. An EOT OMRA was performed on Monday classifying him into the ES2 non-therapy RUG. He missed 5 consecutive calendar days of therapy. A new therapy evaluation was completed and he resumed therapy services on Thursday. An SOT OMRA was then completed and Mr. G. was placed back into the RVX therapy RUG category.

- Mrs. B., who had been classified into RHC did not receive therapy on Monday, Tuesday, and Wednesday because of an infection, and it was determined that she would be able to start therapy again on Thursday. An EOT OMRA was completed to pay for the three days she did not have therapy with a non-therapy RUG classification of HC2. It was determined that Mrs. B. would not be able to resume therapy at the same RUG-IV therapy classification, and an SOT OMRA was completed to place her into the RMB RUG-IV therapy category. A new therapy evaluation was required.
3. In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level, and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. For Example:
- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment, but resumed therapy Tuesday. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. An EOT-R was completed and Mrs. A was placed into ES3 for the three days she did not receive therapy. On Tuesday, Mrs. A. was placed back into RVL, which was the same therapy RUG group she was in prior to the discontinuation of therapy. A new therapy evaluation was not required.

NOTE: If the EOT OMRA has not been accepted in the QIES ASAP when therapy resumes, code the EOT-R items (O0450A and O0450B) on the assessment and submit the record. If the EOT OMRA without the EOT-R items has been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the EOT-R items and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

In cases when the therapy end date is in one payment period and the resumption date is in the next payment period, the facility should bill the non-therapy RUG given on the EOT OMRA beginning the day after the last day of therapy treatment and begin billing the therapy RUG that was in effect prior to the EOT OMRA beginning on the day that therapy resumed (O0450B). If the resumption of therapy occurs after the next billing period has started, then this therapy RUG should be used until modified by a future scheduled or unscheduled assessment.

- For example, a resident misses therapy on Days 11, 12, and 13 and resumes therapy on Day 15. In this case the facility should bill the non-therapy RUG for Days 11, 12, 13, and 14 and on Day 15 the facility should bill the RUG that was in effect prior to the EOT.

Change of Therapy (COT) OMRA

- Required when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.
- ARD is set for Day 7 of a COT observation period. The COT observation periods are successive 7-day windows with the first observation period beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment, except for an EOT-R assessment (see below). For example:
 - If the ARD for a patient's 30-day assessment is set for day 30, and there are no intervening assessments, then the COT observation period ends on Day 37.
 - If the ARD for the patient's most recent COT (whether the COT was completed or not) was Day 37, the next COT observation period would end on Day 44.
- In cases where the last PPS Assessment was an EOT-R, the end of the first COT observation period is Day 7 after the Resumption of Therapy date (O0450B) on the EOT-R, rather than the ARD. The resumption of therapy date is counted as day 1 when determining Day 7 of the COT observation period. For example:
 - If the ARD for an EOT-R is set for day 35 and the resumption date is the equivalent of day 37, then the COT observation period ends on day 43.
- An evaluation of the necessity for a COT OMRA (that is, an evaluation of the therapy intensity, as described above) must be completed after the COT observation period is over.
- The COT would be completed if the patient's therapy intensity, as described above, has changed to classify the resident into a higher or lower RUG category. For example:

If a facility sets the ARD for its 14-day assessment to day 14, Day 1 for purposes of the COT period would be Day 15 of the SNF stay, and the facility would be required to review the therapy services provided to the patient for the week consisting of Day 15 through 21. The ARD for the COT OMRA would then be set for Day 21, if the facility were to determine that, for example, the total RTM has changed such that the resident's RUG classification would change from that found on the 14-day assessment (assuming no intervening assessments). If the total RTM would not result in a RUG classification change, and all other therapy category qualifiers have remained consistent with the patient's current RUG classification, then the COT OMRA would not be completed.
- If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS Assessment, the SNF may choose to complete the PPS Assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is *on or prior to* Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS Assessment ARD. Alternatively, the SNF may

choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.

- In cases where a resident is discharged from the SNF on or prior to Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the discharge assessment.
- 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 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 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 qualify 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.

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.

- 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.

- When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)
- Establishes a new RUG-IV category. Payment begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other PPS assessment.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Significant Change in Status Assessment (SCSA)

- Is an OBRA required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification.
- When a SCSA for a SNF PPS resident is not combined with a PPS assessment (A0310A = 04 and A0310B = 99), the RUG-IV classification and associated payment rate begin on the ARD. For example, a SCSA is completed with an ARD of day 20 then the RUG-IV classification begins on day 20.
- When the SCSA is completed with a scheduled Medicare-required assessment and grace days are not used when setting the ARD, the RUG-IV classification begins on the ARD. For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.

When the SCSA is completed with a scheduled Medicare-required assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. For example, the SCSA is combined with the Medicare-required 30-day scheduled assessment, which pays for days 31 to 60, and the ARD is set at day 33, the RUG-IV classification begins day 31.

Swing Bed Clinical Change Assessment

- Is a required assessment for swing bed providers. Staff is responsible for determining whether a change (either an improvement or decline) in a patient's condition constitutes a "clinical change" in the patient's status.
- Is similar to the OBRA Significant Change in Status Assessment with the exceptions of the CAA process and the timing related to the OBRA Admission assessment. See Section 2.6 of this chapter.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Significant Correction to Prior Comprehensive Assessment

- Is an OBRA required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Coding Tips and Special Populations

- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.
- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. For example, if Day 7 of the COT observation period is May 23rd and the COT is required, then the ARD for this COT must be set for May 23rd and this must be done by May 25th. Facilities may still exercise the use of this flexibility period in cases where the resident discharges from the facility during that period.
- Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, J) on or prior to the ARD for a standalone unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).

2.10 Combining Medicare Scheduled and Unscheduled Assessments

There may be instances when more than one Medicare-required assessment is due in the same time period. To reduce provider burden, CMS allows the combining of assessments. Two Medicare-required Scheduled Assessments may **never** be combined since these assessments have specific ARD windows that do not occur at the same time. However, it is possible that a Medicare-required Scheduled Assessment and a Medicare Unscheduled Assessment may be combined or that two Medicare Unscheduled assessments may be combined.

When combining assessments, the more stringent requirements must be met. For example, when a nursing home Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the PPS item set must be used. The PPS item set contains all the required items for the 14-Day Medicare-required assessment, whereas the Start of Therapy OMRA item set consists of fewer items, thus the provider would need to complete the PPS item set. The ARD window (including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the

requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in this chapter and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software 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).

In cases when a facility fails to combine a scheduled and unscheduled PPS assessment as required by the combined assessment policy, the payment is controlled by the unscheduled assessment. For

DEFINITION

USED FOR PAYMENT

An assessment is considered to be "used for payment" in that it either controls the payment for a given period or, with scheduled assessments may set the basis for payment for a given period.

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, 05, or 06 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, 05, or 06 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, 05, or 06 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, 05, or 06, 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

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 = 3

A0310D = 1

2.11 Combining Medicare Assessments and OBRA Assessments⁷

SNF providers are required to meet two assessment standards in a Medicare certified nursing facility:

- The OBRA standards are designated by the reason selected in Item A0310A, **Federal OBRA Reason for Assessment**, and Item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, and Item A0310C, **PPS Other Medicare Required Assessment - OMRA** and are required for resident's whose stay is covered by Medicare Part A.
- When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA Admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining

⁷ OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.

the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

Some states require providers to complete additional state-specific items (Section S) for selected assessments. States may also add comprehensive items to the Quarterly and/or PPS item sets. Providers must ensure that they follow their state requirements in addition to any OBRA and/or Medicare requirements.

The following tables provide the item set for each type of assessment or tracking record. When two or more assessments are combined then the appropriate item set contains all items that would be necessary if each of the combined assessments were being completed individually.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly/ PPS* Item Sets	Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities
Stand-alone Assessment Types	<ul style="list-style-type: none"> • OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA) 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Entry Tracking Record • Discharge assessments • Death in Facility Tracking Record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • Change of Therapy OMRA • OMRA • OMRA and Discharge
Combined Assessment Types	<ul style="list-style-type: none"> • OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required • Annual and any OMRA • SCSA and any Medicare-required • SCSA and any OMRA • SCPA and any Medicare-required • SCPA and any OMRA • Any OBRA comprehensive and any Discharge 	<ul style="list-style-type: none"> • Quarterly and any Medicare-scheduled • Quarterly and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Discharge and any Medicare-required • Quarterly and any Discharge • Significant Correction to Prior Quarterly and any Discharge • Any Medicare-required and any Discharge 	N/A

*Provider must check with State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS	Other Required Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	<ul style="list-style-type: none"> • 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) • Clinical Change Assessment 	<ul style="list-style-type: none"> • Entry Record • Discharge assessments • Death in Facility record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • Change of Therapy OMRA • OMRA • OMRA and Discharge
Assessment Type Combinations	<ul style="list-style-type: none"> • Clinical Change and any Medicare-required • Any Medicare-required and any Discharge 	N/A

Tracking records (Entry and Death in Facility) are never combined with other assessments.

The OMRA item sets are all unique item sets and are never completed when combining with other assessments, which require completion of additional items. For example, a **Start of Therapy OMRA** item set is completed only when an assessment is conducted to capture the start of therapy **and** assign a RUG-IV therapy group. In addition, a **Start of Therapy OMRA and Discharge** item set is only completed when the facility staff choose to complete an assessment to reflect the start of therapy and discharge from facility. If those assessments are completed in combination with another assessment type, an item set that contains all items required for both assessments must be selected.

2.12 Medicare and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. 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).

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required 14-Day and OBRA Admission Assessment

- Comprehensive item set.

- ARD (Item A2300) must be set on days 13 or 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 18 (i.e., grace days may not be used).
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Quarterly assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Quarterly ARD is met.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Medicare-required Scheduled Assessment and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Annual assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Annual ARD is met.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- Must be completed (Item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- Must be completed (Item Z0500B) within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Quarterly Assessment

- See Medicare-required Scheduled Assessment and OBRA Quarterly Assessment.

Medicare-required Scheduled Assessment and Discharge Assessment

- PPS item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion

Start of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) and meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start of Therapy OMRA and Annual Assessment

- Comprehensive item set
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after determination that an uncorrected significant error in a comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in a comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment

Start of Therapy OMRA and Discharge Assessment

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) within 14 days after the ARD.

End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1-3 days after the last day therapy was furnished (difference is 3 or less for Item A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 1-3 days after the end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.

- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and Discharge Assessment

- OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start and End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **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 the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (Item A2300) must be 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 the latest) **and** meet the requirements for OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start and End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 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** meet the requirements for OBRA Annual assessment requirements as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status 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 end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Z0500B) within 14 days after the ARD and within 14 days after the determination that criteria are met for a Significant Change in Status assessment.

- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See Start and End of Therapy OMRA and OBRA Quarterly Assessment.

Start and End of Therapy OMRA and Discharge Assessment

- OMRA-Start of Therapy and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must fall within 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). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).

- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing..
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Change of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier after admission **and** be on the last day of a COT 7-day observation period. Must be completed (Item Z0500B) by day 14 after admission (admission date plus 13 calendar days).
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change).
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must meet the requirements for an OBRA Quarterly assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period. Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Change of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must meet the requirements for an OBRA Annual assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.

- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected error in the prior comprehensive assessment has occurred **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Correction assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and Discharge Assessment

- COT OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** be on the last day of a COT 7-day observation period. The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

2.13 Factors Impacting the SNF Medicare Assessment Schedule⁸

Resident Expires Before or On the Eighth Day of SNF Stay

If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

Resident Transfers or Discharged Before or On the Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or transferred to another payer source before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). When the beneficiary is discharged from the SNF, the provider must also complete a Discharge assessment (see Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a discharge assessment).

Short Stay

If the beneficiary dies, is discharged from the SNF, or discharged from Part A level of care on or before the eighth day of covered SNF stay, the resident may be a candidate for the short stay policy. The short stay policy allows the assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident received rehabilitation therapy and was not able to have received 5 days of therapy due to discharge from Medicare Part A. See Chapter 6, Section 6.4 for greater detail.

Resident is Admitted to an Acute Care Facility and Returns

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.

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.

⁸ These requirements/policies also apply to swing bed providers.

Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, the Medicare assessment schedule is not restarted. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the “midnight rule.” The Medicare assessment schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment clock is adjusted by skipping that day in calculating when the next Medicare assessment is due. For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes day 22 of his Part A stay.

Resident Takes a Leave of Absence from the SNF

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-12 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments. For **scheduled PPS assessments**, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves a SNF at 6:00pm on Wednesday, which is Day 27 of the resident’s stay and returns to the SNF on Thursday at 9:00am, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident’s stay. Therefore, a facility that would choose Day 27 for the ARD of their 30-day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day.

In the case of **unscheduled PPS assessments**, the ARD of the relevant assessment is not affected by the LOA because the ARDs for unscheduled assessments are not tied directly to the Medicare assessment calendar or to a particular day of the resident’s stay. For instance, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. For example, if the ARD for a resident’s 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 9, returning on November 10, Day 7 of the COT observation period would remain November 14.

Moreover, a SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary’s 100 days due to a leave of absence (LOA), as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident’s 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

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 Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation when a beneficiary is discharged from Medicare Part A services but remains in the facility in a Medicare and/or Medicaid certified bed with another pay source, the OBRA schedule will be continued. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. If and when the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

The original date of entry (Item A1600) is retained. The beneficiary should be assessed to determine if there was a significant change in status. A SCSA could be completed with either the Medicare-required 5-day or 14-day assessment or separately.

Delay in Requiring and Receiving Skilled Services

There are instances when the beneficiary does not require SNF level of care services when initially admitted to the SNF. See Chapter 6, Section 6.7.

Non-Compliance with the PPS Assessment Schedule

According to Part 42 Code of Federal Regulation (CFR) Section 413.343, an assessment that does not have its ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 12

(1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. On November 8, which is Day 7 of the COT observation period, it is determined that a COT is required. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

If the ARD on the late assessment is set for **prior to the end of the period during which the late assessment would have controlled the payment**, had the ARD been set timely, and/or **no intervening assessments have occurred, the SNF will bill the default rate for the number of days that the assessment is out of compliance**. This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment**. For example, a Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for 8 days and therefore would be paid at the default rate for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. In this example, if there are no other assessments until the 60-day assessment, the remaining 22 days are billed according to the HIPPS code on the late assessment.

A second example, involving a late unscheduled assessment would be if a COT OMRA was completed with an ARD of Day 39, while Day 7 of the COT observation period was Day 37. In this case, the COT OMRA would be considered 2 days late and the facility would bill the default rate for 2 days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment, in this case, for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar.

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment**, had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment**. For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A

late assessment cannot be used to replace a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8).

A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the resident's last day of therapy was Day 39. Upon further review of the resident's record on Day 52, the facility determines that a COT should have been completed with an ARD of Day 37 but was not. The ARD for the COT OMRA is set for day 52. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. Because there was an intervening assessment (in this case the EOT OMRA) prior to the ARD of the late COT OMRA, the facility would bill the default rate for 9 days (the period during which the COT OMRA would have controlled payment). The facility would bill the RUG from the EOT OMRA as per normal beginning the first non-therapy day, in this case Day 40, until the next scheduled or unscheduled assessment used for payment.

Missed PPS Assessment

If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system may be used to bill for some Part A days when specific circumstances are met. See Chapter 6, Section 6.8 for greater detail.

In the case of an unscheduled PPS assessment, if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with the late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

Errors on a PPS Assessment

To correct an error on an MDS that has been submitted to the QIES ASAP system, the nursing facility must follow the normal MDS correction procedures (see Chapter 5).

*These requirements/policies also apply to swing bed providers.

2.14 Expected Order of MDS Records

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (Item A1700) indicating admission, and the next record is expected to be an admission assessment, a 5-

day PPS assessment, a discharge, or death in facility. The QIES ASAP system will issue a warning when an unexpected record is submitted. Examples include, an assessment record after a discharge (an entry is expected) or any record after a death in facility record.

The target date, rather than the submission date, is used to determine the order of records. The target date is the assessment reference date (Item A2300) for assessment records, the entry date (Item A1600) for entry records, and the discharge date (Item A2000) for discharge or death in facility records. In the following table, the prior record is represented in the columns and the next (subsequent) record is represented in the rows. A “no” has been placed in a cell when the next record is not expected to follow the prior record; the QIES ASAP system will issue a record order warning for record combinations that contain a “no”. A blank cell indicates that the next record is expected to follow the prior record; a record order warning will *not* be issued for these combinations.

For the first MDS 3.0 record with event date on or after October 1, 2010, the last MDS 2.0 record (if available) should be used to determine if the record order is expected. The QIES ASAP system will find the last MDS 2.0 record and issue a warning if the order of these two records is unexpected.

Note that there are not any QIES ASAP record order warnings produced for Swing Bed MDS records.

Expected Order of MDS Records

Next Record	Prior Record												
	Entry	OBRA Admission	OBRA annual	OBRA quarterly	PPS 5-day or readmission/return	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.

2.15 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, and A0310 F). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set, when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, and A0310F. Item A0310D (swing bed clinical change assessment) has been omitted because it will always be skipped on a nursing home record. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, and A0310F for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of Items A0310A, A0310B, A0310C, and A0310F values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	ISC	Description
01	01,02, 99	0	10,11,99	NC	Comprehensive
01	01,02, 07	1,2,3	10,11,99	NC	Comprehensive
01	02,07	4	10,11,99	NC	Comprehensive
03	01 thru 05,99	0	10,11,99	NC	Comprehensive
03,04,05	01 thru 07	1,2,3	10,11,99	NC	Comprehensive
03,04,05	02 thru 05,07	4	10,11,99	NC	Comprehensive
04,05	01 thru 07,99	0	10,11,99	NC	Comprehensive
02,06	01 thru 05,99	0	10,11,99	NQ	Quarterly
02,06	01 thru 07	1,2,3	10,11,99	NQ	Quarterly
02,06	02 thru 05,07	4	10,11,99	NQ	Quarterly
99	01 thru 05	0,1,2,3	10,11,99	NP	PPS
99	02 thru 05	4	10,11,99	NP	PPS
99	07	1	99	NS	SOT OMRA
99	07	1	10,11	NSD	SOT OMRA and Discharge
99	07	2,3,4	99	NO	EOT, EOT-R or COT OMRA
99	07	2,3,4	10,11	NOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	10,11	ND	Discharge
99	99	0	01,12	NT	Tracking

Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C= 0 and Item A0310F = 99 (a standalone admission assessment), then these values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected

if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C= 0 and Item A0310F = 12 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C= 0 and A0310F = 99, then no row matches these entries, and the record is invalid and would be rejected.

There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. An inactivation request is indicated by A0050 = 3. The item set for this type of record is “Inactivation” with an ISC code of XX.

The next lookup table is for swing bed records. The first 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, and A0310F. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, and A0310F for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310C, A0310D, and A0310F values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	ISC	Description
99	01 thru 05	0,1,2,3	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	SP	PPS
99	02 thru 05	4	0	10,11,99	SP	PPS
99	02 thru 05,07	4	1	10,11,99	SP	PPS
99	07	1	0	99	SS	SOT OMRA
99	07	1	0	10,11	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	SO	EOT , EOT-R or COT OMRA
99	07	2,3,4	0	10,11	SOD	EOT , EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	SD	Discharge
99	99	0	0	01,12	ST	Tracking

The “Inactivation” (XX) item set is also used for swing beds when Item A0050 = 3.

A0100: Facility Provider Numbers

A0100. Facility Provider Numbers	
	<p>A. National Provider Identifier (NPI):</p> <input style="width: 100%;" type="text"/>
	<p>B. CMS Certification Number (CCN):</p> <input style="width: 100%;" type="text"/>
	<p>C. State Provider Number:</p> <input style="width: 100%;" type="text"/>

Item Rationale

- Allows the identification of the facility submitting the assessment.

Coding Instructions

- Facilities must have a National Provider Identifier (NPI) and a CMS Certified Number (CCN).
- Enter the facility provider numbers:
 - National Provider Identifier (NPI)
 - CMS Certified Number (CCN)
 - State Provider Number (optional) This number is assigned by the Regional Office and provided to the intermediary/carrier and the State survey agency. When known enter the State Provider Number in A0100C. Completion of this is not required; however, your State may require the completion of this item.

DEFINITIONS

NATIONAL PROVIDER IDENTIFIER (NPI)

A unique Federal number that identifies providers of health care services. The NPI applies to the nursing home for all of its residents.

CMS CERTIFICATION NUMBER (CCN)

Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE PROVIDER NUMBER

Medicaid Provider Number established by a state.

A0200: Type of Provider

A0200. Type of Provider	
Enter Code	Type of provider
<input type="checkbox"/>	<ol style="list-style-type: none"> Nursing home (SNF/NF) Swing Bed

Item Rationale

- Allows designation of type of provider.

Coding Instructions

- Code 1, nursing home (SNF/NF):** if a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF).
- Code 2, swing bed:** if a hospital with swing bed approval.

DEFINITION

SWING BED

A rural hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

A0310 Type of Assessment

For Comprehensive, Quarterly, and PPS Assessments, Entry and Discharge Records.

A0310. Type of Assessment	
Enter Code <input type="text"/> <input type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input type="text"/> <input type="text"/>	B. PPS Assessment PPS Scheduled Assessments for a Medicare Part A Stay 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment PPS Unscheduled Assessments for a Medicare Part A Stay 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) Not PPS Assessment 99. None of the above
Enter Code <input type="checkbox"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="checkbox"/>	D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2 0. No 1. Yes
Enter Code <input type="checkbox"/>	E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes
Enter Code <input type="text"/> <input type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input type="checkbox"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned

Item Rationale

- Allows identification of needed assessment content.

Coding Instructions for A0310, Type of Assessment

Enter the code corresponding to the reason or reasons for completing this assessment.

If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B and A0310C) all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.

A0310: Type of Assessment (cont.)

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code “99”.
 - 01.** Admission assessment (required by day 14)
 - 02.** Quarterly review assessment
 - 03.** Annual assessment
 - 04.** Significant change in status assessment
 - 05.** Significant correction to prior comprehensive assessment
 - 06.** Significant correction to prior quarterly assessment
 - 99.** None of the above

Coding Tips and Special Populations

- If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS significant change in status assessment (SCSA). The nursing home is required to complete a SCSA when they come off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
- It is a CMS requirement to have a SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.

Coding Instructions for A0310B, PPS Assessment

- Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01-07, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded as 01-07, enter code “99”.
- See Chapter 2 on assessment schedules for detailed information on the scheduling and timing of the assessments.

PPS Scheduled Assessments for a Medicare Part A Stay

- 01.** 5-day scheduled assessment
- 02.** 14-day scheduled assessment
- 03.** 30-day scheduled assessment
- 04.** 60-day scheduled assessment
- 05.** 90-day scheduled assessment

DEFINITION

PROSPECTIVE PAYMENT SYSTEM (PPS)

Method of reimbursement in which Medicare payment is made based on the classification system of that service (e.g., resource utilization groups, RUGs, for skilled nursing facilities).

A0310: Type of Assessment (cont.)

Coding Instructions for A0310F, Federal OBRA & PPS Entry/Discharge Reporting

- Enter the number corresponding to the reason for completing this assessment or tracking record. This item contains 2 digits. For code 01, enter “0” in the first box and place “1” in the second box. If the assessment is not coded as “01” or “10” or “11” or “12,” enter “99”:
- 01.** Entry tracking record
 - 10.** Discharge assessment-return not anticipated
 - 11.** Discharge assessment-return anticipated
 - 12.** Death in facility tracking record
 - 99.** None of the above

Coding Instructions for A0310G, Type of Discharge

- **Code 1:** if type of discharge is a planned discharge.
- **Code 2:** if type of discharge is an unplanned discharge.

A0410: Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation	
Enter Code <input type="checkbox"/>	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified

Item Rationale

- In coding this item, the facility must consider Medicare and/or Medicaid status as well as the state’s authority to collect MDS records. State regulations may require submission of MDS data to QIES ASAP or directly to the state for residents residing in licensed-only beds.
- Nursing homes and swing-bed facilities must be certain they are submitting MDS assessments to QIES ASAP for those residents who are on a Medicare and/or Medicaid certified unit. For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to QIES ASAP or directly to the state in accordance with state requirements.
- Payer source is not the determinant by which this item is coded. This item is coded solely according to the authority CMS has to collect MDS data for residents who are on a Medicare and/or Medicaid certified unit and the authority that the state may have to collect MDS data under licensure. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.

A0410: Unit Certification or Licensure Designation (cont.)

Steps for Assessment

1. Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, Medicaid certified or dually certified (Medicare/Medicaid).
2. If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative if there are units that are state licensed and if the state requires MDS submission for residents on that unit.
3. Identify all units in the nursing home that are not certified or licensed by the state, if any.

Coding Instructions

- Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does **not** have authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any records are submitted under this certification designation, they will be rejected by the QIES ASAP system.
- Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State : if the nursing home resident is on a unit that is neither Medicare nor Medicaid certified, but the state has authority under state licensure to collect MDS information for residents on such units, the facility should submit the resident's MDS records per the state's requirement to QIES ASAP or directly to the state. Note that this certification designation does not apply to swing-bed facilities. Assessments for swing-bed residents on which A0410 is coded "2" will be rejected by the QIES ASAP system.
- Code 3, Unit is Medicare and/or Medicaid certified: if the resident is on a Medicare and/or Medicaid certified unit, regardless of payer source (i.e., even if the resident is private pay or has his/her stay covered under e.g., Medicare Advantage, Medicare HMO, private insurance, etc.), the facility is required to submit MDS records (OBRA and SNF PPS only) to QIES ASAP for these residents. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.

A0500: Legal Name of Resident

A0500. Legal Name of Resident	
<p>A. First name:</p> <input type="text"/>	<p>B. Middle initial:</p> <input type="text"/>
<p>C. Last name:</p> <input type="text"/>	<p>D. Suffix:</p> <input type="text"/>

Item Rationale

- Allows identification of resident
- Also used for matching each of the resident's records

Steps for Assessment

1. Ask resident, family, significant other, guardian, or legally authorized representative.
2. Check the resident's name on his or her Medicare card, or if not in the program, check a Medicaid card or other government-issued document.

DEFINITION

LEGAL NAME
 Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

- A. First Name
- B. Middle Initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name)
- C. Last Name
- D. Suffix (e.g., Jr./Sr.)

A0700: Medicaid Number (cont.)

Coding Instructions

- Record this number if the resident is a Medicaid recipient.
- Enter one number per box beginning in the leftmost box.
- Recheck the number to make sure you have entered the digits correctly.
- Enter a “+” in the leftmost box if the number is pending. If you are notified later that the resident does have a Medicaid number, just include it on the next assessment.
- If not applicable because the resident is not a Medicaid recipient, enter “N” in the leftmost box.

Coding Tips and Special Populations

- To obtain the Medicaid number, check the resident’s Medicaid card, admission or transfer records, or medical record.
- Confirm that the resident’s name on the MDS matches the resident’s name on the Medicaid card.
- It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. However, a correction may be a State-specific requirement.

A0800: Gender

A0800. Gender	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Male 2. Female

Item Rationale

- Assists in correct identification.
- Provides demographic gender specific health trend information.

Coding Instructions

- Code 1: if resident is male.
- Code 2: if resident is female.

Coding Tips and Special Populations

- Resident gender on the MDS should match what is in the Social Security system.

A0900: Birth Date

A0900. Birth 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

- Assists in correct identification.
- Allows determination of age.

Coding Instructions

- Fill in the boxes with the appropriate birth date. If the complete birth date is known, do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a “0.” For example: January 2, 1918, should be entered as 01-02-1918.
- Sometimes, only the birth year or the birth year and birth month will be known. These situations are handled as follows:
 - If only the birth year is known (e.g., 1918), then enter the year in the “year” portion of A0900, and leave the “month” and “day” portions blank. If the birth year and birth month are known, but the day of the month is not known, then enter the year in the “year” portion of A0900, enter the month in the “month” portion of A0900, and leave the “day” portion blank.

A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓ Check all that apply	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Item Rationale

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Provides demographic race/ethnicity specific health trend information.
- These categories are NOT used to determine eligibility for participation in any Federal program.

A1000: Race/Ethnicity (cont.)

Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to his or her race/ethnicity from the list in A1000.
 - Individuals may be more comfortable if this and the preceding question are introduced by saying, “We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care” (Baker et al., 2005).
2. If the resident is unable to respond, ask a family member or significant other.
3. Category definitions are provided to resident or family only if requested by them in order to answer the item.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used.

Coding Instructions

Check all that apply.

- Enter the race or ethnic category or categories the resident, family or significant other uses to identify him or her.

DEFINITIONS

RACE/ETHNICITY

AMERICAN INDIAN OR ALASKA NATIVE

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.

BLACK OR AFRICAN AMERICAN

A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black” or “African American.”

HISPANIC OR LATINO

A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term Spanish Origin can be used in addition to Hispanic or Latino.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

WHITE

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

A1100: Language

A1100. Language																					
Enter Code <input type="checkbox"/>	<p>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No → Skip to A1200, Marital Status</p> <p>1. Yes → Specify in A1100B, Preferred language</p> <p>9. Unable to determine → Skip to A1200, Marital Status</p> <p>B. Preferred language:</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																				

Item Rationale

Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.

Planning for Care

- When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
- Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the resident is unable to respond, a family member or significant other should be asked.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, ask for preferred language.
5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Coding Instructions for A1100A

- Code 0, no: if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status.
- Code 1, yes: if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.
- Code 9, unable to determine: if no source can identify whether the resident wants or needs an interpreter. Skip to A1200, Marital Status.

A1100: Language (cont.)

Coding Instructions for A1100B

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

A1200: Marital Status

A1200. Marital Status	
Enter Code <input type="checkbox"/>	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.
- Demographic information.

Steps for Assessment

1. Ask the resident about his or her marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither source can report, review the medical record for information.

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:
 1. Never Married
 2. Married
 3. Widowed
 4. Separated
 5. Divorced

A0500: Legal Name of Resident

A0500. Legal Name of Resident	
<p>A. First name:</p> <input type="text"/>	<p>B. Middle initial:</p> <input type="text"/>
<p>C. Last name:</p> <input type="text"/>	<p>D. Suffix:</p> <input type="text"/>

Item Rationale

- Allows identification of resident
- Also used for matching each of the resident's records

Steps for Assessment

1. Ask resident, family, significant other, guardian, or legally authorized representative.
2. Check the resident's name on his or her Medicare card, or if not in the program, check a Medicaid card or other government-issued document.

DEFINITION

LEGAL NAME

Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

- A. First Name
- B. Middle Initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name)
- C. Last Name
- D. Suffix (e.g., Jr./Sr.)

A0700: Medicaid Number (cont.)

Coding Instructions

- Record this number if the resident is a Medicaid recipient.
- Enter one number per box beginning in the leftmost box.
- Recheck the number to make sure you have entered the digits correctly.
- Enter a “+” in the leftmost box if the number is pending. If you are notified later that the resident does have a Medicaid number, just include it on the next assessment.
- If not applicable because the resident is not a Medicaid recipient, enter “N” in the leftmost box.

Coding Tips and Special Populations

- To obtain the Medicaid number, check the resident’s Medicaid card, admission or transfer records, or medical record.
- Confirm that the resident’s name on the MDS matches the resident’s name on the Medicaid card.
- It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. However, a correction may be a State-specific requirement.

A0800: Gender

A0800. Gender	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Male 2. Female

Item Rationale

- Assists in correct identification.
- Provides demographic gender specific health trend information.

Coding Instructions

- **Code 1:** if resident is male.
- **Code 2:** if resident is female.

Coding Tips and Special Populations

- Resident gender on the MDS should match what is in the Social Security system.

A0900: Birth Date

A0900. Birth Date			
	<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

- Assists in correct identification.
- Allows determination of age.

Coding Instructions

- Fill in the boxes with the appropriate birth date. If the complete birth date is known, do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a “0.” For example: January 2, 1918, should be entered as 01-02-1918.
- Sometimes, only the birth year or the birth year and birth month will be known. These situations are handled as follows:
 - If only the birth year is known (e.g., 1918), then enter the year in the “year” portion of A0900, and leave the “month” and “day” portions blank. If the birth year and birth month are known, but the day of the month is not known, then enter the year in the “year” portion of A0900, enter the month in the “month” portion of A0900, and leave the “day” portion blank.

A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓	Check all that apply
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Item Rationale

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Provides demographic race/ethnicity specific health trend information.
- These categories are NOT used to determine eligibility for participation in any Federal program.

A1000: Race/Ethnicity (cont.)

Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to his or her race/ethnicity from the list in A1000.
 - Individuals may be more comfortable if this and the preceding question are introduced by saying, “We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care” (Baker et al., 2005).
2. If the resident is unable to respond, ask a family member or significant other.
3. Category definitions are provided to resident or family only if requested by them in order to answer the item.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used.

Coding Instructions

Check all that apply.

- Enter the race or ethnic category or categories the resident, family or significant other uses to identify him or her.

DEFINITIONS

RACE/ETHNICITY

AMERICAN INDIAN OR ALASKA NATIVE

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.

BLACK OR AFRICAN AMERICAN

A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black” or “African American.”

HISPANIC OR LATINO

A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term Spanish Origin can be used in addition to Hispanic or Latino.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

WHITE

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

A1100: Language (cont.)

Coding Instructions for A1100B

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

A1200: Marital Status

A1200. Marital Status	
Enter Code <input type="text"/>	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.
- Demographic information.

Steps for Assessment

1. Ask the resident about his or her marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither source can report, review the medical record for information.

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:
 - 1.** Never Married
 - 2.** Married
 - 3.** Widowed
 - 4.** Separated
 - 5.** Divorced

A1300: Optional Resident Items (cont.)

Coding Instructions for A1300D, Lifetime Occupation(s)

- Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the nursing home. When two occupations are identified, place a slash (/) between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker." For a resident who is a child or an intellectually disabled/developmentally disabled adult resident who has never had an occupation, record as "none."

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code <input type="checkbox"/>	<p>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?</p> <p>0. No → Skip to A1550, Conditions Related to ID/DD Status</p> <p>1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</p> <p>9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status</p>

Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a Significant Change in Status Assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.¹

¹ The statute may also be referenced as 42 USC 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html> for CMS information on PASRR.

Planning for Care

- The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.
- The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to Resident Review upon change in condition.

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

- **Code 0, no:** and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:
 - PASRR Level I screening did not result in a referral for Level II screening, or
 - Level II screening determined that the resident does not have a serious mental illness and/or intellectual/developmental disability or related condition, or
 - PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- **Code 1, yes:** if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.
- **Code 9, not a Medicaid-certified unit:** if bed is not in a Medicaid-certified nursing home. Skip to A1550, Conditions Related to ID/DD Status. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.
 - Note that the requirement is based on the certification of the part of the nursing home the resident will occupy. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building.

A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ Check all that apply	
<input type="checkbox"/>	A. Serious mental illness
<input type="checkbox"/>	B. Intellectual Disability ("mental retardation" in federal regulation)
<input type="checkbox"/>	C. Other related conditions

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).
2. Check all that apply.

Coding Instructions

- **Code A, Serious mental illness:** if resident has been diagnosed with a serious mental illness.
- **Code B, Intellectual Disability (“mental retardation” in federal regulation)/Developmental Disability:** if resident has been diagnosed with intellectual disability/developmental disability.
- **Code C, Other related conditions:** if resident has been diagnosed with other related conditions.

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

A1550. Conditions Related to ID/DD Status	
If the resident is 22 years of age or older, complete only if A0310A = 01	
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05	
↓ Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely	
	ID/DD With Organic Condition
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
<input type="checkbox"/>	E. ID/DD with no organic condition
	No ID/DD
<input type="checkbox"/>	Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

- If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (Admission assessment).
- If resident is 21 years of age or younger on the assessment reference date, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).

Coding Instructions

- Check all conditions related to ID/DD status that were present before age 22.
- When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- Code A:** if Down syndrome is present.
- Code B:** if autism is present.
- Code C:** if epilepsy is present.
- Code D:** if other organic condition related to ID/DD is present.

DEFINITIONS

DOWN SYNDROME

A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.

AUTISM

A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.

EPILEPSY

A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.

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, macrocephaly, meningocele, congenital hydrocephalus, etc.

Most Recent Admission/Entry or Reentry into this Facility

Most Recent Admission/Entry or Reentry into this Facility																			
A1600. Entry Date																			
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		-			-														
Month			Day			Year													
A1700. Type of Entry																			
Enter Code <input type="checkbox"/>	1. Admission 2. Reentry																		
A1800. Entered From																			
Enter Code <input type="checkbox"/>	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																	
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Month		Day		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"/>	<ol style="list-style-type: none"> 1. Admission 2. Reentry

Item Rationale

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

Coding Instructions

- Code 1, admission/entry:** when one of the following occurs:
 1. resident has never been admitted to this facility before; OR
 2. resident has been in this facility previously and was discharged return not anticipated; OR
 3. 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:
 1. admitted to this facility, AND
 2. discharged return anticipated, AND
 3. returned to facility within 30 days of discharge.

Coding Tips and Special Populations

- 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

A1700: Type of Entry (cont.)

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

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.

A1800: Entered From (cont.)

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.
- 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.

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 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).

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"/>
	Month		Day
		-	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			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.

A2000: Discharge Date (cont.)

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

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.

A2100: Discharge Status (cont.)

- **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 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"/>
	Month		Day
		-	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
			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: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 0.8em;">Month</div> <div style="font-size: 0.8em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 0.8em;">Day</div> <div style="font-size: 0.8em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 0.8em;">Year</div> </div>

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.

Steps for Assessment

- 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.

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.

A2300: Assessment Reference Date (cont.)

- 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.

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>

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**.

A2400: Medicare Stay (cont.)

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.

Coding Tips and Special Populations

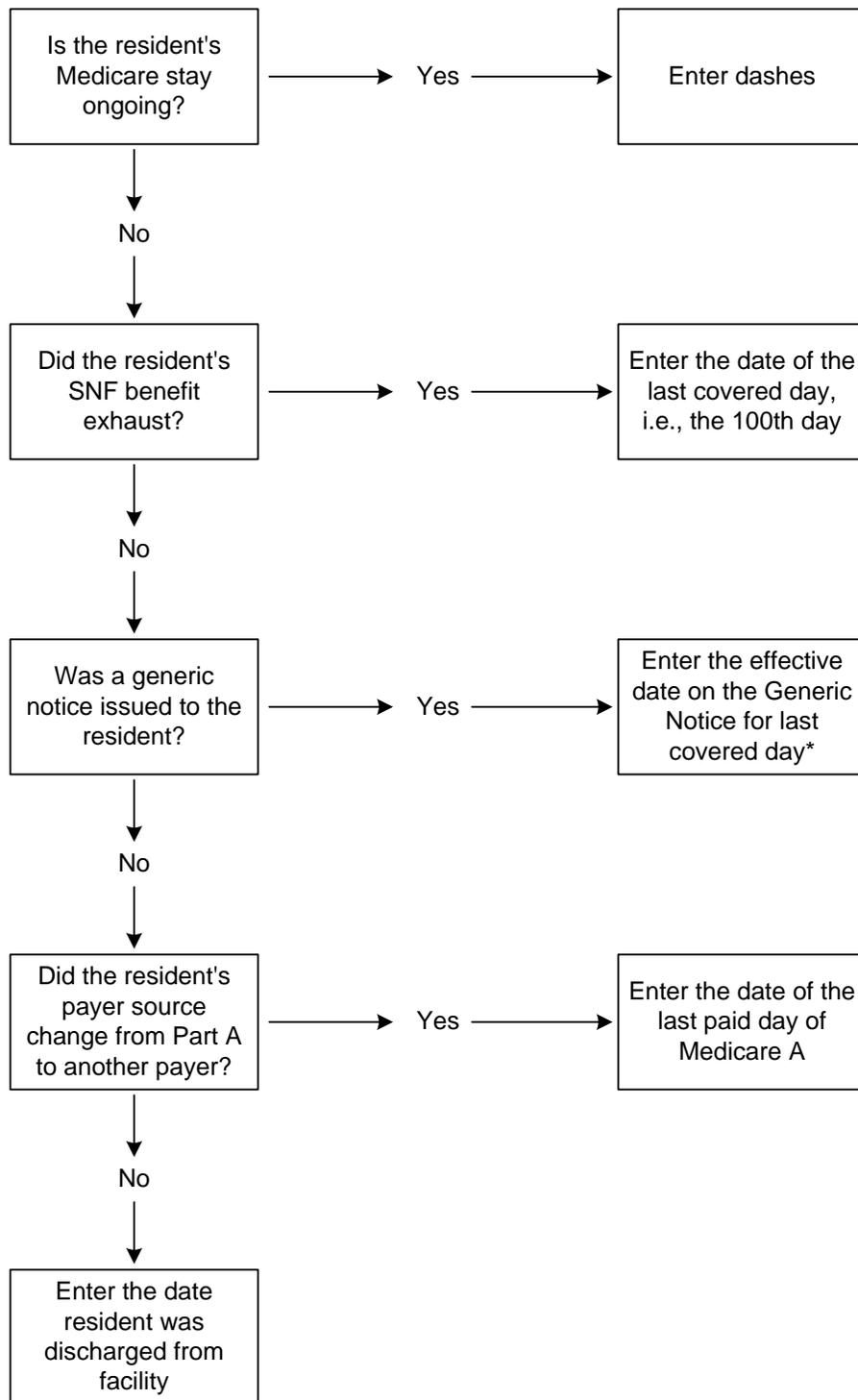
- When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- The end date of the Medicare stay may be earlier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

C1000: Cognitive Skills for Daily Decision Making (cont.)

Coding Instructions

Record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.

- Code 0, independent: if the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values.
- Code 1, modified independence: if the resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations.
- Code 2, moderately impaired: if the resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- Code 3, severely impaired: if the resident's decision making was severely impaired; the resident never (or rarely) made decisions.

Coding Tips

- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be coded 3, severely impaired. If the resident makes decisions, although poorly, code 2, moderately impaired.
- A resident's considered decision to exercise his or her right to decline treatment or recommendations by interdisciplinary team members should **not** be captured as impaired decision making in Item C1000, **Cognitive Skills for Daily Decision Making**.

Examples

1. Mr. B. seems to have severe cognitive impairment and is non-verbal. He usually clamps his mouth shut when offered a bite of food.
2. Mrs. C. does not generally make conversation or make her needs known, but replies "yes" when asked if she would like to take a nap.

Coding: For the above examples, Item C1000 would be coded 3, severe impairment.

Rationale: In both examples, the residents are primarily non-verbal and do not make their needs known, but they do give basic verbal or non-verbal responses to simple gestures or questions regarding care routines. More information about how the residents function in the environment is needed to definitively answer the questions. From the limited information provided it appears that their communication of choices is limited to very particular circumstances, which would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week on the MDS. If such decisions are more frequent or involved more activities, the resident may be only moderately impaired or better.

C1300: Signs and Symptoms of Delirium

Delirium	
C1300. Signs and Symptoms of Delirium (from CAM®)	
Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record	
	↓ Enter Codes in Boxes
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<input type="checkbox"/> A. Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
	<input type="checkbox"/> B. Disorganized thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="checkbox"/> C. Altered level of consciousness - Did the resident have altered level of consciousness (e.g., vigilant - startled easily to any sound or touch; lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch; stuporous - very difficult to arouse and keep aroused for the interview; comatose - could not be aroused)?
	<input type="checkbox"/> D. Psychomotor retardation - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

Disclaimer: This protocol contains unauthorized portions, unauthorized modifications of, and incorrect references to the short Confusion Assessment Method (CAM) contained in “The Confusion Assessment Method (CAM) Training Manual and Coding Guide,” © Hospital Elder Life Program, LLC 1988-2014. All Rights Reserved. This protocol was not approved, authorized, endorsed or reviewed by Hospital Elder Life Program, LLC or the original author of the CAM, Dr. Sharon K. Inouye, M.D., M.P.H., Institute for Aging Research at Hebrew SeniorLife, and all such parties disclaim all responsibility for and liabilities with respect to any use, publication, or implementation of this protocol.

Item Rationale

Health-related Quality of Life

- Delirium is associated with:
 - increased mortality,
 - functional decline,
 - development or worsening of incontinence,
 - behavior problems,
 - withdrawal from activities
 - rehospitalizations and increased length of nursing home stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

Planning for Care

- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection is essential in order to identify and treat or eliminate the cause.

E0100: Potential Indicators of Psychosis (cont.)

Coding Tips and Special Populations

- If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, **do not** code it as a delusion.
- If a resident expresses a false belief but easily accepts a reasonable alternative explanation, **do not** code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, **code as a delusion**.

Examples

1. A resident carries a doll which she believes is her baby and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she's hungry and wants to get her a bottle.

Coding: E0100A would be checked and E0100B would be checked.

Rationale: The resident believes the doll is a baby which is a delusion and she hears the doll crying which is an auditory hallucination.

2. A resident reports that he heard a gunshot. In fact, there was a loud knock on the door. When this is explained to him, he accepts the alternative interpretation of the loud noise.

Coding: E0100Z would be checked.

Rationale: He misinterpreted a real sound in the external environment. Because he is able to accept the alternative explanation for the cause of the sound, his report of a gunshot is not a fixed false belief and is therefore not a delusion.

3. A resident is found speaking aloud in her room. When asked about this, she states that she is answering a question posed to her by the gentleman in front of her. Staff note that no one is present and that no other voices can be heard in the environment.

Coding: E0100A would be checked.

Rationale: The resident reports auditory and visual sensations that occur in the absence of any external stimulus. Therefore, this is a hallucination.

4. A resident announces that he must leave to go to work, because he is needed in his office right away. In fact, he has been retired for 15 years. When reminded of this, he continues to insist that he must get to his office.

Coding: E0100B would be checked.

Rationale: The resident adheres to the belief that he still works, even after being reminded about his retirement status. Because the belief is held firmly despite an explanation of the real situation, it is a delusion.

E1100: Change in Behavioral or Other Symptoms (cont.)

Examples

1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on the unit 2 of the last 7 days but has not attempted to exit the unit. Because the resident is no longer attempting to exit the unit, she is at decreased risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.

Coding: E1100 would be **coded 1, improved.**

Rationale: Although one component of this resident's wandering behavior is worse because it has begun to intrude on the privacy of others, it is less frequent and less dangerous (without recent elopement) and is therefore improved overall since the last assessment. The fact that the behavior requires less intense surveillance or intervention by staff also supports the decision to rate the overall behavior as improved.

2. At the time of the last assessment, the resident was ambulatory and would threaten and hit other residents daily. He recently suffered a hip fracture and is not ambulatory. He is not approaching, threatening, or assaulting other residents. However, the resident is now combative when staff try to assist with dressing and bathing, and is hitting staff members daily.

Coding: E1100 would be **coded 0, same.**

Rationale: Although the resident is no longer assaulting other residents, he has begun to assault staff. Because the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

3. On the prior assessment, a resident with Alzheimer's disease was reported to wander on 2 out of 7 days and has responded well to redirection. On the most recent assessment, it was noted that the resident has been wandering more frequently for 5 out of 7 days and has also attempted to elope from the building on two occasions.

This behavior places the resident at significant risk of personal harm. The resident has been placed on more frequent location checks and has required additional redirection from staff. He was also provided with an elopement bracelet so that staff will be alerted if the resident attempts to leave the building. The intensity required of staff surveillance because of the dangerousness and frequency of the wandering behavior has significantly increased.

Coding: E1100 would be **coded 2, worse.**

Rationale: Because the danger and the frequency of the resident's wandering behavior have increased and there were two elopement attempts, the overall behavior is rated as worse.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

DEFINITION

ADL SUPPORT PROVIDED

Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once.

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident requires from staff for moving to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-10 for an example of using probes when talking to staff.

Activities of Daily Living Definitions

- A. Bed mobility:** how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.
- B. Transfer:** how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).
- C. Walk in room:** how resident walks between locations in his/her room.
- D. Walk in corridor:** how resident walks in corridor on unit.
- E. Locomotion on unit:** how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.
- F. Locomotion off unit:** how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- G. Dressing:** how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.
- H. Eating:** how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).
- I. Toilet use:** how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.
- J. Personal hygiene:** how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers).

Coding Instructions

For each ADL activity:

- Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).
- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the type (weight-bearing, non-weight-bearing, verbal cueing, guided maneuvering, etc.) and level of assistance (supervision, limited assistance, etc.) provided by all disciplines.
- If a resident uses special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handled reacher, or adaptive eating utensils, code ADL Self-Performance and ADL Support Provided based on the level of assistance the resident requires when using such items.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.
- The ADL Self-Performance coding level definitions are intended to reflect real world situations where slight variations in level of ADL self-performance are common.
- To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-7.
- This section involves a two-part ADL evaluation: Self-Performance, which measures how much of the ADL activity the resident can do for himself or herself, and Support Provided, which measures how much facility staff support is needed for the resident to complete the ADL. Each of these sections uses its own scale, therefore, it is recommended that the ADL Self-Performance evaluation (Column 1) be completed for all ADL activities before beginning the ADL Support evaluation (Column 2).

Coding Instructions for G0110, Column 1, ADL Self-Performance

- **Code 0, independent:** if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- **Code 2, limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.
- **Code 3, extensive assistance:** if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
 - Weight-bearing support provided **three or more times, OR**
 - Full staff performance of activity **three or more times** during part but not all of the last 7 days.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Code 4, total dependence:** if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- **Code 7, activity occurred only once or twice:** if the activity occurred **fewer than three times**.
- **Code 8, activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

The Rule of 3

- The “Rule of 3” is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.
- The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
 - **Code 0, Independent** – Coded only if the resident completed the ADL activity with no help or oversight **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
 - **Code 4, Total dependence** – Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
 - **Code 7, Activity occurred only once or twice** – Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period.
 - **Code 8, Activity did not occur** – Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Instructions for the Rule of 3:

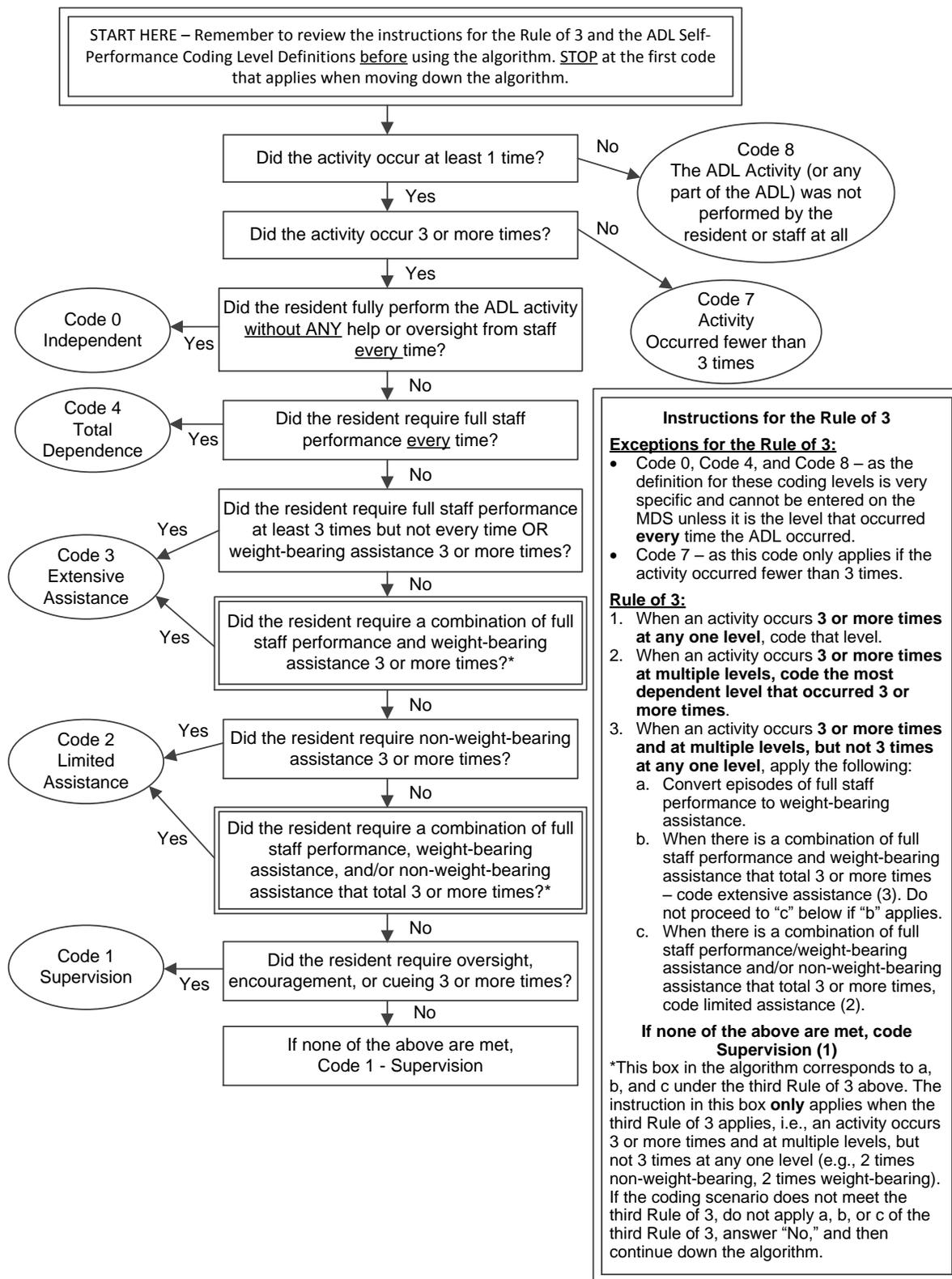
When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below (**keeping the ADL coding level definitions and the above exceptions in mind**) to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs **three or more times at any one level**, code that level.
2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**.
3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:
 - a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).
 - b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).
 - c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).

If none of the above are met, code supervision.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self-Performance Algorithm



G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.*

- **Code 0, no setup or physical help from staff:** if resident completed activity with no help or oversight.
- **Code 1, setup help only:** if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- **Code 2, one person physical assist:** if the resident was assisted by one staff person.
- **Code 3, two+ person physical assist:** if the resident was assisted by two or more staff persons.
- **Code 8, ADL activity itself did not occur during the entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Tips and Special Populations

- Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.
- Do **NOT** record the staff's assessment of the resident's potential capability to perform the ADL activity. The assessment of potential capability is covered in **ADL Functional Rehabilitation Potential** Item (G0900).
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- Do **NOT** include assistance provided by family or other visitors.
- **Some examples for coding for ADL Support Setup Help when the activity involves the following:**
 - Bed Mobility—handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and then provides no further help.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Transfer—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- Locomotion
 - o Walking—handing the resident a walker or cane.
 - o Wheeling—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- Dressing—retrieving clothes from the closet and laying out on the resident's bed; handing the resident a shirt.
- Eating—cutting meat and opening containers at meals; giving one food item at a time.
- Toilet Use—handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
- Personal Hygiene—providing a washbasin and grooming articles.
- **Supervision**
 - **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
 - General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Coding activity did not occur, 8:**
 - **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
 - **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
 - **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.
- **Coding activity occurred only once or twice, 7:**
 - Walk in corridor would be **coded 7, activity occurred only once or twice**: if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the 7-day look-back period.
 - Locomotion off unit would be **coded 7, activity occurred only once or twice**: if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Residents with tube feeding, TPN, or IV fluids**
 - **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
 - **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"

NA: "She can lay down and sit up by herself, but I help her turn on her side."

RN: "She lays down and sits up without any verbal instructions or physical help?"

NA: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

RN: "How do you help her turn side to side?"

NA: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

RN: "Do you lift her by yourself or does someone help you?"

NA: "I do it by myself."

RN: "How many times during the last 7 days did you give this type of help?"

NA: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, so be sure to consider each activity definition fully. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of the actual assistance Mrs. L. received. This information is important to know and document because accurate coding and supportive documentation provides the basis for reporting on the type and amount of care provided.

Coding: Bed Mobility ADL assistance would be **coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.**

Examples for G0110A, Bed Mobility

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. She requires use of a single side rail that staff place in the up position when she is in bed.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110A1 would be **coded 0, independent.**

G0110A2 would be **coded 1, setup help only.**

Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must verbally remind her to reposition off her right side daily during the 7-day look-back period.

Coding: G0110A1 would be **coded 1, supervision.**

G0110A2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place her hands on the side rail and encourage her to change her position when in bed daily over the 7-day look-back period.

Coding: G0110A1 would be **coded 2, limited assistance.**

G0110A2 would be **coded 2, one person physical assist.**

Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

4. Mr. Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition him toward the head of the bed. Mr. Q. was able to assist by bending his knees and pushing with legs when reminded by staff.

Coding: G0110A1 would be **coded 3, extensive assistance.**

G0110A2 would be **coded 3, two+ persons physical assist.**

Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She must be physically assisted to a seated position in bed when reading.

Coding: G0110A1 would be **coded 4, total dependence.**

G0110A2 would be **coded 3, two+ persons physical assist.**

Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position her in bed.

Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110B1 would be **coded 0, independent.**

G0110B2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident is independent each and every time she transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as she transfers from her bed to wheelchair daily. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

Coding: G0110B1 would be **coded 1, supervision.**

G0110B2 would be **coded 1, setup help only.**

Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then assist the resident with guided maneuvering as she transfers. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

Coding: G0110B1 would be **coded 2, limited assistance.**

G0110B2 would be **coded 2, one person physical assist.**

Rationale: Resident requires staff to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

4. Mrs. B. requires weight-bearing assistance of one staff member to partially lift and support her when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

Coding: G0110B1 would be **coded 3, extensive assistance.**

G0110B2 would be **coded 2, one person physical assist.**

Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

5. Mr. T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. T. is unable to assist or participate in any way.

Coding: G0110B1 would be **coded 4, total dependence.**

G0110B2 would be **coded 3, two+ persons physical assist.**

Rationale: Resident did not participate and required two staff to transfer him out of his bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

Coding: G0110B1 would be **coded 8, activity did not occur.**

G0110B2 would be **coded 8, ADL activity itself did not occur during entire period.**

Rationale: Activity did not occur.

- Mr. M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

Coding: G0110B1 would be **coded 7, activity occurred only once or twice.**

G0110B2 would be **coded 3, two+ persons physical assist.**

Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

Examples for G0110C, Walk in Room

- Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff at all during the entire 7-day look-back period.

Coding: G0110C1 would be **coded 0, independent.**

G0110C2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident is independent.

- Mr. B. was able to walk in his room daily, but a staff member needed to cue and stand by during ambulation because the resident has had a history of an unsteady gait.

Coding: G0110C1 would be **coded 1, supervision.**

G0110C2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident requires staff supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from staff.

- Mr. K. is able to walk in his room, and, with hand-held assist from one staff member, the resident was noted to ambulate daily during the 7-day look-back period.

Coding: G0110C1 would be **coded 2, limited assistance.**

G0110C2 would be **coded 2, one person physical assist.**

Rationale: Resident requires hand-held (non-weight-bearing) assistance of one staff member daily for ambulation in his room.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to help support him when he selects clothing from his closet. During the 7-day look-back period the resident was able to ambulate with weight-bearing assistance from one staff member in his room four times.

Coding: G0110C1 would be **coded 3, extensive assistance.**

G0110C2 would be **coded 2, one person physical assist.**

Rationale: The resident was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one staff member.

5. Mr. J. is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance to stand pivot to a commode next to his bed.

Coding: G0110C1 would be **coded 8, activity did not occur.**

G0110C2 would be **coded 8, ADL activity itself did not occur during entire period.**

Rationale: Activity did not occur.

Examples for G0110D, Walk in Corridor

1. Mr. X. ambulated daily up and down the hallway on his unit with a cane and did not require any setup or physical help from staff at any time during the 7-day look-back period.

Coding: G0110D1 would be **coded 0, independent.**

G0110D2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident requires no setup or help from the staff at any time during the entire 7-day look-back period.

2. Staff members provided verbal cueing while resident was walking in the hallway every day during the 7-day look-back period to ensure that the resident walked slowly and safely.

Coding: G0110D1 would be **coded 1, supervision.**

G0110D2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident requires staff supervision, cueing, and reminders daily while ambulating in the hallway during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- A resident had back surgery 2 months ago. Two staff members must physically support the resident as he is walking down the hallway because of his unsteady gait and balance problem. During the 7-day look-back period the resident was ambulated in the hallway three times with physical assist of two staff members.

Coding: G0110D1 would be **coded 3, extensive assistance.**

G0110D2 would be **coded 3, two+ persons physical assist.**

Rationale: The resident was ambulated three times during the 7-day look-back period, with the resident partially participating in the task. Two staff members were required to physically support the resident so he could ambulate.

- Mrs. J. ambulated in the corridor once with supervision and once with non-weight-bearing assistance of one staff member during the 7-day look-back period.

Coding: G0110D1 would be **coded 7, activity occurred only once or twice.**

G0110D2 would be **coded 2, one person physical assist.**

Rationale: The activity occurred only twice during the look-back period. It does not matter that the level of assistance provided by staff was at different levels. During ambulation, the most support provided was physical help by one staff member.

Examples for G0110E, Locomotion on Unit

- Mrs. L. is on complete bed rest. During the 7-day look-back period she did not get out of bed or leave the room.

Coding: G0110E1 would be **coded 8, activity did not occur.**

G0110E2 would be **coded 8, ADL activity itself did not occur during entire period.**

Rationale: The resident was on bed rest during the look-back period and never left her room.

Examples for G0110F, Locomotion off Unit

- Mr. R. does not like to go off his nursing unit. He prefers to stay in his room or the day room on his unit. He has visitors on a regular basis, and they visit with him in the day room on the unit. During the 7-day look-back period the resident did not leave the unit for any reason.

Coding: G0110F1 would be **coded 8, activity did not occur.**

G0110F2 would be **coded 8, ADL activity itself did not occur during entire period.**

Rationale: Activity did not occur at all.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

2. Mr. Q. is a wheelchair-bound and is able to self-propel on the unit. On two occasions during the 7-day look-back period, he self-propelled off the unit into the courtyard.

Coding: G0110F1 would be **coded 7, activity occurred only once or twice.**

G0110F2 would be **coded 0, no setup or physical help from staff.**

Rationale: The activity of going off the unit happened only twice during the look-back period with no help or oversight from staff.

3. Mr. H. enjoyed walking in the nursing home garden when weather permitted. Due to inclement weather during the assessment period, he required multiple levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.

Coding: G0110F1 would be **coded 1, supervision.**

G0110F2 would be **coded 2, one person physical assist.**

Rationale: Activity did not occur at any one level for three times and he did not require physical assistance for at least three times. The most support provided by staff was one person assist.

Examples for G0110G, Dressing

1. Mrs. C. did not feel well and chose to stay in her room. She requested to stay in night clothes and rest in bed for the entire 7-day look-back period. Each day, after washing up, Mrs. C. changed night clothes with staff assistance to guide her arms and assist in guiding her nightgown over her head and buttoning the front.

Coding: G0110G1 would be **coded 2, limited assistance.**

G0110G2 would be **coded 2, one person physical assist.**

Rationale: Resident was highly involved in the activity and changed clothing daily with non-weight-bearing assistance from one staff member during the 7-day look-back period.

Examples for G0110H, Eating

1. After staff deliver Mr. K.'s meal tray, he consumes all food and fluids without any cueing or physical help during the entire 7-day look-back period.

Coding: G0110H1 would be **coded 0, independent.**

G0110H2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

2. One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.

Coding: G0110H1 would be **coded 1, supervision.**

G0110H2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.

3. Mr. V. is able to eat by himself. Staff must set up the tray, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the resident to eat and handing him his utensils and cups, staff must also guide the resident's hand so he will get the utensil to his mouth.

Coding: G0110H1 would be **coded 2, limited assistance.**

G0110H2 would be **coded 2, one person physical assist.**

Rationale: Resident is unable to complete the evening meal without staff providing him non-weight-bearing assistance daily.

4. Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

Coding: G0110H1 would be **coded 3, extensive assistance.**

G0110H2 would be **coded 2, one person physical assist.**

Rationale: Resident partially participated in the task daily at each meal, but one staff member provided weight-bearing assistance with some portion of each meal.

5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. She relied on one staff member for all nourishment during the 7-day look-back period.

Coding: G0110H1 would be **coded 4, total dependence.**

G0110H2 would be **coded 2, one person physical assist.**

Rationale: Resident did not participate and required one staff person to feed her all of her meals during the 7-day look-back period.

6. Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she did not participate in the gastrostomy nourishment process.

Coding: G0110H1 would be **coded 4, total dependence.**

G0110H2 would be **coded 2, one person physical assist.**

Rationale: During the 7-day look-back period, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full staff performance of these functions.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110I, Toilet Use

1. Mrs. L. transferred herself to the toilet, adjusted her clothing, and performed the necessary personal hygiene after using the toilet without any staff assistance daily during the entire 7-day look-back period.

Coding: G0110I1 would be **coded 0, independent.**

G0110I2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident was independent in all her toileting tasks.

2. Staff member must remind resident to toilet frequently during the day and to unzip and zip pants and to wash his hands after using the toilet. This occurred multiple times each day during the 7-day look-back period.

Coding: G0110I1 would be **coded 1, supervision.**

G0110I2 would be **coded 0, no setup or physical help from staff.**

Rationale: Resident required staff supervision, cueing and reminders daily.

3. Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.

Coding: G0110I1 would be **coded 2, limited assistance.**

G0110I2 would be **coded 2, one person physical assist.**

Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Mrs. M. has had recent bouts of vertigo. During the 7-day look-back period, the resident required one staff member to assist and provide weight-bearing support to her as she transferred to the bedside commode four times.

Coding: G0110I1 would be **coded 3, extensive assistance.**

G0110I2 would be **coded 2, one person physical assist.**

Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

5. Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and hygiene needs several times each day.

Coding: G0110I1 would be **coded 4, total dependence.**

G0110I2 would be **coded 2, one person physical assist.**

Rationale: Resident did not participate and required one staff person to provide total care for toileting and hygiene each time during the entire 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110J, Personal Hygiene

1. The nurse assistant takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

Coding: G0110J1 would be **coded 1, supervision**.

G0110J2 would be **coded 1, setup help only**.

Rationale: Staff placed grooming devices at sink for his use, and during the 7-day look-back period staff provided cueing three times.

2. Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.

Coding: G0110J1 would be **coded 3, extensive assistance**.

G0110J2 would be **coded 2, one person physical assist**.

Rationale: A staff member had to complete part of the activity of personal hygiene for the resident 3 out of 7 days during the look-back period. The assistance, although non-weight-bearing, is considered full staff performance of the personal hygiene sub-task of brushing and styling her hair. Because this ADL sub-task was completed for the resident 3 times, but not every time during the last 7 days, it qualifies under the second criterion of the extensive assistance definition.

Scenario Examples

1. **Scenario:** The following dressing assistance was provided to Mr. X during the look-back period: Two times, he required guided maneuvering of his arms to don his shirt; this assistance was non-weight-bearing assistance. Four times, he required the staff to assist him to put his shirt on due to pain in his shoulders. During these four times that the staff had to assist Mr. X to put his shirt on, the staff had to physically assist him by lifting each of his arms. This component of the dressing activity occurred six times in the 7-day look-back period. There were two times where Mr. X required non-weight-bearing assistance and four times where he required weight-bearing assistance, therefore the appropriate code to enter on the MDS is Extensive assistance (3).

Rationale: This ADL activity component occurred six times in the 7-day look-back period. Mr. X required limited assistance two times and weight-bearing (extensive) assistance four times. Lifting the resident's arms is considered weight-bearing assistance. The ADL activity component occurred three or more times at one level, extensive - thus, this weight-bearing assistance is the highest level of dependence identified that occurred three or more times. The scenario is consistent with the ADL

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Self-Performance coding level definition of Extensive assistance and meets the first Rule of 3. The assessor uses the steps in the Rule of 3 in sequence and stops once one has been identified as applying to the scenario. Therefore the final code that should be entered in Column 1, ADL Self-Performance, G0110G – Dressing is Extensive assistance (3).

- Scenario:** The following assistance was provided to Mrs. C over the last seven days: Four times, she required verbal cueing for hand placement during stand-pivot transfers to her wheelchair and three times she required weight-bearing assistance to help her rise from the wheelchair, steady her and help her turn with her back to the edge of the bed. Once she was at the edge of the bed and put her hand on her transfer bar, she was able to sit. She completed the activity without assistance the 14 remaining instances during the 7-day look-back period. The four times that she required verbal cueing from the staff for hand placement are considered supervision. The three times that the staff had to physically support Mrs. C during a portion of the transfer are considered weight-bearing assistance. This ADL occurred 21 times over the 7-day look-back period. There were three or more times where supervision was required, and three times where weight-bearing assistance was required; therefore, the appropriate code to enter on the MDS is Extensive assistance (3).

Rationale: The ADL activity occurred 21 times over the 7-day look-back period. Mrs. C required supervision four times and weight-bearing assistance was provided three times during the 7-day look-back period. The ADL activity also occurred three or more times at multiple levels (four times with supervision, three times with weight-bearing assistance, and 14 times without assistance). Weight-bearing assistance is also the highest level of dependence identified that occurred three or more times. The first Rule of 3 does not apply because the ADL activity occurred three or more times at multiple levels, not three or more times at any one level. Because the ADL activity occurred three or more times at multiple levels, the scenario meets the second Rule of 3 and the assessor will apply the most dependent level that occurred three or more times. Note that this scenario does meet the definition of Extensive assistance as well, since the activity occurred at least three times and there was weight-bearing support provided three times. The final code that should be entered in Column 1, ADL Self-Performance, G0110B – Transfer is Extensive assistance (3).

- Scenario:** Mrs. F. was in the nursing home for only one day prior to transferring to another facility. While there, she was unable to complete a component of the eating ADL activity without assistance three times. The following assistance was provided: Twice she required weight-bearing assistance to help lift her fork to her mouth. One time in the evening, the staff fed Mrs. F. because she could not scoop the food on her plate with the fork, nor could she lift the fork to her mouth. The three times that Mrs. F. could not complete the activity, the staff had to physically assist her by either holding her hand as she brought the fork to her mouth, or by actually feeding her. There were two times where the staff provided weight-bearing assistance and one time where they provided full staff performance. This component of the ADL eating activity where assistance was required, occurred three times in the look-back period,

G0110: Activities of Daily Living (ADL) Assistance (cont.)

but not three times at any one level. Based on the third Rule of 3, the final code determination is Extensive assistance (3).

Rationale: Eating occurred three times in the look-back period during the day that Mrs. F was in the nursing home. Mrs. F performed part of the activity by scooping the food and holding her fork two times, but staff had to assist by lifting her arm to her mouth resulting in two episodes of weight-bearing assistance. The other time, the staff had to feed Mrs. F. The first Rule of 3 does not apply because even though the ADL assistance occurred three or more times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three or more times it did not occur three or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred three times at multiple levels but not three times at any one level. Sub-item “a” under the third Rule of 3 states to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. Therefore, the one episode of full staff performance is considered weight-bearing assistance and can be added to the other two episodes of weight-bearing assistance. This now totals three episodes of weight-bearing assistance. Therefore, according to the application of the third Rule of 3 and the first two sub-items, “a” and “b,” the correct code to enter in Column 1, ADL Self-Performance, G0110H, Eating is Extensive assistance (3). Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3 and the first two sub-items that the facility is able to code this item as extensive assistance.

4. **Scenario:** Mr. N was admitted to the facility, but was sent to the hospital on the 2nd day he was there. The following assistance was provided to Mr. N over the look-back period: Weight-bearing assistance one time to lift Mr. N’s right arm into his shirt sleeves when dressing in the morning on day one, non-weight-bearing assistance one time to button his shirt in the morning on day two, and full staff performance one time on day two to put on his pants on after resting in bed in the afternoon. Mr. N was independent in the evening on day one when undressing and getting his bed clothes on. Based on the application of the third Rule of 3s sub-items, the final code determination is Limited assistance (2).

Rationale: There was one episode where Mr. N required full staff performance to put his pants on, one episode of weight-bearing assistance to put his right arm into his shirt sleeve, and one episode of non-weight-bearing assistance to button his shirt. The first Rule of 3 does not apply because even though the ADL assistance occurred three times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three times it did not occur three times at multiple levels. The third Rule of 3 applies because the activity occurred three times, and at multiple levels but not three times at any one level. The third Rule of 3, sub-item “a,” instructs providers to convert episodes of full staff performance to weight-bearing assistance. Therefore, there are now two weight-bearing episodes and

G0110: Activities of Daily Living (ADL) Assistance (cont.)

one non-weight-bearing episode. The third Rule of 3, sub-item “b,” does not apply because even though there are two episodes of weight-bearing assistance, there are not enough weight-bearing episodes to consider it Extensive assistance. There is one episode of non-weight-bearing assistance that can be accounted for. The third sub-item, “c,” under the third Rule of 3 applies because there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that together total three times (two episodes of weight-bearing assistance and one episode of non-weight-bearing assistance). Therefore, the appropriate code is Limited assistance (2) which is the correct code to enter in Column 1, ADL Self-Performance, G0110G, Dressing. Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3, working through all of the sub-items, that the facility is able to code this item as Limited assistance.

5. **Scenario:** During the look-back period, Mr. S was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision.

Rationale: Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, she determined that Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Mr. S did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either. The assessor continued to apply the coding instructions, looking at the Rule of 3. The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times it did not occur three times at multiple levels and the third Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur at multiple levels or three times at any one level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, there is one final instruction to the provider, that when none of the ADL Self-Performance coding level definitions and the Rule of 3 do not apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use the code Supervision (1) was entered.

G0120: Bathing

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support.	
Enter Code <input type="checkbox"/>	A. Self-performance 0. Independent - no help provided 1. Supervision - oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code <input type="checkbox"/>	B. Support provided (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)

Item Rationale

Health-related Quality of Life

- The resident's choices regarding his or her bathing schedule should be accommodated when possible so that facility routine does not conflict with resident's desired routine.

Planning for Care

- The care plan should include interventions to address the resident's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

DEFINITION

BATHING

How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.

Coding Instructions for G0120A, Self-Performance

Code for the maximum amount of assistance the resident received during the bathing episodes.

- Code 0, independent:** if the resident required no help from staff.
- Code 1, supervision:** if the resident required oversight help only.
- Code 2, physical help limited to transfer only:** if the resident is able to perform the bathing activity, but required help with the transfer only.
- Code 3, physical help in part of bathing activity:** if the resident required assistance with some aspect of bathing.
- Code 4, total dependence:** if the resident is unable to participate in any of the bathing activity.
- Code 8, ADL activity itself did not occur during entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

G0120: Bathing (cont.)

Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance)**, do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADLs in the 7-day look-back period.
- If a nursing home has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the resident self-performance as supervision, even if the supervision is precautionary because the resident is still being individually supervised. Support for bathing in this instance would be coded according to whether or not the staff had to actually assist the resident during the bathing activity.

Examples

1. Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

Coding: G0120A would be **coded 1, supervision**.

G0120B would be **coded 0, no setup or physical help from staff**.

Rationale: Resident needed only supervision to perform the bathing activity with no setup or physical help from staff.

2. For one bath, the resident received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one staff member.

Coding: G0120A would be **coded 4, total dependence**.

G0120B would be **coded 2, one person physical assist**.

Rationale: Coding directions for bathing state, “code for most dependent in self-performance and support.” Resident’s most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.

3. On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, the resident had physical help of one person to get into tub but washed himself completely.

Coding: G0120A would be **coded 3, physical help in part of bathing activity**.

G0120B would be **coded 2, one person physical assist**.

Rationale: Resident’s most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one staff person.

G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking	
After observing the resident, code the following walking and transition items for most dependent	
Coding: 0. Steady at all times 1. Not steady, but <u>able</u> to stabilize without staff assistance 2. Not steady, <u>only able</u> to stabilize with staff assistance 8. Activity did not occur	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Moving from seated to standing position
	<input type="checkbox"/> B. Walking (with assistive device if used)
	<input type="checkbox"/> C. Turning around and facing the opposite direction while walking
	<input type="checkbox"/> D. Moving on and off toilet
	<input type="checkbox"/> E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

Item Rationale

Health-related Quality of Life

- Individuals with impaired balance and unsteadiness during transitions and walking
 - are at increased risk for falls;
 - often are afraid of falling;
 - may limit their physical and social activity, becoming socially isolated and despondent about limitations; and
 - can become increasingly immobile.

Planning for Care

- Individuals with impaired balance and unsteadiness should be evaluated for the need for
 - rehabilitation or assistive devices;
 - supervision or physical assistance for safety; and/or
 - environmental modification.
- Care planning should focus on preventing further decline of function, and/or on return of function, depending on resident-specific goals.
- Assessment should identify all related risk factors in order to develop effective care plans to maintain current abilities, slow decline, and/or promote improvement in the resident's functional ability.

DEFINITION

INTERDISCIPLINARY TEAM

Refers to a team that includes staff from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.

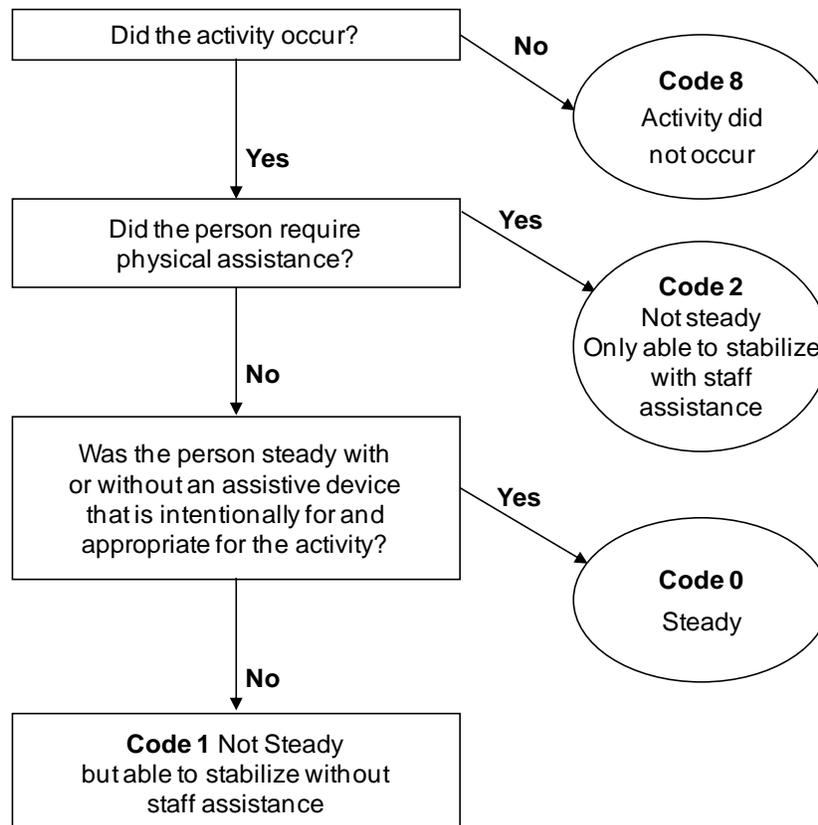
Steps for Assessment

1. Complete this assessment for all residents.
2. Throughout the 7-day look-back period, interdisciplinary team members should carefully observe and document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair (for residents who use a wheelchair).

G0300: Balance During Transitions and Walking (cont.)

3. If staff have not systematically documented the resident's stability in these activities at least once during the 7-day look-back period, use the following process to code these items:
 - a. Before beginning the activity, explain what the task is and what you are observing for.
 - b. Have assistive devices the resident normally uses available.
 - c. Start with the resident sitting up on the edge of his or her bed, in a chair or in a wheelchair (if he or she generally uses one).
 - d. Ask the resident to stand up and stay still for 3-5 seconds. **Moving from seated to standing position (G0300A) should be rated at this time.**
 - e. Ask the resident to walk approximately 15 feet using his or her usual **assistive device. Walking (G0300B) should be rated at this time.**
 - f. Ask the resident to turn around. **Turning around (G0300C) should be rated at this time.**
 - g. Ask the **resident to walk or wheel** from a starting point in his or her room into the bathroom, **prepare for toileting** as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. **Moving on and off toilet (G0300D) should be rated at this time.**
 - h. Ask residents who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. **Surface-to-surface transfer should be rated at this time (G0300E).**

Balance During Transitions and Walking Algorithm



G0300: Balance During Transitions and Walking (cont.)

Coding Instructions G0300A, Moving from Seated to Standing Position

Code for the least steady episode, using assistive device if applicable.

- **Code 0, steady at all times:**

- If all of the transitions from seated to standing position and from standing to seated position observed during the 7-day look-back period are steady.
- If resident is stable when standing up using the arms of a chair or an assistive device identified for this purpose (such as a walker, locked wheelchair, or grab bar).
- If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
- If resident appears steady and not at risk of a fall when standing up.

- **Code 1, not steady, but able to stabilize without staff assistance:**

- If any of transitions from seated to standing position or from standing to seated position during the 7-day look-back period are not steady, but the resident is able to stabilize without assistance from staff or object (e.g., a chair or table).
- If the resident is unsteady using an assistive device but does not require staff assistance to stabilize.
- If the resident attempts to stand, sits back down, then is able to stand up and stabilize without assistance from staff or object.
- Residents coded in this category appear at increased risk for falling when standing up.

DEFINITION

UNSTEADY

Residents may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

- **Code 2, not steady, only able to stabilize with staff assistance:**

- If any of transitions from seated to standing or from standing to sitting are not steady, and the resident cannot stabilize without assistance from staff.
- If the resident cannot stand but can transfer unassisted without staff assistance.
- If the resident returned back to a seated position or was unable to move from a seated to standing or from standing to sitting position during the look-back period.
- Residents coded in this category appear at high risk for falling during transitions.
- If a lift device (a mechanical device operated by another person) is used because the resident requires staff assistance to stabilize, code as 2.

- **Code 8, activity did not occur:** if the resident did not move from seated to standing position during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300A, Moving from Seated to Standing Position

1. A resident sits up in bed, stands, and begins to sway, but steadies herself and sits down smoothly into her wheelchair.

Coding: G0300A would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: Resident was unsteady, but she was able to stabilize herself without assistance from staff.

2. A resident requires the use of a gait belt and physical assistance in order to stand.

Coding: G0300A would be **coded 2, not steady, only able to stabilize with staff assistance.**

Rationale: Resident required staff assistance to stand during the observation period.

3. A resident stands steadily by pushing himself up using the arms of a chair.

Coding: G0300A would be **coded 0, steady at all times.**

Rationale: Even though the resident used the arms of the chair to push himself up, he was steady at all times during the activity.

4. A resident locks his wheelchair and uses the arms of his wheelchair to attempt to stand. On the first attempt, he rises about halfway to a standing position then sits back down. On the second attempt, he is able to stand steadily.

Coding: G0300A would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: Even though the second attempt at standing was steady, the first attempt suggests he is unsteady and at risk for falling during this transition.

Coding Instructions G0300B, Walking (with Assistive Device if Used)

Code for the least steady episode, using assistive device if applicable.

- **Code 0, steady at all times:**
 - If during the 7-day look-back period the resident's walking (with assistive devices if used) is steady at all times.
 - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device and is steady while walking with it.
 - Residents in this category do not appear at risk for falls.
 - Residents who walk with an abnormal gait and/or with an assistive device can be steady, and if they are they should be coded in this category.
- **Code 1, not steady, but able to stabilize without staff assistance:**
 - If during the 7-day look-back period the resident appears unsteady while walking (with assistive devices if used) but does not require staff assistance to stabilize.
 - Residents coded in this category appear at risk for falling while walking.

G0300: Balance During Transitions and Walking (cont.)

- **Code 2, not steady, only able to stabilize with staff assistance:**
 - If during the 7-day look-back period the resident at any time appeared unsteady and required staff assistance to be stable and safe while walking.
 - If the resident fell when walking during the look-back period.
 - Residents coded in this category appear at high risk for falling while walking.
- **Code 8, activity did not occur:**
 - If the resident did not walk during the 7-day look-back period.

Examples for G0300B, Walking (with Assistive Device if Used)

1. A resident with a recent stroke walks using a hemi-walker in her right hand because of left-sided weakness. Her gait is slow and short-stepped and slightly unsteady as she walks, she leans to the left and drags her left foot along the ground on most steps. She has not had to steady herself using any furniture or grab bars.

Coding: G0300B would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: Resident's gait is unsteady with or without an assistive device but does not require staff assistance.

2. A resident with Parkinson's disease ambulates with a walker. His posture is stooped, and he walks slowly with a short-stepped shuffling gait. On some occasions, his gait speeds up, and it appears he has difficulty slowing down. On multiple occasions during the 7-day observation period he has to steady himself using a handrail or a piece of furniture in addition to his walker.

Coding: G0300B would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: Resident has an unsteady gait but can stabilize himself using an object such as a handrail or piece of furniture.

3. A resident who had a recent total hip replacement ambulates with a walker. Although she is able to bear weight on her affected side, she is unable to advance her walker safely without staff assistance.

Coding: G0300B would be **coded 2, not steady, only able to stabilize with staff assistance.**

Rationale: Resident requires staff assistance to walk steadily and safely at any time during the observation period.

4. A resident with multi-infarct dementia walks with a short-stepped, shuffling-type gait. Despite the gait abnormality, she is steady.

Coding: G0300B would be **coded 0, steady at all times.**

Rationale: Resident walks steadily (with or without a normal gait and/or the use of an assistive device) at all times during the observation period.

G0300: Balance During Transitions and Walking (cont.)

Coding Instructions G0300C, Turning Around and Facing the Opposite Direction while Walking

Code for the least steady episode, using an assistive device if applicable.

- **Code 0, steady at all times:**
 - If all observed turns to face the opposite direction are steady without assistance of a staff during the 7-day look-back period.
 - If the resident is stable making these turns when using an assistive device.
 - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
 - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- **Code 1, not steady, but able to stabilize without staff assistance:**
 - If any transition that involves turning around to face the opposite direction is not steady, but the resident stabilizes without assistance from a staff.
 - If the resident is unstable with an assistive device but does not require staff assistance.
 - Residents coded in this category appear at increased risk for falling during transitions.
- **Code 2, not steady, only able to stabilize with staff assistance:**
 - If any transition that involves turning around to face the opposite direction is not steady, and the resident cannot stabilize without assistance from a staff.
 - If the resident fell when turning around to face the opposite direction during the look-back period.
 - Residents coded in this category appear at high risk for falling during transitions.
- **Code 8, activity did not occur:**
 - If the resident did not turn around to face the opposite direction while walking during the 7-day look-back period.

Examples for G0300C, Turning Around and Facing the Opposite Direction while Walking

1. A resident with Alzheimer's disease frequently wanders on the hallway. On one occasion, a nursing assistant noted that he was about to fall when turning around. However, by the time she got to him, he had steadied himself on the handrail.

Coding: G0300C would be **coded 1, Not steady, but able to stabilize without staff assistance.**

Rationale: The resident was unsteady when turning but able to steady himself on an object, in this instance, a handrail.

G0300: Balance During Transitions and Walking (cont.)

2. A resident with severe arthritis in her knee ambulates with a single-point cane. A nursing assistant observes her lose her balance while turning around to sit in a chair. The nursing assistant is able to get to her before she falls and lowers her gently into the chair.

Coding: G0300C would be **coded 2, not steady, only able to stabilize with staff assistance.**

Rationale: The resident was unsteady when turning around and would have fallen without staff assistance.

Coding for G0300D, Moving on and off Toilet

Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable. Include stability while manipulating clothing to allow toileting to occur in this rating.

- **Code 0, steady at all times:**
 - If all of the observed transitions on and off the toilet during the 7-day look-back period are steady without assistance of a staff.
 - If the resident is stable when transferring using an assistive device or object identified for this purpose.
 - If an assistive device is used (e.g., grab bar), the resident appropriately plans and integrates the use of the device into the transition activity.
 - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- **Code 1, not steady, but able to stabilize without staff assistance:**
 - If any transitions on or off the toilet during the 7-day look-back period are not steady, **but** the resident stabilizes **without** assistance from a staff.
 - If resident is unstable with an assistive device but does not require staff assistance.
 - Residents coded in this category appear at increased risk for falling during transitions.
- **Code 2, not steady, only able to stabilize with staff assistance:**
 - If any transitions on or off the toilet during the 7-day look-back period are not steady, and the resident cannot stabilize without assistance from a staff.
 - If the resident fell when moving on or off the toilet during the look-back period.
 - Residents coded in this category appear at high risk for falling during transitions.
 - If lift device is used.
- **Code 8, activity did not occur:**
 - If the resident did not transition on and off the toilet during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300D, Moving on and off Toilet

1. A resident sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

Coding: G0300D would be **coded 0, steady at all times.**

Rationale: This resident's use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The resident was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. A resident wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

Coding: G0300D would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: The resident was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. A resident wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, and then is able to steady himself with the grab bar.

Coding: G0300D would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: The resident was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

Code for the least steady episode.

- **Code 0, steady at all times:**
 - If all of the observed transfers during the 7-day look-back period are steady without assistance of a staff.
 - If the resident is stable when transferring using an assistive device identified for this purpose.
 - If an assistive device or equipment is used, the resident uses it independently and appropriately plans and integrates the use of the device into the transition activity.
 - Residents **coded 0** should not appear to be at risk of a fall during a transition.

G0300: Balance During Transitions and Walking (cont.)

- **Code 1, not steady, but able to stabilize without staff assistance:**
 - If any transfers during the look-back period are not steady, but the resident stabilizes without assistance from a staff.
 - If the resident is unstable with an assistive device but does not require staff assistance.
 - Residents coded in this category appear at increased risk for falling during transitions.
- **Code 2, not steady, only able to stabilize with staff assistance:**
 - If any transfers during the 7-day look-back period are not steady, and the resident can only stabilize with assistance from a staff.
 - If the resident fell during a surface-to-surface transfer during the look-back period.
 - Residents coded in this category appear at high risk for falling during transitions.
 - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the resident requires staff assistance to stabilize, **code 2**.
- **Code 8, activity did not occur:**
 - If the resident did not transfer between bed and chair or wheelchair during the 7-day look-back period.

Examples for G0300E, Surface-to-Surface Transfer (Transfer Between Bed and Chair or Wheelchair)

1. A resident who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.

Coding: G0300E would be **coded 0, steady at all times**.

Rationale: The resident was steady when transferring from bed to wheelchair.

2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.

Coding: G0300E would be **coded 2, not steady, only able to stabilize with staff assistance**.

Rationale: The resident was unsteady when transferring from bed to chair and required staff assistance to make a steady transfer.

3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

Coding: G0300E would be **coded 1, not steady, but able to stabilize without staff assistance**.

G0300: Balance During Transitions and Walking (cont.)

Rationale: The resident was unsteady when transferring from bed to wheelchair but did not require staff assistance to complete the activity.

4. A resident who uses her wheelchair for mobility stands up from the edge of her bed, sways to the right, but then is quickly able to pivot and sits in her locked wheelchair in a steady fashion.

Coding: G0300E would be **coded 1, not steady, but able to stabilize without staff assistance.**

Rationale: The resident was unsteady when transferring from bed to wheelchair but was able to steady herself without staff assistance or an object.

Additional examples for G0300A-E, Balance during Transitions and Walking

1. A resident sits up in bed, stands up, pivots and sits in her locked wheelchair. She then wheels her chair to the bathroom where she stands, pivots, lifts gown and smoothly sits on the commode.

Coding: G0300A, G0300D, G0300E would be **coded 0, steady at all times.**

Rationale: The resident was steady during each activity.

G0400: Functional Limitation in Range of Motion

G0400. Functional Limitation in Range of Motion	
Code for limitation that interfered with daily functions or placed resident at risk of injury	
↓ Enter Codes in Boxes	
Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides	<input type="checkbox"/> A. Upper extremity (shoulder, elbow, wrist, hand)
	<input type="checkbox"/> B. Lower extremity (hip, knee, ankle, foot)

Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform.

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION

Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

Item Rationale

Health-related Quality of Life

- Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living.

Planning for Care

- Individualized care plans should address possible reversible causes such as de-conditioning and adverse side effects of medications or other treatments.

G0400: Functional Limitation in Range of Motion (cont.)

Steps for Assessment

1. Review the medical record for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a 3 step process:
 - Test the resident's upper and lower extremity ROM (See #6 below for examples).
 - If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
 - Code G0400 A/B as appropriate based on the above assessment.
4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
5. Staff observations of various activities, including ADLs, may be used to determine if any ROM limitations impact the resident's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM; thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
 - Ask the resident to follow your verbal instructions for each movement.
 - Demonstrate each movement (e.g., ask the resident to do what you are doing).
 - Actively assist the resident with the movements by supporting his or her extremity and guiding it through the joint ROM.

Lower Extremity – includes hip, knee, ankle, and foot

While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot. Then ask the resident to lift his or her leg one at a time, bending it at the knee to a right angle (90 degrees) Then ask the resident to slowly lower his or her leg and extend it flat on the mattress. If assessing lower extremity ROM by observing the resident, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower body clothing.

Upper Extremity – includes shoulder, elbow, wrist, and fingers

For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct him or her to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

G0400: Functional Limitation in Range of Motion (cont.)

Coding Tips

- Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury. For example, if the resident has an amputation it does not automatically mean that they are limited in function. He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that the resident with an amputation has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If the resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

- **Code 0, no impairment:** if resident has full functional range of motion on the right and left side of upper/lower extremities.
- **Code 1, impairment on one side:** if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.
- **Code 2, impairment on both sides:** if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.

Examples for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is able to perform grooming activities (e.g. brush teeth, comb her hair) with her right upper extremity, and is also able to pivot to her wheelchair with the assist of one person. She is, however, unable to voluntarily move her left side (limited arm, hand and leg motion) as she has a flaccid left hemiparesis from a prior stroke.

Coding: G0400A would be **coded 1, upper extremity impairment on one side**. G0400B would be **coded 1, lower extremity impairment on one side**.

Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows for the resident to be as independent as possible.

G0400: Functional Limitation in Range of Motion (cont.)

- The resident had shoulder surgery and can't brush her hair or raise her right arm above her head. The resident has no impairment on the lower extremities.

Coding: G0400A would be **coded 1, upper extremity impairment on one side**. G0400B would be **coded 0, no impairment**.

Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities.

- The resident has a diagnosis of Parkinson's and ambulates with a shuffling gate. The resident has had 3 falls in the past quarter and often forgets his walker which he needs to ambulate. He has tremors of both upper extremities that make it very difficult to feed himself, brush his teeth or write.

Coding: G0400A would be **coded 2, upper extremity impairment on both sides**. G0400B would be **coded 2, lower extremity impairment on both sides**.

Rationale: Impairment due to Parkinson's disease affects the resident at the upper and lower extremities on both sides.

G0600: Mobility Devices

G0600. Mobility Devices	
↓ Check all that were normally used	
<input type="checkbox"/>	A. Cane/crutch
<input type="checkbox"/>	B. Walker
<input type="checkbox"/>	C. Wheelchair (manual or electric)
<input type="checkbox"/>	D. Limb prosthesis
<input type="checkbox"/>	Z. None of the above were used

Item Rationale

Health-related Quality of Life

- Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.

Planning for Care

- Resident ability to move about his or her room, unit or nursing home may be directly related to the use of devices. It is critical that nursing home staff assure that the resident's independence is optimized by making available mobility devices on a daily basis, if needed.

G0600: Mobility Devices (cont.)

Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the look-back period.
3. Observe the resident during locomotion.

Coding Instructions

Record the type(s) of mobility devices the resident normally uses for locomotion (in room and in facility). Check all that apply:

- **Check G0600A, cane/crutch:** if the resident used a cane or crutch, including single prong, tripod, quad cane, etc.
- **Check G0600B, walker:** if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with/without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.
- **Check G0600C, wheelchair (manual or electric):** if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person.
- **Check G0600D, limb prosthesis:** if the resident used an artificial limb to replace a missing extremity.
- **Check G0600Z, none of the above:** if the resident used none of the mobility devices listed in G0600 or locomotion did not occur during the look-back period.

Examples

1. The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that she self-propels when leaving the unit due to her issues with endurance.

Coding: **G0600A, use of cane/crutch,** and **G0600C, wheelchair,** would be checked.

Rationale: The resident uses a quad cane in her room and on the unit and a wheelchair off the unit.

2. The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied the resident is able to ambulate independently.

Coding: **G0600D, limb prosthesis,** would be checked.

Rationale: The resident uses a leg prosthesis for ambulating.

G0900: Functional Rehabilitation Potential

Complete only on OBRA Admission Assessment (A0310A = 1)

G0900. Functional Rehabilitation Potential	
Complete only if A0310A = 01	
Enter Code <input type="checkbox"/>	A. Resident believes he or she is capable of increased independence in at least some ADLs 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	B. Direct care staff believe resident is capable of increased independence in at least some ADLs 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Attaining and maintaining independence is important to an individual's feelings of autonomy and self-worth.
- Independence is also important to health status, as decline in function can trigger all of the complications of immobility, depression, and social isolation.

Planning for Care

- Beliefs held by the resident and staff that the resident has the capacity for greater independence and involvement in self-care in at least some ADL areas may be important clues to assist in setting goals.
- Even if highly independent in an activity, the resident or staff may believe the resident can gain more independence (e.g., walk longer distances, shower independently).
- Disagreement between staff beliefs and resident beliefs should be explored by the interdisciplinary team.

Steps for Assessment: Interview Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the resident thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the resident believes, even if it appears unrealistic.
 - It is sometimes helpful to have a conversation with the resident that helps him/her break down this question. For example, you might ask the resident what types of things staff assist him with and how much of those activities the staff do for the resident. Then ask the resident, "Do you think that you could get to a point where you do more or all of the activity yourself?"

Coding Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

- **Code 0, no:** if the resident indicates that he or she believes he or she will probably stay the same and continue with his or her current needs for assistance.

G0900: Functional Rehabilitation Potential (cont.)

- **Code 1, yes:** if the resident indicates that he or she thinks he or she can improve. Code even if the resident's expectation appears unrealistic.
- **Code 9, unable to determine:** if the resident cannot indicate any beliefs about his or her functional rehabilitation potential.

Example for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Mr. N. is cognitively impaired and receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff are not looking.

Coding: G0900A would be **coded 1, yes**.

Rationale: The resident believes he is capable of increased independence.

Steps for Assessment for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. Discuss in interdisciplinary team meeting.
2. Ask staff who routinely care for or work with the resident if they think he or she is capable of greater independence in at least some ADLs.

Coding Instructions for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

- **Code 0, no:** if staff believe the resident probably will stay the same and continue with current needs for assistance. Also **code 0** if staff believe the resident is likely to experience a decrease in his or her capacity for ADL care performance.
- **Code 1, yes:** if staff believe the resident can gain greater independence in ADLs or if staff indicate they are not sure about the potential for improvement, because that indicates some potential for improvement.

Example for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. The nurse assistant who totally feeds Mrs. W. has noticed in the past week that Mrs. W. has made several attempts to pick up finger foods. She believes Mrs. W. could become more independent in eating if she received close supervision and cueing in a small group for restorative care in eating.

Coding: G0900B would be **coded 1, yes**.

Rationale: Based upon observation of the resident, the nurse assistant believes Mrs. W. is capable of increased independence.

H0200: Urinary Toileting Program (cont.)

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- **Code 1, yes:** for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
 - simply tracking continence status,
 - changing pads or wet garments, and
 - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
 - H0200A would be **coded 1, yes,**
 - H0200B would be **coded 9, unable to determine or trial in progress,** and
 - H0200C would be **coded 1, yes.**

Example

1. Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment/diary indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb her sleep.

Coding: H0200A would be **coded as 0, no** H0200B and H0200C would be skipped.

Rationale: Based on this resident's voiding assessment/diary, there was no pattern to her incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no skip to H0300, Urinary Continence.

J0100: Pain Management (cont.)

- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Steps for Assessment

1. Review medical record to determine if a pain regimen exists.
2. Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received during the 5-day look-back period. Include information from all disciplines.

Coding Instructions for J0100A-C

Determine all interventions for pain provided to the resident during the 5-day look-back period. Answer these items even if the resident currently denies pain.

Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen

- Code 0, no: if the medical record does not contain documentation that a scheduled pain medication was received.
- Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- Code 0, no: if the medical record does not contain documentation that a PRN medication was received or offered.
- Code 1, yes: if the medical record contains documentation that a PRN medication was either received OR was offered but declined.

DEFINITIONS

SCHEDULED PAIN

MEDICATION REGIMEN

Pain medication order that defines dose and specific time interval for pain medication administration. For example, "once a day," "every 12 hours."

PRN PAIN

MEDICATIONS

Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as "every 4 hours as needed for pain" or "every 6 hours as needed for pain."

NON-MEDICATION

PAIN INTERVENTION

Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.

K0310: Weight Gain (cont.)

- If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0510: Nutritional Approaches

K0510. Nutritional Approaches		
Check all of the following nutritional approaches that were performed during the last 7 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

DEFINITIONS

PARENTERAL/IV FEEDING

Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

FEEDING TUBE

Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B columns 2 and 3 would be coded **2, 501cc/day or more.**

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc
 6,300 cc divided by 7 days = 900 cc/day
 900 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more** is correct.

2. Calculation for Average Daily Fluid Intake

Mrs. G. received 1 liter of IV fluids in the hospital on the Tuesday prior to her admission to the nursing home on Saturday afternoon. She received no other intake via IV or tube feeding during the last 7 days.

IV Fluid Intake	
Sun.	0 cc
Mon.	0 cc
Tues.	1,000 cc
Wed.	0 cc
Thurs.	0 cc
Fri.	0 cc
Sat.	0 cc
Total	1,000 cc

Coding: K0710B column 1 would be coded **1, 500 cc/day or less.**

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc
 1000 cc divided by 7 days = 142.9 cc/day
 142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.

3. Mr. K. has been able to take some fluids orally, however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

While in the Hospital		While in the Nursing Home	
Mon.	400 cc	Mon.	510 cc
Tues.	520 cc	Tues.	520 cc
Weds.	500 cc	Weds.	490 cc
Thurs.	480 cc		
Total	1,900 cc	Total	1,520 cc

Coding: K0710B1 would be coded 1, 500 cc/day or less. K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident.**

The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more is correct for K0710B2, While a Resident.**

The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days.**

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

7. Considering **only** the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Stage and measure each pressure ulcer separately.

Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar

- **Enter the current longest length** of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- **Enter the widest width** in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.
- **Enter the depth** measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

Coding Tips

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.

N0410: Medications Received (cont.)

- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
 - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at <http://www.cms.gov/Manuals/IOM/list.asp>]), which may
 - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
 - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website <http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm>.

Example

1. The Medication Administration Record for Mrs. P. reflects the following:
 - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
 - Lorazepam 1 mg PO QAM: Received every day.
 - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

Coding: Medications in N0410, would be coded as follows: **A. Antipsychotic = 3**, risperidone is an antipsychotic medication, **B. Antianxiety = 7**, lorazepam is an antianxiety medication, and **D. Hypnotic = 2**, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

O0100: Special Treatments, Procedures, and Programs (cont.)

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 1

Check all treatments, procedures, and programs received or performed by the resident **prior** to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, **check Z, none of the above.**

Coding Instructions for Column 2

Check all treatments, procedures, and programs received or performed by the resident **after** admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **O0100A, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. IVs, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O0100I (Transfusions).

- **O0100B, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100C, Oxygen therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

- **O0100F, Ventilator or respirator**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

- **O0100G, BiPAP/CPAP**

Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask.

- **O0100H, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:

- The Orange Book, <http://www.fda.gov/cder/ob/default.htm>
- The National Drug Code Directory, <http://www.fda.gov/drugs/informationondrugs/ucm142438.htm>

00100: Special Treatments, Procedures, and Programs (cont.)

- **00100I, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **00100J, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.

- **00100K, Hospice care**

Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided 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.

- **00100L, Respite care**

Code only when the resident's care program involves a short-term stay in the facility for the purpose of providing relief to a primary home-based caregiver(s) in this item.

- **00100M, Isolation for active infectious disease (does not include standard precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "single room isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.

00100: Special Treatments, Procedures, and Programs (cont.)

4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

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

Finally, when coding for isolation, the facility should review the resident’s status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident’s function and plan of care. The definition and criteria of “significant change of status” is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident’s plan of care will likely need to be completed.

- **O0100Z, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

00250: Influenza Vaccine

00250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period	
Enter Code <input type="checkbox"/>	<p>A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?</p> <p>0. No → Skip to O0250C, If influenza vaccine not received, state reason</p> <p>1. Yes → Continue to O0250B, Date influenza vaccine received</p>
	<p>B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?</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>
Enter Code <input type="checkbox"/>	<p>C. If influenza vaccine not received, state reason:</p> <p>1. Resident not in this facility during this year's influenza vaccination season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible - medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain influenza vaccine due to a declared shortage</p> <p>9. None of the above</p>

O0250: Influenza Vaccine (cont.)

Item Rationale

Health-related Quality of Life

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

Planning for Care

- Influenza vaccines have been proven effective in preventing hospitalizations.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.
 - **Mild problems:** soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days.
 - **Severe problems:**
 - Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
 - In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.
- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine.
- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

O0250: Influenza Vaccine (cont.)

- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC:
http://www.cdc.gov/vaccinesafety/vaccine_monitoring/
- Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020
(<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23>) national goal of increasing to 90 percent, the percentage of adults aged 18 years or older in long-term care nursing homes who are vaccinated annually against seasonal influenza.

Steps for Assessment

1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.

Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?

- **Code 0, no:** if the resident **did NOT receive the influenza vaccine in this facility** during this year's influenza vaccination season. Proceed to **If influenza vaccine not received, state reason** (O0250C).
- **Code 1, yes:** if the resident **did receive the influenza vaccine in this facility** during this year's influenza season. Continue to **Date influenza vaccine received** (O0250B).

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
 - If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
 - If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
 - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250C, If influenza vaccine not received, state reason

If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

- **Code 1, Resident not in this facility during this year's influenza vaccination season:** resident was not in this facility during this year's influenza vaccination season.
- **Code 2, Received outside of this facility:** includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.
- **Code 3, Not eligible—medical contraindication:** if influenza vaccine not received due to medical contraindications. Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination.
- **Code 4, Offered and declined:** resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.
- **Code 5, Not offered:** resident or responsible party/legal guardian not offered the influenza vaccine.
- **Code 6, Inability to obtain influenza vaccine due to a declared shortage:** vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
- **Code 9, None of the above:** if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

Coding Tips and Special Populations

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza:
<http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>,
<http://www.cdc.gov/flu/weekly/usmap.htm>.
- Facilities can also contact their local health department website for local influenza surveillance information.

O0250: Influenza Vaccine (cont.)

- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.
- A “high dose” inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident’s primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.

Examples

1. Mrs. J. received the influenza vaccine in the facility during this year’s influenza vaccination season, on January 7, 2014.

Coding: O0250A would be **coded 1, yes**; O0250B would be **coded 01-07-2014**, and O0250C would be skipped.

Rationale: Mrs. J. received the vaccine in the facility on January 7, 2014, during this year’s influenza vaccination season.

2. Mr. R. did not receive the influenza vaccine in the facility during this year’s influenza vaccination season due to his known allergy to egg protein.

Coding: O0250A would be **coded 0, no**; O0250B is skipped, and O0250C would be **coded 3, not eligible-medical contraindication**.

Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Mr. R did not receive the vaccine.

3. Mrs. T. received the influenza vaccine at her doctor’s office during this year’s influenza vaccination season. Her doctor provided documentation of receipt of the vaccine to the facility to place in Mrs. T.’s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks of the influenza vaccine prior to administration.

Coding: O0250A would be **coded 0, no**; and O0250C would be **coded 2, received outside of this facility**.

Rationale: Mrs. T. received the influenza vaccine at her doctor’s office during this year’s influenza vaccination season.

4. Mr. K. wanted to receive the influenza vaccine if it arrived prior to his scheduled discharge on October 5th. Mr. K. was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Mr. K. did not receive the influenza vaccine in the facility.

Mr. K. was encouraged to receive the influenza vaccine at his next scheduled physician visit.

Coding: O0250A would be **coded 0, no**; O0250B is skipped, and O0250C would be **coded 9, none of the above**.

Rationale: Mr. K. was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after his discharge. None of the codes in O0250C, **Influenza vaccine not received, state reason**, are applicable.

O0300: Pneumococcal Vaccine

O0300. Pneumococcal Vaccine	
Enter Code <input type="checkbox"/>	A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies
Enter Code <input type="checkbox"/>	B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered

Item Rationale

Health-related Quality of Life

- Pneumococcal disease accounts for more deaths than any other vaccine-preventable bacterial disease.
- Case fatality rates for pneumococcal bacteremia are approximately 20%; however, they can be as high as 60% in the elderly (CDC, 2009).

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Conditions that increase the risk of invasive pneumococcal disease include: decreased immune function, damaged or no spleen, chronic diseases of the heart, lungs, liver and kidneys. Other risk factors include smoking and cerebrospinal fluid (CSF) leak (CDC, 2009).
- Determining the rate of pneumococcal vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23>) national goal of 90% immunization among nursing home residents.

Steps for Assessment

1. Determine whether or not the resident should receive the vaccine.
 - All adults 65 years of age or older should receive the pneumococcal vaccine. However, certain person should be vaccinated before the age of 65, which include but are not limited to the following:
 - Immunocompromised persons 2 years of age and older who are at increased risk of pneumococcal disease should be vaccinated. This group includes those with the risk factors listed under **Planning for Care**, as well as Hodgkin's disease, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, cochlear implant, or those who have had organ transplants and are on immunosuppressive protocols. Those on chemotherapy who are immunosuppressed, or those taking high-dose corticosteroids (14 days or longer) should also be vaccinated.
 - Individuals 2 years of age or older with asymptomatic or symptomatic HIV should be vaccinated.

O0300: Pneumococcal Vaccine (cont.)

- Individuals living in environments or social settings (e.g., nursing homes and other long-term care facilities) with an identified increased risk of invasive pneumococcal disease or its complications should be considered for vaccination populations.
- If vaccination status is unknown or the resident/family is uncertain whether or not the vaccine was received, the resident should be vaccinated.
- Pneumococcal vaccine is given once in a lifetime, with certain exceptions. Revaccination is recommended for the following:
 - Individuals 2 years of age or older who are at highest risk for serious pneumococcal infection and for those who are likely to have a rapid decline in pneumococcal antibody levels. Those at highest risk include individuals with asplenia (functional or anatomic), sickle-cell disease, HIV infections or AIDS, cancer, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression (e.g., organ or bone marrow transplant, medication regimens that lower immunity (such as chemotherapy or long-term steroids).
 - Persons 65 years or older should be administered a second dose of pneumococcal vaccine if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.
- If the resident has had a severe allergic reaction to vaccine components or following a prior dose of the vaccine, they should not be vaccinated.

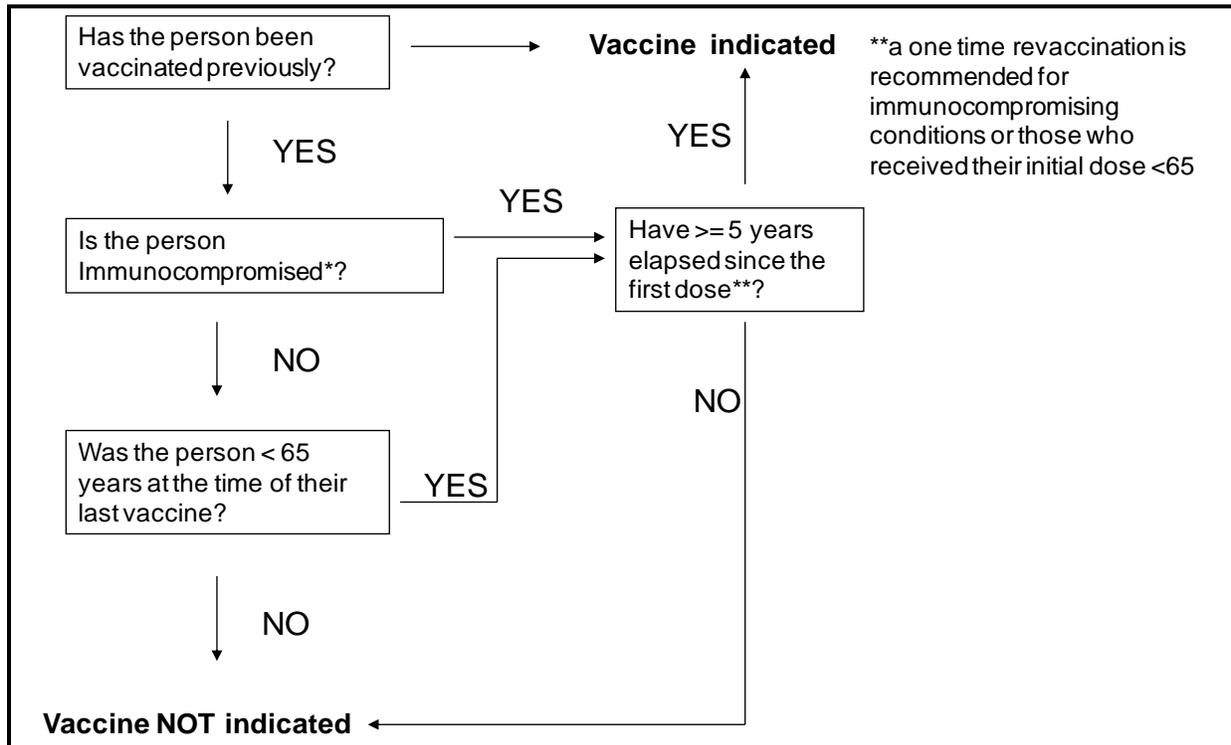
If the resident has a moderate to severe acute illness, he or she should not be vaccinated until his or her condition improves. However, someone with a minor illness (e.g., a cold) should be vaccinated since minor illnesses are not a contraindication to receiving the vaccine.

[Centers for Disease Control and Prevention. (2012, May). *The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (12th ed.)*. Retrieved from <http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters>]

Note: Please refer to the algorithm below for pneumococcal vaccine administration ONLY.

O0300: Pneumococcal Vaccine (cont.)

Figure 1 Adopted from the CDC Recommendations and Reports, Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP) Recommended Adult Immunization Schedule --- United States. (2009, January 9). *MMWR*, 57(53),Q-1-Q-4.



2. Review the resident’s medical record and interview resident or responsible party/legal guardian and/or primary care physician to determine pneumococcal vaccination status, using the following steps:
 - Review the resident’s medical record to determine whether a pneumococcal vaccine has been received. If vaccination status is unknown, proceed to the next step.
 - Ask the resident if he/she received a pneumococcal vaccine. If vaccination status is still unknown, proceed to the next step.
 - If the resident is unable to answer, ask the same question of a responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
 - If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice.

O0300: Pneumococcal Vaccine (cont.)

Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?

- **Code 0, no:** if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, **If Pneumococcal vaccine not received, state reason.**
- **Code 1, yes:** if the resident's pneumococcal vaccination status is up to date. Skip to O0400, **Therapies.**

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason

If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- **Code 1, Not eligible:** if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.
- **Code 2, Offered and declined:** resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- **Code 3, Not offered:** resident or responsible party/legal guardian not offered the pneumococcal vaccine.

Coding Tips

- The CDC has evaluated inactivated influenza vaccine co-administration with the pneumococcal vaccine systematically among adults. It is safe to give these two vaccinations simultaneously. If the influenza vaccine and pneumococcal vaccine will be given to the resident at the same time, they should be administered at different sites (CDC, 2009). If the resident has had both upper extremities amputated or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

Examples

1. Mr. L., who is 72 years old, received the pneumococcal vaccine at his physician's office last year.

Coding: O0300A would be **coded 1, yes;** skip to O0400, **Therapies.**

Rationale: Mr. L is over 65 years old and received the pneumococcal vaccine in his physician's office last year at age 71.

O0300: Pneumococcal Vaccine (cont.)

2. Mrs. B, who is 95 years old, has never received a pneumococcal vaccine. Her physician has an order stating that she is NOT to be immunized.

Coding: O0300A would be **coded 0, no**; and O0300B would be **coded 1, not eligible**.

Rationale: Mrs. B. has never received the pneumococcal vaccine, therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.

3. Mrs. A. received the pneumococcal vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 and is being admitted to the nursing home for rehabilitation. Her covering physician offered the pneumococcal vaccine to her during his last visit in the nursing home, which she accepted. The facility administered the pneumococcal vaccine to Mrs. A.

Coding: O0300A would be **coded 1, yes**; skip to O0400, **Therapies**.

Rationale: Mrs. A. received the pneumococcal vaccine prior to the age of 65.

Guidelines suggest that she should be revaccinated since she is over the age of 65 and 5 years have passed since her original vaccination. Mrs. A received the pneumococcal vaccine in the facility.

4. Mr. T. received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 65 years old and is being admitted to the nursing home for chemotherapy and respite care.

Coding: O0300A would be **coded 1, yes**; skip to O0400, **Therapies**.

Rationale: Mr. T. received his first dose of pneumococcal vaccine prior to the age of 65 due to him residing in congregate care at the age of 62. Even though Mr. T. is now immunocompromised, less than 5 years have lapsed since he originally received the vaccine. He would be considered up to date with his vaccination.

O0400: Therapies

O0400. Therapies	
<p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>A. Speech-Language Pathology and Audiology Services</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <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>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <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>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>B. Occupational Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <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>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <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>O0400 continued on next page</p>	

O0400: Therapies (cont.)

O0400. Therapies - Continued	
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>C. Physical Therapy</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> <small>Month Day Year</small> </div> </div> Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> <small>Month Day Year</small> </div> </div>
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>D. Respiratory Therapy</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>E. Psychological Therapy (by any licensed mental health professional)</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>F. Recreational Therapy (includes recreational and music therapy)</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

O0400: Therapies (cont.)

Planning for Care

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

Steps for Assessment

1. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

O0400: Therapies (cont.)

- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Skip the item if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.
- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident's EOT OMRA, in cases where the resident discontinued and then resumed therapy.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

Coding Tips and Special Populations

- **Therapy Start Date:**
 1. Look at the date at A1600.
 2. Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.
 3. If so, enter the date that the therapy regimen started; if there was more than one therapy regimen since the A1600 date, enter the start date of the most recent therapy regimen.

O0400: Therapies (cont.)

- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

Minutes of Therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.
- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted.
- The therapist's time spent on documentation or on initial evaluation is not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- Family education when the resident is present is counted and must be documented in the resident's record.
- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives more than one mode of therapy per visit.
 - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
 - Code as concurrent minutes when the resident receives only concurrent therapy or concurrent therapy followed by another mode(s); and
 - Code as group minutes when the resident receives only group therapy or group therapy followed by another mode(s).

O0400: Therapies (cont.)

- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services **must** meet **all** of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):
 - for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
 - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
 - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
 - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
 - the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.
- Record the actual minutes of therapy. **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute.** The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
- When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.

O0400: Therapies (cont.)

- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
 - the physician orders the therapy;
 - the physician's order includes a statement of frequency, duration, and scope of treatment;
 - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services must be reasonable and necessary for treatment of the resident's condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 **Therapies**, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident's medical record.
- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies**. The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

O0400: Therapies (cont.)

Co-treatment

For Part A:

When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of four participants who were doing the same or similar activities in each discipline. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

For Part B:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.

Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

O0400: Therapies (cont.)

Therapy Students

Medicare Part A—Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (**Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed.

Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

- Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
 - The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
 - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
 - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
 - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. (Please also see the section on group therapy for limited exceptions related to group size.) The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look back period for an MDS assessment).

O0400: Therapies (cont.)

Individual Therapy

The treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the resident individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals **and** he/she is able to immediately intervene/assist the student as needed.

Example:

- A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.'s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.'s therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy

Medicare Part A

The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of concurrent therapy, the minutes will be divided by 2.

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

O0400: Therapies (cont.)

Medicare Part B

- The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment

Examples:

- A physical therapist provides therapies that are not the same or similar, to Mrs. Q and Mrs. R at the same time, for 30 minutes. Mrs. Q's stay is covered under the Medicare SNF PPS Part A benefit. Mrs. R. is paying privately for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. Q. received concurrent therapy for 30 minutes.
 - Mrs. R received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar, to Mrs. S. and Mrs. T. at the same time, for 30 minutes. Mrs. S.'s stay is covered under the Medicare SNF PPS Part A benefit. Mr. T.'s therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. S. received concurrent therapy for 30 minutes.
 - Mr. T. received group therapy (Medicare Part B definition) for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr. K. received concurrent therapy for 60 minutes.
 - Mr. R. received concurrent therapy for 60 minutes.

Group Therapy

Medicare Part A

The treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of group therapy, the minutes will be divided by 4.

O0400: Therapies (cont.)

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B

The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

Examples:

- A Physical Therapist provides similar therapies to Mr. W, Mr. X, Mrs. Y. and Mr. Z. at the same time, for 30 minutes. Mr. W. and Mr. X.'s stays are covered under the Medicare SNF PPS Part A benefit. Mrs. Y.'s therapy is covered under Medicare Part B, and Mr. Z has private insurance paying for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr W. received group therapy for 30 minutes.
 - Mr. X. received group therapy for 30 minutes.
 - Mrs. Y. received group therapy for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
 - Mr. Z. received group therapy for 30 minutes.
- Mrs. V, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with Mr. S., whose therapy is covered by Medicare Part B, while Mrs. V. continues with her skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to Mrs. V. and Mr. S. for 24 minutes who are not performing the same or similar activities, at which time Mrs. V.'s therapy session ends. The therapist continues to treat Mr. S. individually for 10 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. V. received individual therapy for 13 minutes and concurrent therapy for 24.

O0400: Therapies (cont.)

- Mr. S. received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B. are joined by Mr. T. and Mr. E., whose stays are also covered by Medicare Part A., and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Mr. A. becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr. A. received concurrent therapy for 30 minutes and group therapy for 15 minutes.
 - Mr. B. received concurrent therapy for 30 minutes and group therapy for 30 minutes.
 - Mr. T. received group therapy for 30 minutes.
 - Mr. E. received group therapy for 30 minutes.

Therapy Modalities

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met, see page O-17) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the resident's plan of care.

Dates of Therapy

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident's episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. Therapy is considered to be ongoing if:

- The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
- The resident's SNF benefit exhausted and therapy continued to be provided, or

O0400: Therapies (cont.)

- The resident's payer source changed and therapy continued to be provided.

For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November 2011. Occupational and Physical therapy started December 3, 2011. His physical therapy ended January 27, 2012 and occupational therapy ended January 29, 2012. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, 2012 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, 2012. Coding values for his MDS are:

- O0400A5 (SLP start date) is 02102012,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112012,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032011, and
- O0400C6 (PT end date) is 01272012.

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be dash filled.

For example, Mr. T. was admitted to the nursing home following a fall that resulted in a hip fracture in May 2013. Occupational and Physical therapy started May 10, 2013. His physical therapy ended May 23, 2013 but the occupational therapy continued. Due to observed swallowing issues, he was referred to SLP on May 31, 2013 and the speech-language pathologist evaluated him on that day. Though Mr. T was able to receive both occupational therapy and speech therapy on June 12, he is unable to receive therapy on June 13 or June 14 due to a minor bout with the flu. The facility does not provide therapy on the weekends, which means that June 15, 2013 represents the third day of missed therapy, triggering an EOT OMRA. The therapy staff and nurses discuss Mr. T's condition and agree that Mr. T should be able to resume the same level of therapy beginning on June 18, 2013, so the facility decides to complete the EOT OMRA as an EOT-R, with an ARD of June 15, 2013.

Coding values for Mr. T's EOT-R are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is 06122013,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is 06122013,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

Subsequent to the EOT-R, the next PPS assessment completed for Mr. T is the 30-day assessment, with an ARD of June 23, 2013. There were no changes in the therapy services delivered to Mr. T since the EOT-R was completed.

O0400: Therapies (cont.)

Coding values for Mr. T's 30-day assessment are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

General Coding Example:

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

- Speech-language pathology services that were provided over the 7-day look-back period. Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

Coding:

O0400A1 would be **coded 190**; O0400A2 would be **coded 70**; O0400A3 would be **coded 75**; O0400A4 would be **coded 5**; O0400A5 would be **coded 10062011**; and O0400A6 would be **coded with dashes**.

Rationale:

Individual minutes totaled 190 over the 7-day look-back period $[(30 \times 5) + (20 \times 2) = 190]$; concurrent minutes totaled 70 over the 7-day look-back period $(35 \times 2 = 70)$; and group minutes totaled 75 over the 7-day look-back period $(25 \times 3 = 75)$. Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.

O0400: Therapies (cont.)

Coding:

O0400B1 would be **coded 113**, O0400B2 would be **coded 0**, O0400B3 would be **coded 80**, O0400B3A would be **coded 60**, O0400B4 would be **coded 5**, O0400B5 would be **coded 10092011**, and O0400B6 would be **coded with dashes**.

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period $[(30 \times 2) + 23 + 18 + 12 = 113]$; concurrent minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$; and group minutes totaled 80 over the 7-day look-back period $(20 \times 4 = 80)$. Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

Coding:

O0400C1 would be **coded 287**, O0400C2 would be **coded 100**, O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 10072011**, and O0400C6 would be **coded with dashes**.

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period $[(30 \times 2) + (35 \times 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]$; concurrent minutes totaled 100 over the 7-day look-back period $(20 \times 5 = 100)$; and group minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$. Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

Coding:

O0400D1 would be **coded 50**, O0400D2 would be **coded 0**.

O0400: Therapies (cont.)

Rationale:

Total minutes were 50 over the 7-day look-back period ($10 \times 5 = 50$). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.

Psychological therapy services that were provided over the 7-day look-back period:

Psychological therapy services were not provided at all over the 7-day look-back period.

Coding:

O0400E1 would be **coded 0**, O0400E2 would be **left blank**.

Rationale:

There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

Recreational therapy services that were provided over the 7-day look-back period:

Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.

Coding:

O0400F1 would be **coded 90**, O0400F2 would be **coded 3**.

Rationale:

Total minutes were 90 over the 7-day look-back period ($30 \times 3 = 90$). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

O0400: Therapies (cont.)

O0400. Therapies	
<p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="7"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="7"/> <input type="text" value="5"/></p> <p>Enter Number of Minutes <input type="text" value="6"/> <input type="text" value="5"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>A. Speech-Language Pathology and Audiology Services</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="6"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> Month Day Year
<p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="1"/> <input type="text" value="3"/></p> <p>Enter Number of Minutes <input type="text" value="8"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="6"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>B. Occupational Therapy</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="9"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> Month Day Year
<p>O0400 continued on next page</p>	

O0400: Therapies (cont.)

O0400. Therapies - Continued	
<p>Enter Number of Minutes <input type="text" value="2"/> <input type="text" value="8"/> <input type="text" value="7"/></p> <p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value="3"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>C. Physical Therapy</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <ol style="list-style-type: none"> 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="7"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> Month Day Year
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value="5"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="0"/></p>	<p>D. Respiratory Therapy</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value=""/></p>	<p>E. Psychological Therapy (by any licensed mental health professional)</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value="9"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>F. Recreational Therapy (includes recreational and music therapy)</p> <ol style="list-style-type: none"> Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

O0420: Distinct Calendar Days of Therapy

O0420. Distinct Calendar Days of Therapy	
<p>Enter Number of Days <input type="text" value=""/></p>	<p>Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.</p>

Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Coding Instructions:

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past

O0420: Distinct Calendar Days of Therapy (cont.)

7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Mrs. T. received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mrs. T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the 7-day look-back period. Given the therapy services received by Mrs. T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).
- Example 2: Mr. F. received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mr. F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the 7-day look-back period. Finally, Mr. F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Mr. F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0450: Resumption of Therapy

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99	
Enter Code <input type="checkbox"/>	<p>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</p> <p>0. No → Skip to O0500, Restorative Nursing Programs 1. Yes</p> <p>B. Date on which therapy regimen resumed:</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>

Item Rationale

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

Coding Instructions:

When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same level for each discipline, if **no**, skip to **O0500**, Restorative Nursing Programs. If **Yes**, code item **O0450A as 1**. Determine when therapy will resume and code item **O0450B with the date** that therapy will resume. For example:

O0450: Resumption of Therapy (cont.)

- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450 A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. Item **O0450B was coded as 11132011** because therapy resumed on November 13, 2011.

NOTE: If the EOT OMRA has not been accepted in the QIES ASAP when therapy resumes, code the EOT-R items (O0450A and O0450B) on the assessment and submit the record. If the EOT OMRA without the EOT-R items have been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy items (O0450A and O0450B) and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers.

Planning for Care

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record.
2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative nursing programs must be met in order to code O0500:

O0500: Restorative Nursing Programs (cont.)

- Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
- This category does not include groups with more than four residents per supervising helper or caregiver.

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A, **Occupational Therapy** item O0400B, and **Physical Therapy** O0400C.
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive]** item O0500A, 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item O0500A, 5 minutes of **Technique—Range of Motion [Active]** item O0500B, and 5 minutes of **Splint or Brace Assistance** item O0500C, over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

O0500: Restorative Nursing Programs (cont.)

Technique

Activities provided by restorative nursing staff.

- **O0500A, Range of Motion (Passive)**

Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- **O0500B, Range of Motion (Active)**

Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.

- **O0500C, Splint or Brace Assistance**

Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

- **O0500D, Bed Mobility**

Code activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500E, Transfer**

Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500F, Walking**

Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

- **O0500G, Dressing and/or Grooming**

Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500H, Eating and/or Swallowing**

Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500I, Amputation/ Prosthesis Care**

Code activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500J, Communication**

Code activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Coding Tips and Special Populations

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored, evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff

O0500: Restorative Nursing Programs (cont.)

have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.

- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Examples

1. Mr. V. has lost range of motion in his right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist, and hand three times per day. The nurse's aides and Mr. V.'s wife have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in Mr. V.'s care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse's aides report that there is less resistance in Mr. V.'s affected extremity when bathing and dressing him.

Coding: Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be **coded 7**.

Rationale: Because this was the number of days these restorative nursing techniques were provided.

2. Mrs. R.'s right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, her physician diagnosed her with right shoulder impingement syndrome. Mrs. R. was given exercises to perform on a daily basis to help improve her right shoulder ROM. After initial training in these exercises by the physical therapist, Mrs. R. and the nursing staff were provided with instructions on how to cue and sometimes actively assist Mrs. R. when she cannot make the full ROM required by the exercises on her own. Her exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in Mrs. R.'s medical record. The nursing staff cued and sometimes actively assisted Mrs. R. two times daily over the past 7 days.

Coding: **Range of motion (active)** item (O0500B), would be **coded 7**.

Rationale: Because this was the number of days restorative nursing training and skill practice for active ROM were provided.

O0500: Restorative Nursing Programs (cont.)

3. Mrs. K. was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in Mrs. K.'s medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the 5 days Mrs. K. has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, her endurance and strength have improved, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing restorative intervention has been decreasing, so that for the past 5 days, the average time is 45 minutes.

Coding: Both **Bed Mobility** item (O0500D), **Transfer** item (O0500E), would be **coded 5**.

Rationale: Because this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.

4. Mrs. D. is receiving training and skill practice in walking using a quad cane. Together, Mrs. D. and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to walk with her quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

Coding: **Walking** item (O0500F), would be **coded 7**.

Rationale: Because this was the number of days that restorative nursing skill and practice training for walking was provided.

5. Mrs. J. had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J. has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J.'s overall care plan goal is to maximize her independence in ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide Mrs. J. as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. It takes approximately 20 minutes per day for Mrs. J. to complete this task (dressing and undressing).

Coding: **Dressing or Grooming** item (O0500G), would be **coded 7**.

Rationale: Because this was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.

O0500: Restorative Nursing Programs (cont.)

6. Mr. W.'s cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration attempts to promote his independence in feeding himself, he will not eat unless he is fed.

Coding: Eating and/or Swallowing item (O0500H), would be **coded 0**.

Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

7. Mrs. E. has Amyotrophic Lateral Sclerosis. She no longer has the ability to speak or even to nod her head "yes" or "no." Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech-language pathologist taught both Mrs. E. and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has been in use over the past 2 weeks and has proven very successful. The nursing staff, volunteers, and family members are reminded by a sign over Mrs. E.'s bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E.'s care plan. Because the teaching and practice using the communication board had been completed 2 weeks ago and Mrs. E. is able to use the board to communicate successfully, she no longer receives skill and practice training in communication.

Coding: Communication item (O0500J), would be **coded 0**.

Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

O0600: Physician Examinations

O0600. Physician Examinations	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?

Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician examinations can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician examinations can be an indication of medical complexity and stability of the resident's health status.**

O0600: Physician Examinations (cont.)

Steps for Assessment

1. **Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.**

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
 - Chapter 15 of the *Medicare Benefit Policy Manual* (Pub. 100-2) and Chapter 12 of the *Medicare Claims Processing Manual* (Pub. 100-4) may be accessed at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

O0700. Physician Orders	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?

Item Rationale

Health-related Quality of Life

- Health **status that** requires **frequent physician order changes** can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician **order changes** can be an indication of medical complexity and stability of the resident's health status.

Steps for Assessment

1. Review the physician order sheets in the medical record.
2. Determine the number of days during the 14-day look-back period that a physician changed the resident's orders.

Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders.

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
- Do not count orders prior to the date of admission or re-entry.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

O0700: Physician Orders (cont.)

- When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

X0200: Name of Resident (A0500 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0200C, Last Name

- Enter the last name of the resident exactly as submitted for item A0500C “Legal Name of Resident— Last Name” on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box. The last name in X0200C cannot be blank.
- Note that the last name in X0200C does not have to match the current value of A0500C on a modification request. The entries may be different if the modification is correcting the last name.

X0300: Gender (A0800 on existing record to be modified/inactivated)

X0300. Gender (A0800 on existing record to be modified/inactivated)	
Enter Code <input type="checkbox"/>	1. Male 2. Female

Coding Instructions for X0300, Gender

- Enter the gender code 1 “Male,” 2 “Female,” or – (dash value indicating unable to determine) exactly as submitted for item A0800 “Gender” on the prior erroneous record to be modified/inactivated.
- Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record.
- Note that the gender in X0300 does not have to match the current value of A0800 on a modification request. The entries may be different if the modification is correcting the gender.

X0400: Birth Date (A0900 on existing record to be modified/inactivated)

X0400. Birth Date (A0900 on existing record to be modified/inactivated)										
	<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			

Coding Instructions for X0400, Birth Date

- Fill in the boxes with the birth date exactly as submitted for item A0900 “Birth Date” on the prior erroneous record to be modified/inactivated. If the month or day contains only a single digit, fill in the first box with a 0 For example, January 2, 1918, should be entered as:

0	1	0	2	1	9	1	8
---	---	---	---	---	---	---	---

If the birth date in MDS item A0900 on the prior record was a partial date, with day of the month unknown and the day of the month boxes were left blank, then the day of the month boxes must be blank in X0400. If the birth date in MDS item A0900 on the prior record was a partial date with both month and day of the month unknown and the month and day of the month boxes were left blank, then the month and day of the month boxes must be blank in X0400.

- Note that the birth date in X0400 does not have to match the current value of A0900 on a modification request. The entries may be different if the modification is correcting the birth date.

X0500: Social Security Number (A0600A on existing record to be modified/inactivated)

X0500. Social Security Number (A0600A on existing record to be modified/inactivated)	
	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Coding Instructions for X0500, Social Security Number

- Fill in the boxes with the Social Security number exactly as submitted for item A0600 "Social Security and Medicare numbers" on the prior erroneous record to be modified/inactivated. If the Social Security number was unknown or unavailable and left blank on the prior record, leave X0500 blank.
- Note that the Social Security number in X0500 does not have to match the current value of A0600 on a modification request. The entries may be different if the modification is correcting the Social Security number.

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated)

These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated.

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)	
Enter Code <input type="text"/> <input type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input type="text"/> <input type="text"/>	B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above
Enter Code <input type="text"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="text"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="text"/> <input type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0600A, Federal OBRA Reason for Assessment

- Fill in the boxes with the Federal OBRA reason for assessment/tracking code exactly as submitted for item A0310A “Federal OBRA Reason for Assessment” on the prior erroneous record to be modified/inactivated.
- Note that the Federal OBRA reason for assessment/tracking code in X0600A must match the current value of A0310A on a modification request.
- If item A0310A was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

Coding Instructions for X0600B, PPS Assessment

- Fill in the boxes with the PPS assessment type code exactly as submitted for item A0310B “PPS Assessment” on the prior erroneous record to be modified/inactivated.
- Note that the PPS assessment code in X0600B must match the current value of A0310B on a modification request.
- If item A0310B was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

Coding Instructions for X0600C, PPS Other Medicare Required Assessment—OMRA

- Fill in the boxes with the PPS OMRA code exactly as submitted for item A0310C “PPS—OMRA” on the prior erroneous record to be modified/inactivated.
- Note that the PPS OMRA code in X0600C must match the current value of A0310C on a modification request.
- If item A0310C was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)

- Enter the code exactly as submitted for item A0310D “Is this a Swing Bed clinical change assessment?” on the prior erroneous record to be modified/inactivated.
- **Code 0, no:** if the assessment submitted was not coded as a swing bed clinical change assessment.
- **Code 1, yes:** if the assessment submitted was coded as a swing bed clinical change assessment.

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)

- Note that the code in X0600D must match the current value of A0310D on a modification request.
- If item A0310D was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

Coding Instructions for X0600F, Entry/discharge reporting

- Enter the number corresponding to the entry/discharge code exactly as submitted for item A0310F “Entry/discharge reporting” on the prior erroneous record to be modified/inactivated.
 - 01.** Entry tracking record
 - 10.** Discharge assessment-return not anticipated
 - 11.** Discharge assessment-return anticipated
 - 12.** Death in facility tracking record
 - 99.** None of the above
- Note that the Entry/discharge code in X0600F must match the current value of A0310F on a modification request.
- If item A0310F was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

X0700: Date on Existing Record to Be Modified/Inactivated – Complete one only

The item that is completed in this section is the event date for the prior erroneous record to be modified/inactivated. The event date is the assessment reference date for an assessment record, the discharge date for a discharge record, or the entry date for an entry record. In the QIES ASAP system, this date is often referred to as the “target date.” Enter only one (1) date in X0700.

X0700. Date on existing record to be modified/inactivated - Complete one only																					
<p>A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99</p>	<table border="1" style="margin: auto;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</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			
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Month			Day			Year															
<p>B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12</p>	<table border="1" style="margin: auto;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</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			
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Month			Day			Year															
<p>C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01</p>	<table border="1" style="margin: auto;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 10px;">-</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															

X0700: Date on Existing Record to Be Modified/Inactivated (cont.)

Coding Instructions for X0700A, Assessment Reference Date— (A2300 on existing record to be modified/inactivated) – Complete Only if X0600F = 99

- If the prior erroneous record to be modified/inactivated is an OBRA assessment or a PPS assessment, where X0600F = 99, enter the assessment reference date here exactly as submitted in item A2300 “Assessment Reference Date” on the prior record.
- Note that the assessment reference date in X0700A must match the current value of A2300 on a modification request.

Coding Instructions for X0700B, Discharge Date—(A2000 on existing record to be modified/inactivated) – Complete Only If X0600F = 10, 11, or 12

- If the prior erroneous record to be modified/inactivated is a discharge record (indicated by X0600F = 10, 11, or 12), enter the discharge date here exactly as submitted for item A2000 “Discharge Date” on the prior record. If the prior erroneous record was a discharge combined with an OBRA or PPS assessment, then that prior record will contain both a completed assessment reference date (A2300) and discharge date (A2000) and these two dates will be identical. If such a record is being modified or inactivated, enter the prior discharge date in X0700B and leave the prior assessment reference date in X0700A blank.
- Note that the discharge date in X0700B must match the current value of A2000 on a modification request.

Coding Instructions for X0700C, Entry Date—(A1600 on existing record to be modified/inactivated) – Complete Only If X0600F = 01

- If the prior erroneous record to be modified/inactivated is an entry record (indicated by X0600F = 01), enter the entry date here exactly as submitted for item A1600 “Entry Date [date of admission/reentry into the facility]” on the prior record.
- Note that the entry date in X0700C must match the current value of A1600 on a modification request.

X0800: Correction Attestation Section

The items in this section indicate the number of times the QIES ASAP database record has been corrected, the reason for the current modification/inactivation request, the person attesting to the modification/inactivation request, and the date of the attestation.

This item may be populated automatically by the nursing home’s date entry software, however, if it is not, the nursing home should enter this information.

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request			
X0800. Correction Number			
<small>Enter Number</small>	Enter the number of correction requests to modify/inactivate the existing record, including the present one		
<table border="1" style="width: 50px; height: 20px;"> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> </tr> </table>			

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting			
<p>I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.</p>			
Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.
- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
 - the development of an individualized care plan;
 - the Medicare Prospective Payment System
 - Medicaid reimbursement programs
 - quality monitoring activities, such as the quality measure reports
 - the data-driven survey and certification process
 - the quality measures used for public reporting
 - research and policy development.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion	
A. Signature:	B. Date RN Assessment Coordinator signed assessment as complete: <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> Month Day Year </div>

Item Rationale

- Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

Steps for Assessment

- Verify that all items on this assessment are complete.
- Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Coding Instructions

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date will generally be later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.
- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Coding Tips

- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.
- Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
- Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.

CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).

5.1 Transmitting MDS Data

All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans. After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>

The provider indicates the certification or licensure of the unit on which the resident resides in item A0410, Unit Certification or Licensure Designation. In addition to reflecting certification or licensure of the unit, this item indicates the submission authority for a record.

- Value = 1 Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State.
- Value = 2 Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
- Value = 3 Unit is Medicare and/or Medicaid certified

See Chapter 3 for details concerning the coding of item A0410, Unit Certification or Licensure Designation. Note: CMS certified Swing Bed unit assessments are always Value 3, Unit is Medicare and/or Medicaid certified.

Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office web site at: <https://www.qtso.com>.

Once communication is established with the QIES ASAP system, the provider can access the CMS MDS Welcome Page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the QTSO MDS 3.0 web site at <https://www.qtso.com/mds30.html>.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
 - For all non-Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
 - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).
 - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).
 - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively.
 - For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000 for a DeathIn Facility tracking record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of State RAI Coordinators.)
- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:

- For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
- For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).
- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- **Submission Format:** For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Each MDS record must be a separate file in a required XML format. The submission file is a compressed ZIP file that may contain multiple XML files. See the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site for details concerning file and record formats, XML structure, and ZIP files.
- **Transmitting Data:** Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted.
 - **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
 - **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Submission Time Frame for MDS Records

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Admission Assessment	01	All values	10, 11, 99	V0200C2	V0200C2 + 14
Annual Assessment	03	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Change in Status Assessment	04	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Correction to Prior Comprehensive Assessment	05	All values	10, 11, 99	V0200C2	V0200C2 + 14
Quarterly Review Assessment	02	All values	10, 11, 99	Z0500B	Z0500B + 14
Sign. Correction Prior Quarterly Assessment.	06	All values	10, 11, 99	Z0500B	Z0500B + 14

(continued)

Submission Time Frame for MDS Records (continued)

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
PPS Assessment	99	01 through 07	10, 11, 99	Z0500B	Z0500B + 14
Discharge Assessment	All values	All values	10 or 11	Z0500B	Z0500B + 14
Death in Facility Tracking	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	1	A1600	A1600 + 14
Correction Request (Modification or Inactivation)	N/A	N/A	N/A	X1100E	X1100E + 14

Table Legend:

Item	Description
V0200C2	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the CAA Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
Z0500B	MDS Assessment Completion Date: Date of the RN assessment coordinator's signature, indicating that the MDS assessment is complete.
A2000	Date of discharge or death
A1600	Date of entry
X1100E	Date of the RN coordinator's signature on the Correction Request (Section X) certifying completion of the correction request information and the corrected assessment or tracking information.

- Assessment Schedule:** An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 2 for details.

5.3 Validation Edits

The QIES ASAP system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.

Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission number as well as the date and time the file was received for processing.

Validation and Editing Process. Each time a user accesses the QIES ASAP system and transmits an MDS file, the QIES ASAP system performs three types of validation:

1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.
2. **Fatal Record Errors.** If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:
 - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).
 - Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600).

Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening Discharge assessment (A0310F = 10 or 11). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

Storage to the QIES ASAP System. If there are any Fatal Record Errors, the record will be rejected and not stored in the QIES ASAP system. If there are no Fatal Record Errors, the record is loaded into the QIES ASAP system, even if the record has Non-Fatal Errors (Warnings).

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide* on the QTSO MDS 3.0 web site.

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS “are required to submit the resident assessment data described at §483.20... in the manner necessary to administer the payment rate methodology described in §413.337.” This provision includes the

frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments in specified windows near the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. The first three positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident, and the last two positions are an Assessment Indicator (AI) code indicating which type of assessment was completed. Standard “grouper” logic and software for RUG-IV and the AI code are provided by CMS on the MDS 3.0 web site.

The standard grouper uses MDS 3.0 items to determine both the RUG-IV group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the RUG-IV group and AI code. Detailed logic for determining the RUG-IV group and AI code is provided in Chapter 6.

The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes.

1. The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The RUG version code in Item Z0100B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare Part A HIPPS code.
2. The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS. An example when the non-therapy HIPPS is to be billed is when the resident has been receiving rehabilitation therapy (physical therapy, occupational therapy, and/or speech-language pathology services), all rehabilitation therapy ends, and the resident continues on Part A (see Chapter 6 for details, including other instances when this HIPPS code is used for billing purposes). The RUG version code in Item Z0150B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare non-therapy Part A HIPPS code.

There is also a Medicare Short Stay indicator (Item Z0100C) on the MDS. For a qualifying Medicare short stay, the RUG-IV grouper uses alternative rehabilitation classification logic when there has been insufficient time to establish a full rehabilitation regime. The standard grouper uses MDS 3.0 items to determine the Medicare short stay indicator. See Chapter 6 for details.

Both HIPPS codes (Z0100A and Z0150A), the RUG version codes (Z0100B and Z0150B), and the Medicare Short Stay indicator (Z0100C) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B= 01, 02, 03, 04, 05, or 07). All of these values are validated by the QIES ASAP system. The Final Validation Report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare-Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP

system calculated value for the Medicare Part A HIPPS code (Z0100A) is not a group that begins with 'R', i.e., Rehabilitation Plus Extensive Services or Rehabilitation group.

The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in the QIES ASAP system. The claim must include the correct HIPPS code for the assessment. If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3616a).

5.5 MDS Correction Policy

Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay – the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Corrections made to the electronic record after QIES ASAP acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in the QIES ASAP system:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the QIES ASAP system.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures **must** be implemented by the provider to assure that the QIES ASAP system information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to

Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.

5.6 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the QIES ASAP System

If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, production records that were inadvertently submitted as test records, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the QIES ASAP system. The paper copy should be corrected according to standard procedures detailed below.

Errors Identified During the Encoding Period

Facilities have up to 7 days to encode (enter into the software) and edit an MDS assessment after the MDS has been completed. Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a provider may correct item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as was used for the original item completion (i.e., the same ARD (A2300) and look-back period). Both the electronic and paper copies of the MDS must be corrected.

Errors Identified After the Encoding Period

Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record in error is an OBRA comprehensive or Quarterly assessment record (i.e., Item A0310A = 01 through 06).

Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**.

If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.

The correction process is more complicated for nursing home OBRA comprehensive or Quarterly assessments with ***any significant errors*** identified after the end of the 7-day encoding and editing period but before the records have been accepted into the QIES ASAP system. First, the nursing home must correct the original OBRA comprehensive or Quarterly assessment to reflect the resident's actual status as of the ARD for that original assessment and submit the record. Second, to insure an up-to-date view of the resident's status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident's status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.

In summary, the nursing home must take the following actions for an OBRA comprehensive or Quarterly assessment that has ***not*** been submitted to the QIES ASAP system when it contains significant errors:

- Correct the errors in the original OBRA comprehensive or Quarterly assessment.
- Submit the corrected assessment.
- Perform a ***new*** assessment – a Significant Change in Status Assessment or a Significant Correction to Prior Assessment and update the care plan as necessary.

If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 through 07) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare-only and Discharge assessments.

5.7 Correcting Errors in MDS Records That Have Been Accepted Into the QIES ASAP System

Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within 3 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

Errors identified in QIES ASAP system records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. The following two processes have been established to correct MDS records (assessments, Entry tracking records or Death in Facility tracking records) that have been accepted into the QIES ASAP system:

- Modification
- Inactivation

A Modification request moves the inaccurate record into history in the QIES ASAP system and replaces it with the corrected record as the active record. An Inactivation request also moves the inaccurate record into history in the QIES ASAP system, but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0.

The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable location of the erroneous MDS record previously submitted and accepted into the QIES ASAP system. Section X items are defined in the MDS 3.0 Data Submission Specifications posted on the CMS MDS 3.0 web site.

When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. In addition, the facility would keep a hard copy of the Correction Request items (Section X) with an inactivated record. For details on electronic records, see Chapter 2, Section 2.4.

Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include:

- Target Date
 - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)

- Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)

*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013. This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.
- An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done. Consider the following examples:

- A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.
- An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

- An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:

- Unit Certification or Licensure Designation (Item A0410),
- State-assigned facility submission ID (FAC_ID),
- Production/test code (PRODN_TEST_CD).

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in Section 5.8) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in a nursing home OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06) in the QIES ASAP system, then the nursing home must determine if there are any significant errors. If the *only errors are minor errors*, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any *significant error* is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if correction of the MDS item(s) revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Discharge Date (Item A2000) on a Discharge assessment record (Item A0310F = 10, 11) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that the Type of Provider is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct Type of Provider, ensuring that the clinical information is accurate.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system cannot be corrected with an automated Modification or Inactivation request. These errors are:

1. The record is a test record inadvertently submitted as production.

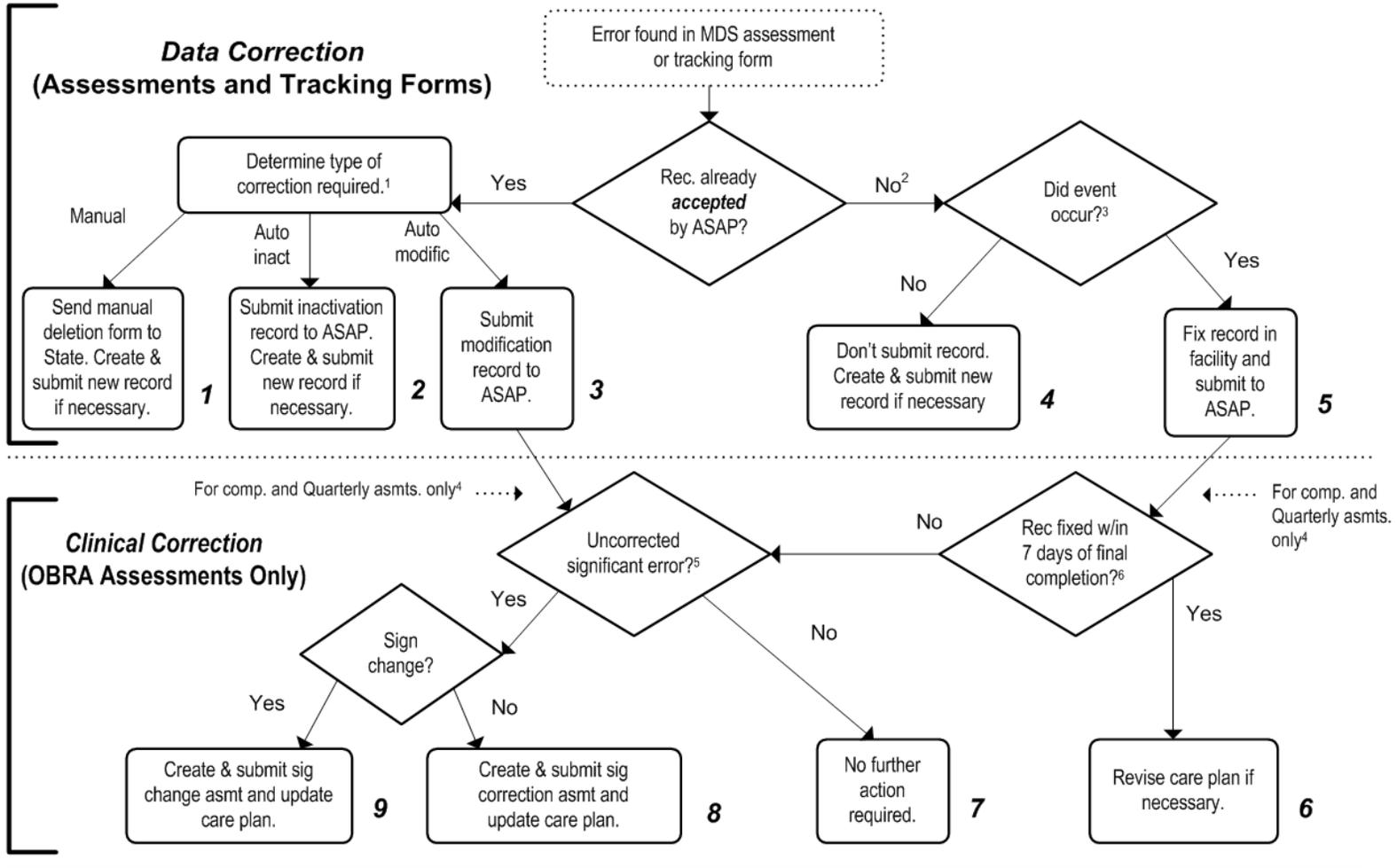
2. The record has the wrong unit certification or licensure designation in Item A0410.
3. The record has the wrong state_cd or facility ID in the control Items STATE_CD or FAC_ID.

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the appropriate MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility must submit the completed form to the State Agency. Completed forms with privacy information must be sent via certified mail through the United States Postal Service (USPS). The State Agency will review the request for completion and accuracy. After approving the provider's request, the state must sign the form and send it to the QTSO Help Desk. Completed forms with privacy data must be sent via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be evaluated and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual deletion is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect unit certification or licensure designation in Item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (Unit is Medicare and/or Medicaid certified) when actually the unit is neither Medicare nor Medicaid certified and MDS data is not required by the State (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual deletion is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 indicating that the Unit is Medicare and/or Medicaid certified but actually the unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.

If a QIES ASAP system record has the wrong state code or facility ID (control item STATE_CD, FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct STATE_CD and FAC_ID value.



¹ Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an Unit Certification or Licensure Designation (A0410), for example sent in as Unit is Medicare and/or Medicaid certified (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 = 2). Otherwise, automated inactivation or modification required: (a) if event did not occur (see note #3 below), submit automated inactivation, (b) if event occurred, submit automated modification.

² Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP.

³ The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a Discharge assessment was created for a resident who was not actually discharged), then the event did not occur.

⁴ OBRA comprehensive assessments with A0310 A=01,03,04,05 and Quarterly assessments with A0310B=02.

⁵ The assessment contains a significant error which has not been corrected by a subsequent assessment.

⁶ Final completion date is item V0200C2 for a comprehensive and Z0500B for all other assessments.

Table 1. Eight Major RUG-IV Classification Categories (continued)

Major RUG-IV Category	Characteristics Associated With Major RUG-IV Category
Behavioral Symptoms and Cognitive Performance	Residents satisfying the following two conditions: <ul style="list-style-type: none"> • Having a maximum ADL dependency score of 5 or less. • Having behavioral or cognitive performance symptoms, involving any of the following: <ul style="list-style-type: none"> — difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status ≤ 9), — difficulty in making self understood, short term memory, or decision making, — hallucinations, — delusions, — physical behavioral symptoms toward others, — verbal behavioral symptoms toward others, — other behavioral symptoms, — rejection of care, or — wandering.
Reduced Physical Function	Residents whose needs are primarily for support with activities of daily living and general supervision.

6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement. There are scheduled PPS assessments performed around Day 5, Day 14, Day 30, Day 60, and Day 90 of a Medicare Part A stay (as defined in Chapter 2). These scheduled assessments establish per diem payment rates for associated standard payment periods. Unscheduled off-cycle assessments are performed under certain circumstances when required under the regulations (e.g., when the resident’s condition changes). See Chapter 2 for greater detail on assessment types and requirements. These unscheduled assessments may impact the per diem payment rates for days within a standard payment period.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements.

For example, if resident’s status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a RUG is not an indication that the requirements for SNF Part A have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all inclusive and definitive. Refer to

Reduced Physical Function:

PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1

Default:

AAA

There are two different Medicare HIPPS codes that may be recorded on the MDS 3.0 in Items Z0100A (Medicare Part A HIPPS code) and Z0150A (Medicare Part A non-therapy HIPPS code). The Medicare Part A HIPPS code may consist of any RUG-IV group code. The Medicare Part A non-therapy HIPPS code is restricted to the RUG-IV groups of Extensive Services and below. The HIPPS code included on the Medicare claim depends on the specific type of assessment involved.

The RUG codes in Items Z0100A and Z0150A are validated by CMS when the assessment is submitted. If the submitted RUG code is incorrect, the validation report will include a warning giving the correct code, and the facility must use the correct code in the HIPPS code on the bill.

The provider must ensure that all Medicare assessment requirements are met. When the provider fails to meet the Medicare assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the RUG group validated by CMS in Items Z0100A and Z01050A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

AI Code

The last two positions of the HIPPS code represent the Assessment Indicator (AI), identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of Item A0310. CMS provides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility is to use the correct AI code in the HIPPS code on the bill. The code consists of two digits, which are defined below. In situations when the provider is to bill the default code, such as a late assessment, the AI provided on the validation report is to be used along with the default code, AAA, on the Medicare claim.

Refer to the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

First AI Digit

The first digit of the AI code identifies scheduled PPS assessments that establish the RUG payment rate for the standard PPS scheduled payment periods. These assessments are PPS 5-day, 14-day, 30-day, 60-day, and 90-day. The Omnibus Budget Reconciliation Act (OBRA 1987) required assessments are also included, because they can be used under certain circumstances for payment (see Section 6.8). Table 2 displays the first AI code for each

of the scheduled PPS assessment types and the standard payment period for each assessment type.

Table 2. Assessment Indicator First Digit Table

1st Digit Values	Assessment Type (abbreviation)	Standard* Scheduled Payment Period
0	Unscheduled PPS assessment (unsched)	Not applicable
1	PPS 5-day (5d)	Day 1 through 14
2	PPS 14-day (14d)	Day 15 through 30
3	PPS 30-day (30d)	Day 31 through 60
4	PPS 60-day (60d)	Day 61 through 90
5	PPS 90-day (90d)	Day 91 through 100
6	OBRA assessment (not coded as a PPS assessment) **	Not applicable

* These are the payment periods that apply when only the scheduled Medicare-required assessments are performed. These are subject to change when unscheduled assessments used for PPS are performed, e.g., significant change in status, or when other requirements must be met.

** In some cases, such an assessment may be used for PPS if it is later determined that qualification for Part A coverage was present at the time of the assessment (see Missed Assessment, section 6.8). For these assessments A0310A will be 01 to 06 and A0310B will be 99.

Second AI Digit

The second digit of the AI code identifies unscheduled assessments used for PPS. Unscheduled PPS assessments are conducted in addition to the required standard scheduled PPS assessments and include the following OBRA unscheduled assessments: Significant Change in Status Assessment (SCSA) and Significant Correction to Comprehensive Assessment (SCPA), as well as the following PPS unscheduled assessments: Start of Therapy Other Medicare-required Assessment (OMRA), End of Therapy OMRA, Change of Therapy OMRA, and Swing Bed Clinical Change Assessment (CCA). Unscheduled assessments may be required at any time during the resident’s Part A stay. They may be performed as separate assessments or combined with other assessments.

A stand-alone unscheduled assessment used for PPS will not establish the payment rate for a standard payment period. Rather a stand-alone unscheduled assessment will modify the payment rate for all or part of a standard payment period, but only when the rate for that standard period has been established by a prior PPS scheduled assessment. For example, if a PPS 14-day scheduled assessment has established the payment rate for the standard Day 15 to Day 30 payment period, then an SCSA with an ARD on Day 20 will modify the payment rate from the ARD (Day 20) to the end of the payment period (Day 30).

Special requirements apply when there are multiple assessments within one PPS scheduled assessment window. If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment, and the ARD of the scheduled assessment is not set for a day that is prior to the ARD of the unscheduled assessment, then facilities must combine the scheduled and

Therapy OMRA changes the RUG payment rate for the last 2 days (Days 13 and 14) of the 5-Day assessment payment period and all of the days (Days 15 through 30) of the 14-Day assessment payment period.

3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed with an ARD set for within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. **Example 3** presents the most common situation.
 - **EXAMPLE 3.** Rehabilitation therapy ends on Day 20 of a Medicare stay. An End of Therapy OMRA is performed with ARD on Day 22 and the Medicare Non-Therapy RUG (Z0150A) is billed from Day 21 (day after the last day therapy provided) to the end of the current payment period of Day 30.
4. Consider Example 4 where a scheduled PPS assessment has set the payment rate for the next payment period and then an End of Therapy OMRA is conducted before the beginning of that payment period.
 - **EXAMPLE 4.** The PPS 30-day assessment is performed with ARD on Day 27 to establish a Medicare RUG (Z0100A) for the Day 31 to Day 60 payment period. Rehabilitation therapy ends on Day 26 and an End of Therapy OMRA is performed with ARD on Day 29. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 27 through Day 30. The Medicare **Non-Therapy** RUG from the 30-day assessment is then billed for the next payment period. The Non-Therapy RUG from the 30-day assessment is used since all therapy had previously ended.
5. Consider Example 5 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment.
 - **EXAMPLE 5.** The End of Therapy OMRA assessment is performed with an ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25 through Day 30. The Medicare **Non-Therapy** RUG (Z0150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.
6. Consider Example 6, a complicated example where an End of Therapy OMRA is performed, followed shortly by a scheduled PPS assessment, and then therapy is resumed at the prior level and this is reported with the Resumption of Therapy items

(O0450A and O0450B) being added to the End of Therapy OMRA converting it to an End of Therapy OMRA reporting Resumption of Therapy (EOT-R).

- EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30-Day assessment is then performed with an ARD on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and the EOT-R items (O0450A and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.
7. In all cases where an EOT-R would be completed, the resident must resume therapy at the same RUG-IV therapy level as had been in effect prior to the break in therapy. However, it is possible that the ARD for an EOT OMRA reporting resumption may be set for the first grace day of the allowable grace days for a scheduled PPS assessment, while the ARD for the scheduled assessment was set for a day within the normal ARD window. In this limited subset of cases, the resumption of therapy should occur using the previous RUG-IV therapy level (which should be the same as the therapy level determined on the scheduled PPS assessment if the resumption is appropriate) but using the Activities of Daily Living (ADL) score from the most recent PPS assessment. Consider the following example.
- EXAMPLE 7. A resident, Mr. P, is admitted on 10/01/11. The ARD of the 5-day assessment for Mr. P is set for 10/07/11 (Day 7) and the RUG assigned to Mr. P is RVB. The ARD of the 14-day assessment is set for 10/14/11 (Day 14) and the RUG assigned to Mr. P is again RVB. The ARD of the 30-day assessment is set for 10/28/11 (Day 28) and the RUG assigned to Mr. P is now RVA. Due to an acute illness, Mr. P is unable to receive therapy services from 10/29/11 through 10/31/11, but is expected to resume therapy on 11/2/11 under the same therapy regimen. The facility completes an EOT for Mr. P with an ARD of 10/31/11 and reports that the resumption of therapy will occur on 11/2/11. The EOT OMRA assigns Mr. P a non-therapy RUG of CE2. Mr. P is discharged from the facility on 11/12/11.

In the case described above, assuming no intervening assessments were necessary, the facility would bill in the following manner. Days 1-14 would be billed under HIPPS code RVB10. Days 15-28 would be billed under HIPPS code RVB20. Days 29-32 would be billed under HIPPS code CE20A. Days 33-41 would be billed under HIPPS code RVA0A.

This represents the one and only occasion where the three character RUG-IV therapy RUG code may differ from that which was billed prior to the break in therapy, and the

difference may only be in the third character in the therapy RUG code related to the resident's ADL score.

When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.

The first Change of Therapy OMRA evaluation occurs on Day 7 after the most recent assessment ARD (except in cases where the last assessment is an EOT-R, as outlined in Chapter 2) and the provision of therapy services are evaluated for the first COT observation period (Day 1 through Day 7 after the assessment ARD). If the provision of therapy services during this 7 day period no longer reflects the RUG-IV classification category on the most recent PPS assessment (as described in Chapter 2), then a Change of Therapy OMRA must be performed with the ARD on Day 7 of the COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed and changes in the provision of therapy services would next be evaluated on Day 14 after the most recent assessment ARD using the second COT observation period (Day 8 through Day 14 after the assessment ARD). If a different RUG-IV classification category results for Day 14, then a Change of Therapy OMRA must be performed with an ARD on Day 14, which is Day 7 of that COT observation period, and payment is set retroactively back to the beginning of that COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed with an ARD on Day 14 and the evaluation of the change in therapy services provided would next be evaluated on Day 21 after the most recent assessment ARD using the third COT observation period (Day 15 through Day 21 after the assessment ARD). This process continues until the next scheduled or unscheduled PPS assessment used for payment. When a new PPS assessment is performed (Change of Therapy OMRA, any other unscheduled PPS assessment, or scheduled PPS assessment), then the COT OMRA evaluation process restarts the day following the ARD of that intervening assessment. If at any point, rehabilitation therapy ends before the last day of a COT observation period and an End of Therapy OMRA is performed with an ARD set for on or prior to Day 7 of the COT observation period, then the change of therapy evaluation process ends until the next PPS assessment used for payment reflecting the utilization of skilled therapy services.

8. Example 8 presents a case where a Change of Therapy OMRA is performed.
 - **EXAMPLE 8.** The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were reflective of the RUG-IV classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed with an ARD set for Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different

Rehabilitation category results and a Change of Therapy OMRA is performed with an ARD set for Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the COT observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA.

9. If a new PPS assessment used for payment occurs with an ARD set for on or prior to the last day of a COT observation period, then a Change of Therapy OMRA is not required for that observation period. Example 9 illustrates this case.
 - **EXAMPLE 9.** An SCSA is performed with an ARD of Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed with an ARD on Day 17. Rather, the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22.
10. Example 10 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a COT observation period.
 - **EXAMPLE 10.** The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No Change of Therapy OMRA is performed with an ARD on Day 21 and the change of therapy evaluation process is discontinued.

Table 3 presents the types of unscheduled assessments, the second AI digit associated with each assessment type, and the payment impact for standard payment periods.

Table 3. Assessment Indicator Second Digit Table

Second Digit Values	Assessment Type	Impact on Standard Payment Period
0	Either a scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment OR an OBRA assessment not coded as a PPS assessment	<ul style="list-style-type: none"> No impact on the standard payment period (the assessment is not unscheduled). If the second digit value is 0, then the first digit must be 1 through 6, indicating a scheduled PPS assessment or an OBRA assessment not coded as a PPS assessment. If the first digit value is a 6, then the second digit value must be 0.
1	Either an unscheduled OBRA assessment or Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> Combined with any OMRA Medicare Short Stay assessment 	<ul style="list-style-type: none"> If the ARD of the unscheduled assessment is not within the ARD window of any scheduled PPS assessment, including grace days (the first digit is 0): <ul style="list-style-type: none"> Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. If the ARD of the unscheduled assessment is within the ARD window of a scheduled PPS assessment, not using grace days: <ul style="list-style-type: none"> Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment: <ul style="list-style-type: none"> Use the Medicare RUG (Z0100A) from the start of the standard payment period.
2	Start of Therapy OMRA Do NOT use if <ul style="list-style-type: none"> Medicare Short Stay assessment Combined with End of Therapy OMRA Combined with unscheduled OBRA Combined with Swing Bed CCA 	<ul style="list-style-type: none"> If the unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): <ul style="list-style-type: none"> Use the Medicare RUG (Z0100A) from the unscheduled assessment's earliest start of therapy date (speech-language pathology services in O0400A5, occupational therapy in O0400B5, or physical therapy in O0400C5) through the end of standard payment period. If the unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of standard payment period. This is not a valid assessment and it will not be accepted by CMS.
3	Start of Therapy OMRA combined with either an unscheduled OBRA assessment or a Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> Medicare Short Stay assessment Combined with End of Therapy OMRA 	<ul style="list-style-type: none"> If unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): <ul style="list-style-type: none"> Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the end of standard payment period. If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
4	<p>End of Therapy OMRA not reporting Resumption of Therapy; whether or not combined with unscheduled OBRA assessment and whether or not combined with Swing Bed CCA Do NOT use if</p> <ul style="list-style-type: none"> • Combined with Start of Therapy OMRA • Medicare Short Stay assessment • End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	<p>Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date (speech-language pathology services in O0400A6, occupational therapy in O0400B6, or physical therapy in O0400C6) through the end of current payment period.</p>
5	<p>Start of Therapy OMRA combined with End of Therapy OMRA not reporting Resumption of Therapy Do NOT use if</p> <ul style="list-style-type: none"> • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA • End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date through the end of current payment period. • If unscheduled assessment does not give a therapy group Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
6	<p>Start of Therapy OMRA combined with End of Therapy OMRA not reporting Resumption of Therapy and combined with either an unscheduled OBRA assessment or Swing Bed CCA Do NOT use if</p> <ol style="list-style-type: none"> 1. Medicare Short Stay assessment 2. End of Therapy OMRA reporting Resumption of Therapy (EOT-R) 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the end of current payment period. • If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
7	<p>Medicare Short Stay Assessment (see Medicare Short Stay Assessment below for the definition of this assessment.)</p>	<p>See Medicare Short Stay Assessment below for impact on payment periods.</p>

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
A	<p>End of Therapy OMRA reporting Resumption of Therapy (EOT-R); whether or not combined with unscheduled OBRA assessment and whether or not combined with Swing Bed CCA</p> <p>Do NOT use if</p> <ul style="list-style-type: none"> • Combined with Start of Therapy OMRA • Medicare Short Stay assessment 	<ul style="list-style-type: none"> • Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date (speech-language pathology services in O0400A6, occupational therapy in O0400B6, or physical therapy in O0400C6) through the day before the resumption of therapy date (O0450B). • Use the Medicare RUG (Z0100A) from the assessment (used for SNF/PPS) immediately preceding this End of Therapy OMRA, and bill this RUG from the resumption of therapy date (O0450B) through the end of the standard payment period in which the resumption of therapy occurs.
B	<p>Start of Therapy OMRA combined with End of Therapy OMRA reporting Resumption of Therapy (EOT-R)</p> <p>Do NOT use if</p> <ul style="list-style-type: none"> • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
C	<p>Start of Therapy OMRA combined with End of Therapy OMRA reporting Resumption of Therapy (EOT-R) and combined with either an unscheduled OBRA assessment or Swing Bed CCA</p> <p>Do NOT use if</p> <ul style="list-style-type: none"> • Medicare Short Stay assessment 	<ul style="list-style-type: none"> • If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): <ul style="list-style-type: none"> — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

Second Digit Values	Assessment Type	Impact on Standard Payment Period
D	Change of Therapy OMRA; whether or not combined with unscheduled OBRA assessment and whether or not combined with Swing Bed CCA	<ul style="list-style-type: none"> Use the unscheduled assessment Medicare RUG (Z0100A) from the first day of the Change of Therapy OMRA observation period through the end of the standard payment period. Note that a Change in Therapy OMRA cannot be combined with a 5-day PPS assessment.

The information presented in the preceding table illustrates the impact of one unscheduled PPS assessment within a standard payment period. If there are additional unscheduled PPS assessments, then there may be additional impacts to the standard payment period. Refer to Medicare Claims Processing Manual and Chapter 2 of this manual for details.

When a Start of Therapy OMRA is combined with a scheduled PPS assessment, any OBRA assessment, or a Swing Bed CCA, and the index maximized RUG-IV classification (Item Z0100A) is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will not be accepted by CMS. In these instances, the provider must still complete and submit an assessment that is accepted by CMS in order to be in compliance with OBRA and/or Medicare regulations.

Additional AI Codes

There are also two additional AI Codes (shown in Table 6-4) when a Medicare SNF Part A claim is filed without a corresponding PPS assessment having been completed or the assessment has invalid reasons for assessment.

Table 4. Additional Assessment Indicator Codes

Additional Assessment Indicator (AI) Codes	Description
00	This is the AI required when billing the default RUG code of AAA for a missed assessment only when specific circumstances are met (see Section 6.8 of this chapter for greater detail). The default code is paid based upon the payment associated with the lowest resource utilization group (RUG), PA1.
X	The AI "error" code provided by the RUG-IV grouper when RUG-IV cannot be calculated for the type of record (e.g., the record is an entry record). This is not an appropriate billing code.

Medicare Short Stay Assessment

To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, the assessment must be a Start of Therapy OMRA, the resident must have been discharged from Part A on or before day 8 of the Part A stay, and the resident must have completed only 1 to 4 days of therapy, with therapy having started during the last 4 days of the Part A stay. To be considered a Medicare Short Stay assessment and use the

special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but not combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.
2. **A PPS 5-day (A0310B = 01) assessment has been performed.** The PPS 5-day assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A covered stay (including weekends).** The end of Medicare stay date (A2400C) minus the earliest start date for the three therapy disciplines (O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). Therapy is considered to be ongoing when:
 - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
 - The resident's SNF benefit exhausted and therapy continued to be provided, or
 - The resident's payer source changed and therapy continued to be provided.
8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

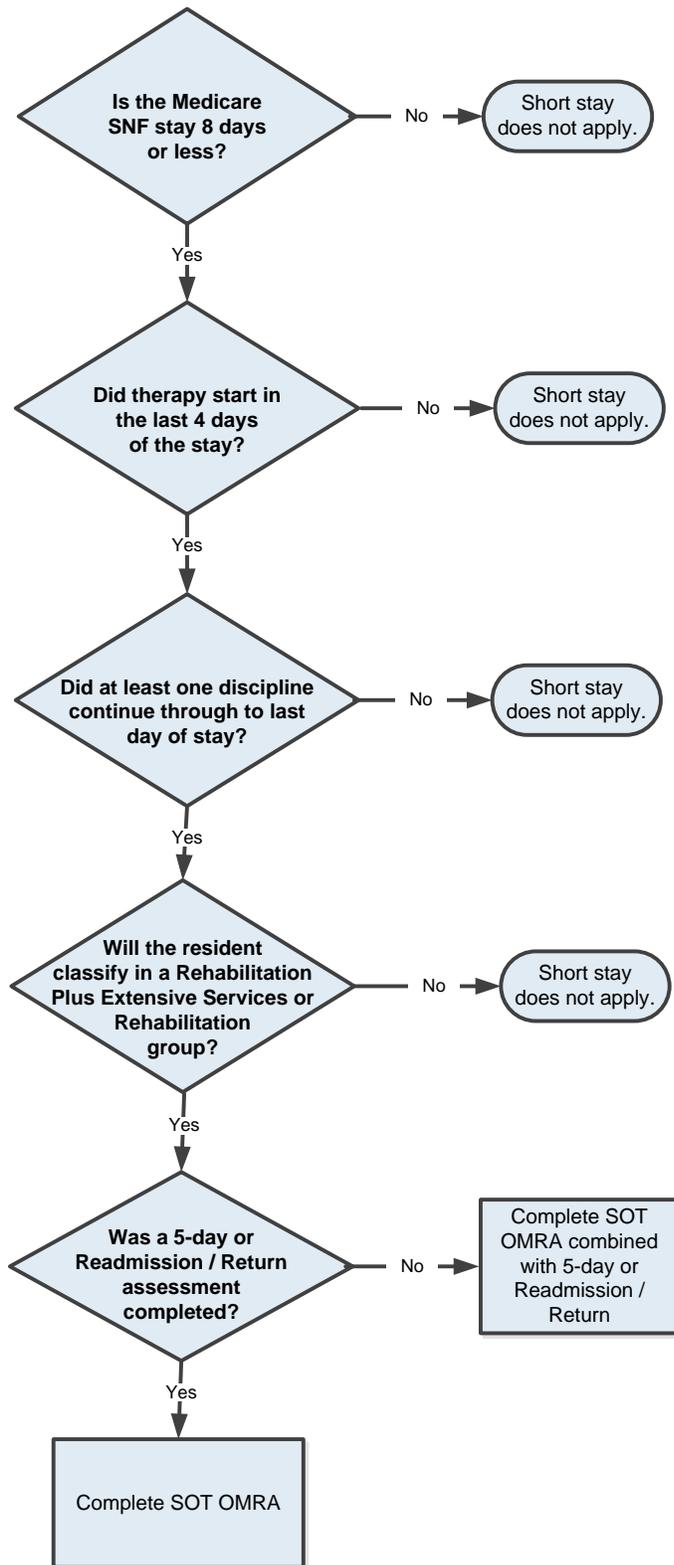
See below for Medicare Short Stay Assessment Algorithm.

If all eight of these conditions are met, then MDS Item Z0100C (Medicare Short Stay Assessment indicator) is coded “Yes.” The assignment of the RUG-IV rehabilitation therapy classification is calculated based on average daily minutes actually provided (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used), and the resulting RUG-IV group is recorded in MDS Item Z0100A (Medicare Part A HIPPS Code).

1. 15-29 average daily therapy minutes ► Rehabilitation Low category (RLx)
2. 30-64 average daily therapy minutes ► Rehabilitation Medium category (RMx)
3. 65-99 average daily therapy minutes ► Rehabilitation High category (RHx)
4. 100-143 average daily therapy minutes ► Rehabilitation Very High category (RVx)
5. 144 or greater average daily therapy minutes ► Rehabilitation Ultra High category (RUx)

See the RUG-IV Calculation Worksheet in Section 6.6 for details of the rehabilitation classification for a Medicare Short Stay Assessment.

Medicare Short Stay Assessment Algorithm



Medicare Short Stay Assessment Requirements:
All 8 must be true

Assessment Requirements:

1. Must be SOT OMRA
2. 5-day or readmission/return assessment must be completed (may be combined with the SOT OMRA)

ARD Requirements:

3. Must be Day 8 or earlier of Part A stay
4. Must be last day of Part A stay (see Item A2400C instructions)
5. Must be no more than 3 days after the start of therapy, not including the start of therapy date

Rehabilitation Requirements:

6. Must have started in last 4 days of Part A stay
7. Must continue through last day of Part A stay

RUG Requirement:

8. Must classify resident into a Rehabilitation Plus Extensive Services or Rehabilitation group

Note: When the earliest start of therapy is 1st day of stay, then the Part A stay must be 4 days or less

The impacts on the payment periods for the Medicare Short Stay assessment are as follows:

1. If the earliest start of therapy date (Items O0400A5, O0400B5, or O0400C5) is the first day of the short stay, use the Medicare Short Stay assessment Medicare Part A RUG (Z0100) from the beginning of the short stay through the end of the stay (the Medicare stay must be 4 days or less).
2. If the earliest start of therapy date is after the first day of the short stay, the following apply:
 - a. If a 5-day assessment was completed prior to Medicare Short Stay assessment, use the Medicare Part A RUG (Z0100A) from that assessment for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the Medicare Short Stay assessment from the day therapy started through the end of the short stay; or
 - b. If the Start of Therapy OMRA is combined with a 5-day assessment, use the Medicare Part A non-therapy RUG (Z0150A) for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the day therapy started through the end of the short stay.

6.5 SNF PPS Eligibility Criteria

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized in this section. Refer to the **Medicare General Information, Eligibility, and Entitlement Manual**, Chapter 1 (Pub. 100-1), and the **Medicare Benefit Policy Manual**, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

Technical Eligibility Requirements

The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay (i.e., three midnights).
- Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Clinical Eligibility Requirements

A beneficiary is eligible for SNF extended care if all of the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition:

- for which the resident was treated during the qualifying hospital stay, or
- that arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

Physician Certification

The attending physician or a physician on the staff of the skilled nursing home who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing home.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
 - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
 - validates via written statement that the beneficiary's assignment to one of the upper RUG-IV (Top 52) groups is correct.
- **Re-certifications** are used to document the continued need for skilled extended care services.
 - The first re-certification is required no later than the 14th day.
 - Subsequent re-certifications are required at no later than 30 days intervals after the date of the first re-certification.
 - The initial certification and first re-certification may be signed at the same time.

6.6 RUG-IV 66-Group Model Calculation Worksheet for SNFs

The purpose of this RUG-IV Version 1.00 calculation worksheet for the 66-group model is to provide a step-by-step walk-through to manually determine the appropriate RUG-IV Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to ensure that it represents the standard logic.

In the RUG-IV 66-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups, representing 10 different levels of rehabilitation services. In the 66-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 66-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care High groups, the Special Care Low groups, the Clinically Complex groups, the Behavioral Symptoms and Cognitive Performance groups, and the Reduced Physical Function groups.

There are two basic approaches to RUG-IV Classification: (1) hierarchical classification and (2) index maximizing classification. The current worksheet was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are

included below (see “Index Maximizing Classification”). Note that the RUG classification used for Medicare PPS Part A billing is based on the index maximizing approach.

Hierarchical Classification. The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the RUG-IV model; the assigned classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-IV model. Then go down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 66 individual RUG-IV groups for which the resident qualifies, assign that group as the RUG-IV classification.

If the resident qualifies in the Extensive Services group and a Special Care High group, always choose the Extensive Services classification because it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care Low and Clinically Complex, always choose Special Care Low. In hierarchical classification, always pick the group nearest the top of the model.

Index Maximizing Classification. Index maximizing classification is used in Medicare PPS (and most Medicaid payment systems) to select the RUG-IV group for payment. There is a designated Case Mix Index (CMI) that represents the relative resource utilization for each RUG-IV group. For index maximizing, first determine all of the RUG-IV groups for which the resident qualifies. Then, from the qualifying groups, choose the RUG-IV group that has the highest CMI. For Medicare PPS, the index maximizing method uses the CMIs effective for the appropriate Federal Fiscal Year.

While the following worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. For index maximizing, evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, again start at the beginning of the worksheet. Then work down through all of the 66 RUG-IV Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When finished, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

Non-Therapy Classification. In some instances, the SNF provider may be required to report, on the SNF Medicare claim, a non-therapy RUG-IV classification according to the SNF PPS policies (as noted elsewhere in this chapter, Chapter 8 of the **Medicare Benefit Policy Manual**, and Chapter 6 of the **Medicare Claims Processing Manual**). The non-therapy classification uses all the RUG-IV payment items except the rehabilitation therapy Items (O0400A,B,C) to determine a non-therapy, clinical RUG. To obtain a non-therapy RUG with this worksheet, skip Category I (Rehabilitation Plus Extensive Services) and Category II (Rehabilitation) and start with Category III (Extensive Services). Both the standard Medicare Part A RUG reported in Item Z0100A and the Medicare Part A non-therapy RUG in Item Z0150A are recorded on the MDS 3.0. When rehabilitation services are not provided, the standard Medicare Part A RUG will match the Medicare Part A non-therapy RUG.

CALCULATION OF TOTAL “ADL” SCORE RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The ADL score is a component of the calculation for placement in all RUG-IV groups. The ADL score is based upon the four “late loss” ADLs (bed mobility, transfer, toilet use, and eating), and this score indicates the level of functional assistance or support required by the resident. It is a very important component of the classification process.

STEP # 1

To calculate the ADL score use the following chart for bed mobility (G0110A), transfer (G0110B), and toilet use (G0110I). **Enter the ADL score for each item.**

Self- Performance Column 1 =	and	Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A = ___
2	and	(any number)	1	G0110B = ___
3	and	-, 0, 1, or 2	2	G0110I = ___
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

STEP # 2

To calculate the ADL score for eating (G0110H), use the following chart. Enter ADL score.

Self-Performance Column 1 (G0110H) =	and	Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 2, 7, or 8	and	-, 0, 1, or 8	0	G0110H = __
-, 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	-, 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

STEP # 3

Add the four scores for the total ADL score. This is the **RUG-IV TOTAL ADL SCORE**. The total ADL score ranges from 0 through 16.

TOTAL RUG-IV ADL SCORE _____

Other ADLs are also very important, but the research indicates that the late loss ADLs predict resource use most accurately. The early loss ADLs do not significantly change the classification hierarchy or add to the prediction of resource use.

CALCULATION OF TOTAL REHABILITATION THERAPY MINUTES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and all minutes in group therapy for non-Medicare classification. For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes.

Skip this section if therapy is not provided.

In Steps #1 through #3 in calculating Rehabilitation Therapy Minutes, retain all decimal places in the calculated values. Values where decimal points are retained are indicated by an asterisk ().*

STEP # 1

Calculate the total minutes for speech-language pathology services as follows:

Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400A3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Speech-Language Pathology Services Minutes* = _____

STEP # 2

Calculate the total minutes for occupational therapy as follows:

Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400B3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes* = _____

STEP # 3

Calculate the total minutes for physical therapy as follows:

Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400C3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes* = _____

STEP # 4

Sum the speech-language pathology services minutes, occupational therapy minutes, and physical therapy minutes and record as Total Therapy Minutes. These are the minutes that will be used for RUG-IV rehabilitation therapy classification (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used).

TOTAL THERAPY MINUTES[^] = _____

[^]Total Therapy Minutes is not rounded. Record only the whole number with all values after the decimal dropped.

Total Rehabilitation Therapy Minutes Calculation Example

Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services as follows:

Speech-language Pathology Services:

Individual minutes = 110 (Item O0400A1),

Concurrent minutes = 99 (Item O0400A2),

Group minutes = 100 (Item O0400A3).

Calculate total SLP minutes = $110 + 99/2 + 100/4 = 184.5$ (retain the decimal).

Check group proportion (after group allocation) = $(100/4)/184.5 = 0.136$.

Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25. Use unadjusted total SLP minutes.

Total Speech-Language Pathology Services Minutes = 184.5 (retain the decimal).

Occupational Therapy:

Individual minutes = 78 (Item O0400B1),

Concurrent minutes = 79 (Item O0400B2),

Group minutes = 320 (Item O0400B3).

Calculate total OT minutes = $78 + 79/2 + 320/4 = 197.5$ (retain the decimal).

Check group proportion = $(320/4)/197.5 = 0.405$.

Adjust OT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Occupational Therapy Minutes = $[(78 + 79/2) \times 4]/3 = 156.6666$ (retain the decimal).

Physical Therapy:

Individual minutes = 92 (Item O0400C1),

Concurrent minutes = 93 (Item O0400C2),

Group minutes = 376 (Item O0400C3).

Calculate total PT minutes = $92 + 93/2 + 376/4 = 232.5$ (retain the decimal).

Check group proportion = $(376/4)/232.5 = 0.404$.

Adjust PT minutes for Medicare Part A since group proportion is greater than .25.

Adjusted Physical Therapy Minutes = $[(92 + 93/2) \times 4]/3 = 184.6666$ (retain the decimal).

Total Adjusted Therapy Minutes:

Sum SLP, OT and PT minutes after any adjustment= $184.5 + 156.6666 + 184.6666 = 525.8332$

Drop decimals = **525 minutes**

(this is the total therapy minutes value for RUG-IV classification).

MEDICARE SHORT STAY ASSESSMENT

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

STEP # 1

Set the Medicare Short Stay Indicator (Z0100C) as follows:

RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.
2. **A PPS 5-day (Item A0310B = 01) assessment has been performed.** The PPS 5-day assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (Item A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare covered stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (Item A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A stay (including weekends).** The end of Medicare stay date (Item A2400C) minus the earliest start date for the three therapy disciplines (Items O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (Items O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (Item A2400C). Therapy is considered to be ongoing when:
 - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
 - The resident's SNF benefit exhausted and therapy continued to be provided, or
 - The resident's payer source changed and therapy continued to be provided.

8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Item Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

If all eight conditions are satisfied, record "Yes" in the Medicare Short Stay Assessment Indicator Z0100C); otherwise record "No."

MEDICARE SHORT STAY ASSESMENT INDICATOR Yes_____ No_____

STEP # 2

If the Medicare Short Stay Assessment Indicator is "Yes," then calculate the Medicare Short Stay Average Therapy Minutes as follows:

This average is the Total Therapy Minutes (calculated above in Calculation of Total Rehabilitation Therapy Minutes) divided by the number of days from the start of therapy (earliest date in O0400A5, O0400B5, and O0400C5) through the assessment reference date (A2300). For example, if therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days. Discard all numbers after the decimal point and record the result.

MEDICARE SHORT STAY AVERAGE THERAPY MINUTES = _____

See Section 6.4 for Medicare Short Stay Assessment Algorithm.

CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

STEP # 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, **go to Step #2.**

If the ADL score is less than 2, skip to Category II now.

STEP # 2

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category II now.

STEP # 3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

- **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
 1. In the past 7 days:
 - Total Therapy Minutes (calculated on page 6-25 – 6-28) of 720 minutes or more
 - and**
 - One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
 - and**
 - A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUX
2-10	RUL

- **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
 1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more
and
 - At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVX
2-10	RVL

- **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
 1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more
and
 - At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days
 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHX
2-10	RHL

- **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
 1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more
and
 - At least 5 distinct calendar days of any combination of the three disciplines (as documented in O0420)
 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMX
2-10	RML

- **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):
 1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more
 - and**
 - At least 3 distinct calendar days of any combination of the three disciplines (as documented in O0420)
 - and**
 - Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day
 2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes

*Restorative Nursing Services

- H0200C, H0500** Urinary toileting program and/or bowel toileting program
- O0500A,B** Passive and/or active ROM
- O0500C Splint or brace assistance
- O0500D,F** Bed mobility and/or walking training
- O0500E Transfer training
- O0500G Dressing and/or grooming training
- O0500H Eating and/or swallowing training
- O0500I Amputation/prostheses care
- O0500J Communication training

**Count as one service even if both provided

RUG-IV ADL Score

2-16

RUG-IV Class

RLX

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

CATEGORY II: REHABILITATION

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

STEP # 1

Determine whether the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for one Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 720 minutes or more
 - and**
 - One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
 - and**
 - A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUC
6-10	RUB
0-5	RUA

B. **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
 - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more
 - and**
 - At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVC
6-10	RVB
0-5	RVA

C. High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
 Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more
and
 At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHC
6-10	RHB
0-5	RHA

D. Medium Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
 Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more
and
 At least 5 distinct calendar days of any combination of the three disciplines (as documented in O0420)
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
 Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMC
6-10	RMB
0-5	RMA

E. Low Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:
 Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more
and
 At least 3 distinct calendar days of any combination of the three disciplines (as documented in O0420)
and
 Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

2. If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes

***Nursing Restorative Services**

H0200C, H0500** Urinary toileting program and/or bowel toileting program

O0500A,B** Passive and/or active ROM

O0500C Splint or brace assistance

O0500D,F** Bed mobility and/or walking training

O0500E Transfer training

O0500G Dressing and/or grooming training

O0500H Eating and/or swallowing training

O0500I Amputation/prostheses care

O0500J Communication training

**Count as one service even if both provided

RUG-IV ADL Score

11-16

0-10

RUG-IV Class

RLB

RLA

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category III.

CATEGORY III: EXTENSIVE SERVICES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP # 1

Determine whether the resident is coded for **one** of the following treatments or services:

- O0100E2 Tracheostomy care while a resident
- O0100F2 Ventilator or respirator while a resident
- O0100M2 Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category IV now.

STEP # 2

If at least **one** of these treatments or services is coded and the resident has a total RUG-IV ADL score of 2 or more, he/she classifies as Extensive Services. **Move to Step #3. If the resident's ADL score is 0 or 1, s/he classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

The resident classifies in the Extensive Services category according to the following chart:

<u>Extensive Service Conditions</u>	<u>RUG-IV Class</u>
Tracheostomy care* and ventilator/respirator*	ES3
Tracheostomy care* or ventilator/respirator*	ES2
Infection isolation*	ES1
without tracheostomy care*	
without ventilator/respirator*	

*while a resident

RUG-IV Classification _____

If the resident does not classify in the Extensive Services Category, proceed to Category IV.

CATEGORY IV: SPECIAL CARE HIGH

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A,B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score ≥ 5
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

- (1) K0710A3 is 51% or more of total calories OR
- (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9[®]) or the Staff Assessment of Resident Mood (PHQ-9-OV[®]). Instructions for completing the PHQ-9[®] are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9[®] or (PHQ-9-OV[®]) is complete but all questions are not answered. The following items comprise the PHQ-9[®]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 4

Select the Special Care High classification based on the ADL score and the presence or absence of depression record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	Yes	HE2
15-16	No	HE1
11-14	Yes	HD2
11-14	No	HD1
6-10	Yes	HC2
6-10	No	HC1
2-5	Yes	HB2
2-5	No	HB1

RUG-IV CLASSIFICATION _____

CATEGORY V: SPECIAL CARE LOW

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score ≥ 5
I5200, ADL Score	Multiple sclerosis, with ADL score ≥ 5
I5300, ADL Score	Parkinson's disease, with ADL score ≥ 5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:

- (1) K0710A3 is 51% or more of total calories OR
- (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:

- M1200A,B# Pressure relieving chair and/or bed
- M1200C Turning/repositioning
- M1200D Nutrition or hydration intervention
- M1200E Pressure ulcer care
- M1200G Application of dressings (not to feet)
- M1200H Application of ointments (not to feet)

#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to Category VI now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care Low. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

STEP # 3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9[®]) or the Staff Assessment of Resident Mood (PHQ-9-OV[®]). Instructions for completing the PHQ-9[®] are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9[®] or (PHQ-9-OV[®]) is complete but all questions are not answered. The following items comprise the PHQ-9[®]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 4

Select the Special Care Low classification based on the ADL score and the presence or absence of depression; record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	Yes	LE2
15-16	No	LE1
11-14	Yes	LD2
11-14	No	LD1
6-10	Yes	LC2
6-10	No	LC1
2-5	Yes	LB2
2-5	No	LB1

RUG-IV CLASSIFICATION _____

CATEGORY VI: CLINICALLY COMPLEX

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I2000	Pneumonia
I4900, ADL Score	Hemiplegia/hemiparesis with ADL score ≥ 5
M1040D,E	Surgical wounds or open lesions with any selected skin treatment*
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen therapy while a resident
O0100H2	IV medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments

- M1200F Surgical wound care
- M1200G Application of dressing (not to feet)
- M1200H Application of ointments (not to feet)

If the resident does not have one of these conditions, skip to Category VII now.

STEP # 2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9[®]) or the Staff Assessment of Resident Mood (PHQ-9-OV[®]). Instructions for completing the PHQ-9[®] are in Chapter 3, section D. Refer to Appendix E for cases in which the PHQ-9[®] or (PHQ-9-OV[®]) is complete but all questions are not answered. The following items comprise the PHQ-9[®]:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts better off dead or hurting self
-	D0500J	Short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at Item D0300 and for the staff assessment at Item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for RUG-IV classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP # 3

Select the Clinically Complex classification based on the ADL score and the presence or absence of depression record this classification:

<u>RUG-IV ADL Score</u>	<u>Depressed</u>	<u>RUG-IV Class</u>
15-16	YES	CE2
15-16	NO	CE1
11-14	YES	CD2
11-14	NO	CD1
6-10	YES	CC2
6-10	NO	CC1
2-5	YES	CB2
2-5	NO	CB1
0-1	YES	CA2
0-1	NO	CA1

RUG-IV CLASSIFICATION _____

CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP # 1

Determine the resident's ADL score. If the resident's ADL score is 5 or less, go to Step #2.

If the ADL score is greater than 5, skip to Category VIII now.

STEP # 2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for Item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Determine whether the resident is cognitively impaired. **If the resident's Summary Score is less than or equal to 9, he or she is cognitively impaired and classifies in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.**

If the resident's summary score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

STEP # 3

Determine whether the resident is cognitively impaired based on the staff assessment rather than on resident interview. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.

The resident is cognitively impaired if **one** of the three following conditions exists:

1. B0100 Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all = 4 or 8)
2. C1000 Severely impaired cognitive skills (C1000 = 3)
3. B0700, C0700, C1000 Two or more of the following impairment indicators are present:
 - B0700 > 0 Problem being understood
 - C0700 = 1 Short-term memory problem
 - C1000 > 0 Cognitive skills problem

and

One or more of the following severe impairment indicators are present:

 - B0700 >= 2 Severe problem being understood
 - C1000 >= 2 Severe cognitive skills problem

If the resident meets the criteria for being cognitively impaired, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If he or she does not present with a cognitive impairment as defined here, proceed to Step #4.

STEP # 4

Determine whether the resident presents with **one** of the following behavioral symptoms:

- | | |
|--------|---|
| E0100A | Hallucinations |
| E0100B | Delusions |
| E0200A | Physical behavioral symptoms directed toward others (2 or 3) |
| E0200B | Verbal behavioral symptoms directed toward others (2 or 3) |
| E0200C | Other behavioral symptoms not directed toward others (2 or 3) |
| E0800 | Rejection of care (2 or 3) |
| E0900 | Wandering (2 or 3) |

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If he or she does not present with behavioral symptoms or a cognitive impairment, skip to Category VIII.

STEP # 5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

STEP # 6

Select the final RUG-IV Classification by using the total RUG-IV ADL score and the Restorative Nursing Count.

<u>RUG-IV ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG-IV Class</u>
2-5	2 or more	BB2
2-5	0 or 1	BB1
0-1	2 or more	BA2
0-1	0 or 1	BA1

RUG-IV CLASSIFICATION _____

CATEGORY VIII: REDUCED PHYSICAL FUNCTION

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

STEP # 1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a RUG-IV ADL score greater than 5, are placed in this category.

STEP # 2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A,B**	Passive and/or active ROM
O0500C	Splint or brace assistance
O0500D,F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count _____

STEP # 3

Select the RUG-IV Classification by using the RUG-IV ADL score and the Restorative Nursing Count.

<u>RUG-IV ADL Score</u>	<u>Restorative Nursing</u>	<u>RUG-IV Class</u>
15-16	2 or more	PE2
15-16	0 or 1	PE1
11-14	2 or more	PD2
11-14	0 or 1	PD1
6-10	2 or more	PC2
6-10	0 or 1	PC1
2-5	2 or more	PB2
2-5	0 or 1	PB1
0-1	2 or more	PA2
0-1	0 or 1	PA1

RUG-IV CLASSIFICATION _____

ADJUSTMENT FOR START OF THERAPY OMRA RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

A Start of Therapy (SOT) OMRA is a Medicare assessment used to initiate a Medicare payment level in either a Rehabilitation Plus Extensive or Rehabilitation group after rehabilitation therapy starts. The SOT OMRA is an abbreviated assessment that does not contain all of the items used for RUG-IV classification. The SOT OMRA only contains the RUG-IV items necessary for a Rehabilitation Plus Extensive or Rehabilitation classification. Classifications below the Rehabilitation category cannot be determined from an SOT OMRA unless it is combined with an assessment that contains all of the RUG-IV items (i.e., an OBRA assessment or other type of PPS assessment).

MEDICARE ADJUSTMENTS

Adjustments are performed for Medicare classification (Item Z0100A) on an SOT OMRA. There are three different situations relevant to Medicare classification adjustments as follows:

Situation 1

If an assessment is an SOT OMRA, indicated by MDS Item A0310C = 1 or 3, whether or not it is combined with other types of assessments, then the Medicare Index Maximized RUG-IV classification in item Z0100A must be a Rehabilitation Plus Extensive Services group or a Rehabilitation group. Lower classifications are not valid for Z0100A on an SOT OMRA.

If the Z0100A classification for any SOT OMRA (Item A0310C = 1 or 3) *is not* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment should be made:

1. The Medicare RUG-IV group reported in Item Z0100A should be *adjusted to AAA* (the default group), the assessment should be marked as invalid, and the assessment should be barred from submission. The Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system will *reject the assessment* if submitted.

Situation 2

If the Z0100A classification for an SOT OMRA (Item A0310C = 1), *not combined* with an OBRA assessment or other PPS assessment, *is not* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment applies:

1. The Medicare Non-Therapy RUG-IV group reported in Item Z0150A should be *adjusted to AAA* (the default group).

Situation 3

If the Z0100A classification for an SOT OMRA, *combined* with an OBRA assessment or other PPS assessment, *is* in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then *no adjustment* is necessary.

OTHER PAYER ADJUSTMENT

This other payer adjustment is applied when performing the Medicaid RUG-IV classification for Items Z0200A and Z0250A or for classification for other payers.

1. When an SOT OMRA (MDS Item A0310C = 1) is *not combined* with an OBRA assessment or other type of PPS assessment, then an RUG-IV classification below the Rehabilitation Plus Extensive and Rehabilitation categories should be *adjusted to AAA* (the default group).

6.7 SNF PPS Policies

Requirements and policies for SNF PPS are described in greater detail in the **Medicare Benefit Policy Manual**. Here are some situations that the SNF may encounter that may impact Medicare Part A SNF coverage for a resident, affect the PPS assessment schedule, or impact the reimbursement received by the SNF.

Delay in Requiring and Receiving Skilled Services (30-Day Transfer)

There are instances in which the beneficiary does not require SNF level of care services when initially admitted to the SNF. When the beneficiary requires and receives SNF level of care services within 30 days from the hospital discharge, Day 1 for the Medicare assessment schedule is the day on which SNF level of care services begins. For example, if a beneficiary is discharged from the hospital on August 1 and the SNF determines on August 31 that the beneficiary requires skilled service for a condition that was treated during the qualifying hospital stay, then the SNF would start the Medicare assessment schedule with a 5-day Medicare-required assessment, with August 31 as Day 1 for scheduling purposes. However, if the beneficiary requires and receives a SNF level of care 31 or more days after the hospital discharge, the beneficiary does not qualify for a SNF Part A stay (see Medical Appropriateness Exception below).

Medical Appropriateness Exception (Deferred Treatment)

An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment in a SNF immediately after a qualifying hospital stay discharge. It is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame, and it is medically predictable at the time of hospital discharge that the beneficiary will require SNF level of care within a predetermined time period (for more detailed information see Chapter 8 of the **Medicare Benefit Policy Manual**). For example, a beneficiary is admitted to the SNF after a qualifying hospital stay for an open reduction and internal fixation of a hip. It is determined upon hospital discharge that the beneficiary is not ready for weight-bearing activity but will most likely be ready in 4-6 weeks. The physician writes an order to start therapy when the beneficiary is able to tolerate weight bearing. Once the resident is able to start therapy, the Medicare Part A stay begins, and the Medicare-required 5-day assessment will be performed. Day 1 of the stay will be the first day on which the resident starts therapy services.

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation in which a beneficiary is discharged from SNF Medicare Part A services and later requires SNF Part A skilled level of care services, the resident may be eligible for Medicare Part A SNF coverage if the following criteria are met:

1. Less than 30 days have elapsed since the last day on which SNF level of care services were required and received,

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. The default rate (AAA) takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early Assessment

An assessment must be completed according to the designated Medicare PPS assessment schedule. **If a scheduled Medicare-required assessment or an OMRA is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance.** For example, a Medicare-required 14-day assessment with an ARD of Day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

If the ARD on the late assessment is set for **prior to the end of the period during which the late assessment would have controlled the payment**, had the ARD been set timely, and/or **no intervening assessments have occurred, the SNF will bill the default rate for the number of days that the assessment is out of compliance**. This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment**. For example, a Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for 8 days and therefore would be paid at the default rate for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. In this example, if there are no other assessments until the 60-day assessment, the remaining 22 days are billed according to the HIPPS code on the late assessment.

A second example, involving a late unscheduled assessment would be if a COT OMRA was completed with an ARD of Day 39, while Day 7 of the COT observation period was Day 37. In this case, the COT OMRA would be considered 2 days late and the facility would bill the default rate for 2 days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment, in this case, for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar.

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment**, had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment**. For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8).

A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the

resident's last day of therapy was Day 39. Upon further review of the resident's record on Day 52, the facility determines that a COT should have been completed with an ARD of Day 37 but was not. The ARD for the COT OMRA is set for Day 52. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. Because there was an intervening assessment (in this case the EOT OMRA) prior to the ARD of the late COT OMRA, the facility would bill the default rate for 9 days (the period during which the COT OMRA would have controlled payment). The facility would bill the RUG from the EOT OMRA as per normal beginning the first non-therapy day, in this case Day 40, until the next scheduled or unscheduled assessment used for payment.

Missed Assessment

If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident is no longer a SNF Part A resident, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.

However, there are instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP system. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

In situations 2-6, the provider may use the OBRA Admission assessment to bill for all days of covered care associated with Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. The ARD of the OBRA Admission assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day assessment.

When an OBRA Admission assessment does not exist, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for days 1-14 **or** days 15-30. This assessment may only cover **one** payment period. If the ARD of the valid OBRA assessment falls outside the ARD window of the 5-day and 14-day PPS assessments (including grace days), the

SNF must bill the default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

Under all situations other than exceptions 1-5, the following apply when the SNF failed to set the ARD prior to the end of the last day of the ARD window, including grace days, or later and the resident was already discharged from Medicare Part A when this was discovered:

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

In the case of an unscheduled assessment if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a scheduled PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.

A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections 2.4 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

APPENDIX B: STATE AGENCY AND CMS REGIONAL OFFICE RAI/MDS CONTACTS

Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts is located in the “Downloads” section on CMS’s MDS 3.0 RAI Manual Web page:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

APPENDIX F MDS ITEM MATRIX

APPENDIX G: REFERENCES

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APPENDIX H MDS 3.0 FORMS

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Chapter	Section	Page	Change
1	1.1	1-5	The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practical level of well-being.
1	1.2	1-6	Minimum Data Set (MDS) . A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data items for each MDS assessment and tracking document (e.g., admission Comprehensive, Quarterly, quarterly, annual, significant change, significant correction, discharge Discharge, entry Tracking, PPS assessments, item sets etc.) can be found in Appendix H.
1	1.1	1-6	— Care Area Assessment is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The CAA resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources are is not mandatory and represent the list of Web links is neither an all-inclusive list nor government endorsed ment .
1	1.1	1-6	• Utilization Guidelines . The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_r.pdf

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			http://cms.gov/manuals/Downloads/som107ap_pp_guidelines-htef.pdf).
1	1.3	1-6 & 1-7	Over time, the various uses of the MDS have expanded. While its primary purpose is an assessment tool is used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS instrument has also been adapted for use by non-critical access hospitals with a swing bed agreement. They are required to complete the MDS for reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS) .
1	1.4	1-9	Identification of Outcomes —Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident's active participation in the process.
1	1.4	1-10	The key to successfully using the RAI process is to understanding that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.
1	1.5	1-12	The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0

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Chapter	Section	Page	Change
			<p>and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).</p> <p>The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold- standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).</p>
1	1.7	1-14	<ul style="list-style-type: none"> ○ Special Treatments, Procedures and Procedures Programs <p>Identify any special treatments, procedures, and programs that the resident received during the specified time periods.</p>

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Chapter	Section	Page	Change
2	2.2	2-2	<ul style="list-style-type: none"> • 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	<p>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.</p>
2	2.4	2-6	<p>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.</p>
2	2.5	2-9	<p>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.</p>
2	2.5	2-10	<ul style="list-style-type: none"> • ¶ Resident is discharged from the facility to a private residence (as opposed to going on an LOA); • ¶ Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record); • ¶ 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	<ul style="list-style-type: none"> • 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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Chapter	Section	Page	Change
			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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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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			<p>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.</p> <ul style="list-style-type: none"> 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	<p><i>Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions: Note: this is not an exhaustive list</i></p> <p><i>Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:</i></p> <p><i>Note: this is not an exhaustive list</i></p>
2	2.6	2-26	<ul style="list-style-type: none"> If a SCSA occurs for an individual <i>known</i> or <i>suspected</i> 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 Sstate Mmental Hhealth 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/MRID/DDA authorities and the Sstate Medicaid Agency is available at http://www.ems.gov/ http://www.cms.gov/. The nursing facility must provide the SMH/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/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
2	2.6	2-27	<p><i>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:</i></p> <p><i>Note: this is not an exhaustive list</i></p>

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Chapter	Section	Page	Change
2	2.6	2-27	<i>Examples (PASRR & SCSAs):</i>
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	<i>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</i>
2	2.6	2-28	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Nursing homes should document the initial identification of a

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Chapter	Section	Page	Change
			<p>significant error in an assessment in the progress notes clinical record.</p> <ul style="list-style-type: none"> 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	<p>— is admitted for the first time to this facility; or</p> <p>— is readmitted after a discharge prior to completion of the OBRA Admission assessment; or</p> <p>— is readmitted after a discharge return not anticipated; or</p> <p>— is readmitted after a discharge return anticipated when return was not within 30 days of discharge.</p> <p>— For swing bed facilities, the Entry tracking record will always be coded 1, Admission, since these providers do not complete an OBRA Admission assessment.</p>
2	2.6	2-33	<p>— 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.</p> <ul style="list-style-type: none"> Entry tracking record is coded Reentry every time a person: <ul style="list-style-type: none"> — 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	<i>Examples (Discharge-return not anticipated):</i>
2	2.6	2-35	<p>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:</p> <p style="margin-left: 40px;">A0310F=10 A2000=12-12-2013 A2100=2</p>
2	2.6	2-36 & 2-37	<p>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</p>

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			<p>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.</p> <ul style="list-style-type: none"> 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	<p>Replaced Entry, Discharge, and Reentry Algorithms diagram.</p> <p>OLD:</p> <p>¹A0310A = 99 A0310B = 99 A0310C = 0 A0310D = 0 or blank A0310E = 0 A0310F = 01 ²A0310B - E = appropriate code ³A0310B - F = appropriate code</p> <p>When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.</p> <table border="1" data-bbox="1230 1696 1442 1770"> <tr> <td>ADM</td> <td>Admission</td> </tr> <tr> <td>D/C</td> <td>Discharge</td> </tr> <tr> <td>RA</td> <td>Return Anticipated</td> </tr> <tr> <td>RNA</td> <td>Return Not Anticipated</td> </tr> </table>	ADM	Admission	D/C	Discharge	RA	Return Anticipated	RNA	Return Not Anticipated
ADM	Admission										
D/C	Discharge										
RA	Return Anticipated										
RNA	Return Not Anticipated										

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			<p>NEW:</p> <p>¹A0310A = 99 A0310B = 99 A0310C = 0 A0310D = 0 or blank A0310E = 0 A0310F = 01 ²A0310B – E = appropriate code ³A0310B – F = appropriate code</p> <p>When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.</p> <table border="1"> <tr> <td>ADM</td> <td>Admission</td> </tr> <tr> <td>D/C</td> <td>Discharge</td> </tr> <tr> <td>RA</td> <td>Return Anticipated</td> </tr> <tr> <td>RNA</td> <td>Return Not Anticipated</td> </tr> </table>	ADM	Admission	D/C	Discharge	RA	Return Anticipated	RNA	Return Not Anticipated
ADM	Admission										
D/C	Discharge										
RA	Return Anticipated										
RNA	Return Not Anticipated										
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	<table border="1"> <tr> <td>5-day</td> <td>01</td> </tr> <tr> <td>Readmission/Return</td> <td>06</td> </tr> </table>	5-day	01	Readmission/Return	06				
5-day	01										
Readmission/Return	06										
2	2.8	2-42	<ol style="list-style-type: none"> 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 Ssection 2.6). 2. Significant Correction to Prior Comprehensive Assessment: Complete because a significant error was made in the prior 								

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			<p>comprehensive assessment (see Section 2.6).</p> <p>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 Section 2.9).</p> <p>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.</p> <p>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.</p> <p>A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in</p>

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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	<ul style="list-style-type: none"> See Section 2.123 for instructions involving beneficiaries who transfer or expire day 8 or earlier.
2	2.8	2-44	<ul style="list-style-type: none"> 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	<p>06.— Medicare-required Readmission/Return Assessment</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 <i>both of the following conditions are met</i>: <ol style="list-style-type: none"> Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and 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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			<p>reclassified the resident into a RUG-IV therapy group.</p> <p>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.</p> <p>— 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</p>

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			<p style="text-align: center;">RUA.</p> <p>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.</p> <p>— 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.</p> <p>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.</p>

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			<ul style="list-style-type: none"> <li data-bbox="594 285 1453 506">• 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). <li data-bbox="643 516 1453 1398">— 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. <p data-bbox="643 1409 1453 1661">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.</p> <p data-bbox="643 1671 1453 1818">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.</p>
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-63	<ul style="list-style-type: none"> See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.
2	2.12	2-63	<ul style="list-style-type: none"> 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.
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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-

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			<p>required 5-day or a Medicare Readmission/Return assessment should be completed.</p> <p>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.</p> <p>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.</p> <p>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.</p>
2	2.13	2-75 & 2-76	<p>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.</p> <p>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).</p> <p><i>Resident Leaves the Facility and Returns During an Observation Period</i></p> <p>The ARD is not altered if the beneficiary is out of the facility for a</p>

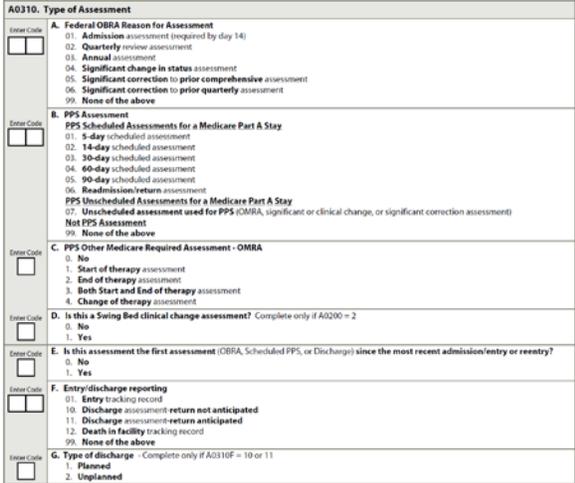
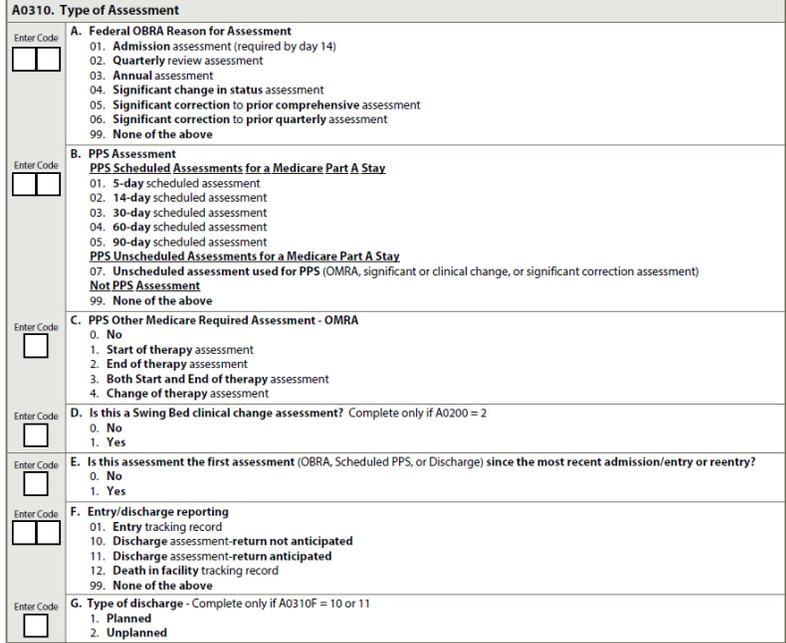
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			temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3) but may not extend the observation period.
2	2.13 & 2-14	2-77, 2-78 & 2-79	Page length change.
2	2.14	2-80	<p>Next Record</p> <p>Entry</p> <p>OBRA Admission</p> <p>OBRA Annual</p> <p>OBRA Quarterly, sign. change, sign correction</p> <p>PPS 5-day or readmission/return</p> <p>PPS 14-day</p> <p>PPS 30-day</p> <p>PPS 60-day</p> <p>PPS 90-day</p> <p>PPS unscheduled</p> <p>Discharge</p> <p>Death in facility</p>
2	2.15	2-81	<p>PPS RFA (A0310B)</p> <p>01,02,06,99</p> <p>01,02,06,07</p> <p>02,07</p> <p>01 thru 05,99</p> <p>01 thru 07</p> <p>02 thru 05,07</p> <p>01 thru 07,99</p> <p>01 thru 06,99</p> <p>01 thru 07</p> <p>02 thru 05,07</p> <p>01 thru 065</p> <p>02 thru 05</p> <p>07</p> <p>07</p>

**Track Changes
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Chapter	Section	Page	Change
			07 07 99 99
2	2.15	2-82	PPS RFA (A0310B) 01 thru 06 ⁵ 01 thru 07 02 thru 05 02 thru 05,07 07 07 07 07 99 99

**Track Changes
from Chapter 3, Section A V1.11
to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
3	A0100	A-3	<p>Item Rationale</p> <ul style="list-style-type: none"> Allows the identification of the nursing home facility submitting the assessment. <p>Coding Instructions</p> <ul style="list-style-type: none"> Nursing homes Facilities must have a National Provider Identifier Number (NPI) and a CMS Certified Number (CCN). Enter the nursing home facility provider numbers:
3	A310	A-4	<p>Replaced screen shot.</p> <p>OLD:</p>  <p>NEW:</p> 

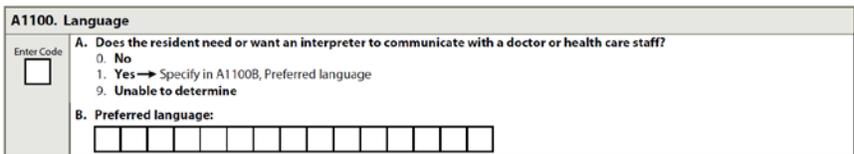
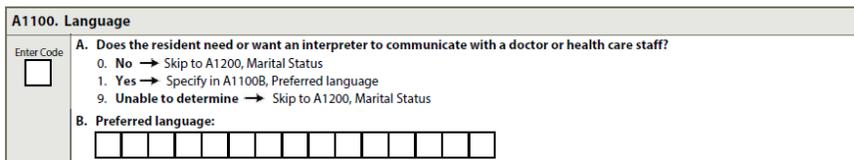
**Track Changes
from Chapter 3, Section A V1.11
to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
3	A310	A-5	06. Readmission/return assessment
3	A0410	A-7	A0410: Unit Certification or Licensure Designation Submission Requirement
3	A0410	A-7	Replaced screen shot. OLD: <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>A0410. Submission Requirement</p> <p>Enter Code <input type="checkbox"/></p> <p>1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission</p> </div> NEW: <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>A0410. Unit Certification or Licensure Designation</p> <p>Enter Code <input type="checkbox"/></p> <p>1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified</p> </div>
3	A0410	A-7	Item Rationale <ul style="list-style-type: none"> In coding this item, the facility must consider Medicare and/or Medicaid status as well as the state’s authority to collect MDS records. State regulations may require submission of MDS data to QIES ASAP or directly to the state for residents residing in licensed-only beds. There must be a federal and/or state authority to submit MDS assessment data to the MDS National Repository. Nursing homes and swing-bed facilities must be certain they are submitting MDS assessments to QIES ASAP under the appropriate authority for those residents who are on a Medicare and/or Medicaid certified unit. For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to QIES ASAP or directly to the state in accordance with state requirements. Payer source is not the determinant by which this item is coded. This item is coded solely according to the authority CMS has to collect MDS data for residents who are on a Medicare and/or Medicaid certified unit and the authority that the state may have to collect MDS data under licensure. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system. With this item, the nursing home indicates the submission authority.
3	A0410	A-8	A0410: Unit Certification or Licensure Designation Submission Requirement (cont.)
3	A0410	A-8	1. Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, if any, and which units are Medicaid certified, or dually certified (Medicare/Medicaid) if any.

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to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
			<p>2. If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative if there are units that are state licensed and if the state requires MDS submission for residents on that unit.</p> <p>3. Identify all units in the nursing home that are not certified, or licensed by the state, if any.</p> <p>• If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative whether the State has authority to collect MDS information for residents on units that are neither Medicare nor Medicaid certified.</p> <p>Coding Instructions</p> <ul style="list-style-type: none"> • Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not federal nor state required by the State submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does not have authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any the records is are submitted under this certification designation, it they will be rejected by the QIES ASAP system and all information from that record will be purged. • Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State but not federal required submission: if the nursing home MDS record is for a resident is on a unit that is neither Medicare nor Medicaid certified, but the state has authority; under state licensure or other requirements, to collect MDS information for these residents on such units, the facility should submit the resident's MDS records per the state's requirement to QIES ASAP or directly to the state. Note that this certification designation does not apply to swing-bed facilities. Assessments for swing-bed residents on which A0410 is coded "2" will be rejected by the QIES ASAP system. • Code 3, Unit is Medicare and/or Medicaid certified Federal required submission: if the MDS record is for a resident is on a Medicare and/or Medicaid

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to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
			certified unit, regardless of payer source (i.e., even if the resident is private pay or has his/her stay covered under e.g., Medicare Advantage, Medicare HMO, private insurance, etc.), the facility is required to submit. There is CMS authority to collect MDS (OBRA and SNF PPS only) records to QIES ASAP for these residents information for residents on this unit. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.
3	-	A-9	Page number change.
3	-	A-10	For PPS assessments (A0310B = 01, 02, 03, 04, 05, 06 , and 07), either the SSN (A0600A) or either the Medicare number/RRB or Railroad Retirement Board (RRB) number (A0600B) must be present and both (i.e., may not be left blank). Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.
3	-	A-11	Page number change.
3	-	A-12	Page number change.
3	-	A-13	Page number change.
3	A1100	A-14	Replaced screen shot. OLD: 
			NEW: 
3	A1100	A-14	Coding Instructions for A1100A <ul style="list-style-type: none"> • Code 0, no: if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status. • Code 1, yes: if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language. • Code 9, unable to determine: if no source can identify whether the resident wants or needs an interpreter. Skip to A1200, Marital Status.
3	-	A-15	Page number change.
3	-	A-16	Page number change.
3	A1700	A-17	<ul style="list-style-type: none"> • A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the

**Track Changes
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to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change																																																
			resident's physical or mental condition. Therefore, when a s Significant e Change in s Status MDS a Assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.																																																
3	A1500	A-18	<ul style="list-style-type: none"> Each State Medicaid aAgency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements. Please see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html https://www.cms.gov/PASRR/01-Overview.asp for CMS information on PASRR. 																																																
3	A1510	A-19	<p>Steps for Assessment</p> <p>1. Complete if A0310A = 01, 03, 04 or 05 (aAdmission assessment, aAnnual assessment, sSignificant eChange in sStatus aAssessment, sSignificant eCorrection to pPrior eComprehensive aAssessment).</p>																																																
3	-	A-20	Page number change.																																																
3	-	A-21	<p>Most Recent Admission Entry or Reentry into this Facility</p> <table border="1"> <thead> <tr> <th colspan="2">Most Recent Admission/Entry or Reentry into this Facility</th> </tr> </thead> <tbody> <tr> <td colspan="2">A1600. Entry Date</td> </tr> <tr> <td></td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td align="center">Month</td> <td align="center">Day</td> <td align="center">Year</td> <td colspan="3"></td> </tr> </table> </td> </tr> <tr> <td colspan="2">A1700. Type of Entry</td> </tr> <tr> <td>Enter Code</td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>1. Admission</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>2. Reentry</td> </tr> </table> </td> </tr> <tr> <td colspan="2">A1800. Entered From</td> </tr> <tr> <td>Enter Code</td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>01. Community (private home/apt., board/care, assisted living, group home)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>02. Another nursing home or swing bed</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>03. Acute hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>04. Psychiatric hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>05. Inpatient rehabilitation facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>06. ID/DD facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>07. Hospice</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>09. Long Term Care Hospital (LTCH)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>99. Other</td> </tr> </table> </td> </tr> </tbody> </table>	Most Recent Admission/Entry or Reentry into this Facility		A1600. Entry Date			<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td align="center">Month</td> <td align="center">Day</td> <td align="center">Year</td> <td colspan="3"></td> </tr> </table>							Month	Day	Year				A1700. Type of Entry		Enter Code	<table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>1. Admission</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>2. Reentry</td> </tr> </table>	<input type="checkbox"/>	1. Admission	<input type="checkbox"/>	2. Reentry	A1800. Entered From		Enter Code	<table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>01. Community (private home/apt., board/care, assisted living, group home)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>02. Another nursing home or swing bed</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>03. Acute hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>04. Psychiatric hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>05. Inpatient rehabilitation facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>06. ID/DD facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>07. Hospice</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>09. Long Term Care Hospital (LTCH)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>99. Other</td> </tr> </table>	<input type="checkbox"/>	01. Community (private home/apt., board/care, assisted living, group home)	<input type="checkbox"/>	02. Another nursing home or swing bed	<input type="checkbox"/>	03. Acute hospital	<input type="checkbox"/>	04. Psychiatric hospital	<input type="checkbox"/>	05. Inpatient rehabilitation facility	<input type="checkbox"/>	06. ID/DD facility	<input type="checkbox"/>	07. Hospice	<input type="checkbox"/>	09. Long Term Care Hospital (LTCH)	<input type="checkbox"/>	99. Other
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3	A1600	A-22	<p>A1600: Entry Date (date of this admission/entry or reentry into the facility)</p> <p>OLD:</p>																																																

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Chapter	Section	Page	Change
			<p>A1600. Entry Date (date of this admission/entry or reentry into the facility)</p> <p> <input type="text"/>-<input type="text"/>-<input type="text"/> <small>Month Day Year</small> </p> <p>NEW:</p> <p>Most Recent Admission/Entry or Reentry into this Facility</p> <p>A1600. Entry Date</p> <p> <input type="text"/>-<input type="text"/>-<input type="text"/> <small>Month Day Year</small> </p>
3	A1600	A-22	<p>Item Rationale</p> <ul style="list-style-type: none"> To document the date of admission/entry or reentry into the nursing home facility. <p>Coding Instructions</p> <ul style="list-style-type: none"> Enter the most recent date of admission/entry or reentry to this nursing home facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
3	A1600	A-22	<p>DEFINITION</p> <p>ENTRY DATE The initial date of admission to the nursing facility, or the date the resident most recently returned to your nursing facility after being discharged.</p>
3	A1700	A-22	<p>Coding Instructions</p> <ul style="list-style-type: none"> Code 1, admission/entry: when one of the following occurs: <ol style="list-style-type: none"> resident has never been admitted to this facility before; OR resident has been in this facility previously and was discharged prior to completion of the OBRA Admission assessment; OR <ol style="list-style-type: none"> 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 3 three of the following occurred prior to the this entry; the resident was: <ol style="list-style-type: none"> admitted to this nursing home facility (i.e., OBRA Admission assessment was completed), AND discharged return anticipated, AND

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Chapter	Section	Page	Change
			<p>3. returned to facility within 30 days of discharge.</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. will always code the resident's entry as an admission, '1', since an OBRA Admission assessment must have been completed to code as a reentry. OBRA Admission assessments are not completed for swing bed residents. 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
3	A1800	A-23	<p>Item Rationale</p> <ul style="list-style-type: none"> Understanding the setting that the individual was in immediately prior to nursing home facility admission/entry or reentry informs care planning and may also inform discharge planning and discussions.
3	A1800	A-24	<p><i>Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission/entry or reentry.</i></p>
3	A1900	A-25	<p>A1900 Admission Date (Date this episode of care in this facility began)</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p style="font-size: small; margin: 0;">A1900. Admission Date (Date this episode of care in this facility began)</p> <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; font-size: 8px;"> </div> - <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center; font-size: 8px;"> </div> - <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: space-between; font-size: 8px;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> Month Day Year </div> </div> <p>Item Rationale</p> <ul style="list-style-type: none"> To document the date this episode of care in this facility began. <p>Coding Instructions</p> <ul style="list-style-type: none"> 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).
3	-	A-26	Page length change.
3	A2200	A-27	<p>Item Rationale</p> <p>To identify the ARD of a previous comprehensive (A0310 = 01,</p>

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Chapter	Section	Page	Change																																																
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3	A1510	A-19	<p>Steps for Assessment</p> <p>1. Complete if A0310A = 01, 03, 04 or 05 (admission assessment, Annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).</p>																																																
3	-	A-20	Page number change.																																																
3	-	A-21	<p>Most Recent Admission Entry or Reentry into this Facility</p> <table border="1"> <thead> <tr> <th colspan="2">Most Recent Admission/Entry or Reentry into this Facility</th> </tr> </thead> <tbody> <tr> <td colspan="2">A1600. Entry Date</td> </tr> <tr> <td></td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td align="center">Month</td> <td align="center">Day</td> <td align="center">Year</td> <td colspan="3"></td> </tr> </table> </td> </tr> <tr> <td colspan="2">A1700. Type of Entry</td> </tr> <tr> <td>Enter Code</td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>1. Admission</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>2. Reentry</td> </tr> </table> </td> </tr> <tr> <td colspan="2">A1800. Entered From</td> </tr> <tr> <td>Enter Code</td> <td> <table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>01. Community (private home/apt., board/care, assisted living, group home)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>02. Another nursing home or swing bed</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>03. Acute hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>04. Psychiatric hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>05. Inpatient rehabilitation facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>06. ID/DD facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>07. Hospice</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>09. Long Term Care Hospital (LTCH)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>99. Other</td> </tr> </table> </td> </tr> </tbody> </table>	Most Recent Admission/Entry or Reentry into this Facility		A1600. Entry Date			<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td align="center">Month</td> <td align="center">Day</td> <td align="center">Year</td> <td colspan="3"></td> </tr> </table>							Month	Day	Year				A1700. Type of Entry		Enter Code	<table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>1. Admission</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>2. Reentry</td> </tr> </table>	<input type="checkbox"/>	1. Admission	<input type="checkbox"/>	2. Reentry	A1800. Entered From		Enter Code	<table border="1"> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>01. Community (private home/apt., board/care, assisted living, group home)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>02. Another nursing home or swing bed</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>03. Acute hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>04. Psychiatric hospital</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>05. Inpatient rehabilitation facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>06. ID/DD facility</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>07. Hospice</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>09. Long Term Care Hospital (LTCH)</td> </tr> <tr> <td style="width: 20px; height: 20px;"><input type="checkbox"/></td> <td>99. Other</td> </tr> </table>	<input type="checkbox"/>	01. Community (private home/apt., board/care, assisted living, group home)	<input type="checkbox"/>	02. Another nursing home or swing bed	<input type="checkbox"/>	03. Acute hospital	<input type="checkbox"/>	04. Psychiatric hospital	<input type="checkbox"/>	05. Inpatient rehabilitation facility	<input type="checkbox"/>	06. ID/DD facility	<input type="checkbox"/>	07. Hospice	<input type="checkbox"/>	09. Long Term Care Hospital (LTCH)	<input type="checkbox"/>	99. Other
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3	A1600	A-22	<p>A1600: Entry Date (date of this admission/entry or reentry into the facility)</p> <p>OLD:</p>																																																

**Track Changes
from Chapter 3, Section A V1.11
to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
			<p>A1600. Entry Date (date of this admission/entry or reentry into the facility)</p> <p><input type="text"/>-<input type="text"/>-<input type="text"/> Month Day Year</p> <p>NEW:</p> <p>Most Recent Admission/Entry or Reentry into this Facility</p> <p>A1600. Entry Date</p> <p><input type="text"/>-<input type="text"/>-<input type="text"/> Month Day Year</p>
3	A1600	A-22	<p>Item Rationale</p> <ul style="list-style-type: none"> To document the date of admission/entry or reentry into the nursing home facility. <p>Coding Instructions</p> <ul style="list-style-type: none"> Enter the most recent date of admission/entry or reentry to this nursing home facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
3	A1600	A-22	<p>DEFINITION</p> <p>ENTRY DATE The initial date of admission to the nursing facility, or the date the resident most recently returned to your nursing facility after being discharged.</p>
3	A1700	A-22	<p>Coding Instructions</p> <ul style="list-style-type: none"> Code 1, admission/entry: when one of the following occurs: <ol style="list-style-type: none"> resident has never been admitted to this facility before; OR resident has been in this facility previously and was discharged prior to completion of the OBRA Admission assessment; OR <ol style="list-style-type: none"> 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 3 three of the following occurred prior to the this entry; the resident was: <ol style="list-style-type: none"> admitted to this nursing home facility (i.e., OBRA Admission assessment was completed), AND discharged return anticipated, AND

**Track Changes
from Chapter 3, Section A V1.11
to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change										
			<p>3. returned to facility within 30 days of discharge.</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 will always code the resident's entry as an admission, '1', since an OBRA Admission assessment must have been completed to code as a reentry. OBRA Admission assessments are not completed for swing bed residents. 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 										
3	A1800	A-23	<p>Item Rationale</p> <ul style="list-style-type: none"> Understanding the setting that the individual was in immediately prior to nursing home facility admission/entry or reentry informs care planning and may also inform discharge planning and discussions. 										
3	A1800	A-24	<p><i>Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission/entry or reentry.</i></p>										
3	A1900	A-25	<p>A1900 Admission Date (Date this episode of care in this facility began)</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>A1900. Admission Date (Date this episode of care in this facility began)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; text-align: center;"> </td> <td style="width: 5%; border: none;">-</td> <td style="width: 25%; border: 1px solid black; text-align: center;"> </td> <td style="width: 5%; border: none;">-</td> <td style="width: 40%; border: 1px solid black; text-align: center;"> </td> </tr> <tr> <td style="font-size: small; text-align: center;">Month</td> <td style="font-size: small; text-align: center;">Day</td> <td colspan="3" style="font-size: small; text-align: center;">Year</td> </tr> </table> </div> <p>Item Rationale</p> <ul style="list-style-type: none"> To document the date this episode of care in this facility began. <p>Coding Instructions</p> <ul style="list-style-type: none"> 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). 		-		-		Month	Day	Year		
	-		-										
Month	Day	Year											
3	-	A-26	Page length change.										
3	A2200	A-27	<p>Item Rationale</p> <p>To identify the ARD of a previous comprehensive (A0310 = 01,</p>										

**Track Changes
from Chapter 3, Section A V1.11
to Chapter 3, Section A V1.12**

Chapter	Section	Page	Change
			03, or 04) or Quarterly assessment (A0310A = 05 or 0602) in which a significant error is discovered.
3	-	A-28	Page length change.
3	-	A-29	Page length change.
3	-	A-30	Page length change.
3	-	A-31	Page number change.
3	-	A-32	Page length change.

**Track Changes
from Chapter 3, Section C V1.10
to Chapter 3, Section C V1.12**

Chapter	Section	Page	Change
3	C1000	C-24	Coding: For the above examples listed in 1A and 1B, Item C1000 would be coded 3, severe impairment.
3	C1300	C-26	<p>*Item C1300 is adapted from the Confusion Assessment Method (CAM; Inouye et al., 1990) that has copyright protection and cannot be modified.</p> <p><i>Disclaimer: This protocol contains unauthorized portions, unauthorized modifications of, and incorrect references to the short Confusion Assessment Method (CAM) contained in "The Confusion Assessment Method (CAM) Training Manual and Coding Guide," © Hospital Elder Life Program, LLC 1988-2014. All Rights Reserved. This protocol was not approved, authorized, endorsed or reviewed by Hospital Elder Life Program, LLC or the original author of the CAM, Dr. Sharon K. Inouye, M.D., M.P.H., Institute for Aging Research at Hebrew SeniorLife, and all such parties disclaim all responsibility for and liabilities with respect to any use, publication, or implementation of this protocol.</i></p>

**Track Changes
from Chapter 3, Section E V1.10
to Chapter 3, Section E V1.12**

Chapter	Section	Page	Change
3	E0100	E-3	Rationale: The resident reports an auditory and visual sensations that occurs in the absence of any external stimulus. Therefore, this is a hallucination.
3	E1100	E-22	<p>1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on the unit 2 of the last 7 days but has not attempted to exit the unit. Because a door alarm system is now in use, the resident was not at risk for elopement and getting to a dangerous place. the resident is no longer attempting to exit the unit, she is at decreased risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.</p>

**Track Changes
from Chapter 3, Section G V1.10
to Chapter 3, Section G V1.12**

Chapter	Section	Page	Change
3	G0110	G-3	<p>Activities of Daily Living Definitions</p> <p>A. Bed mobility: how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.</p> <p>B. Transfer: how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).</p> <p>C. Walk in room: how resident walks between locations in his/her room.</p> <p>D. Walk in corridor: how resident walks in corridor on unit.</p> <p>E. Locomotion on unit: how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.</p> <p>F. Locomotion off unit: how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.</p>
3	G0110	G-4	<p>G0110: Activities of Daily Living (ADL) Assistance (cont.)</p> <p>G. Dressing: how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.</p> <p>H. Eating: how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).</p> <p>I. Toilet use: how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.</p> <p>J. Personal hygiene: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving,</p>

**Track Changes
from Chapter 3, Section G V1.10
to Chapter 3, Section G V1.12**

Chapter	Section	Page	Change
			applying makeup, washing/drying face and hands (excludes baths and showers).
3	G0110	G-5	Page length change.
3	G0110	G-6 through G-8	Page number change.
3	G0110	G-9	<i>Code for the most support provided over all shifts. Code regardless of how Column H1 ADL Self-Performance is coded.</i>
3	G0110	G-10 through G-17	Page number change.
3	G0110	G-18	Page number and page length change.
3	G0110	G-19	Page number and page length change.
3	G0110	G-20	Rationale: A staff member had to complete part of the activity of personal hygiene for the resident 3 out of 7 days during the look-back period; †The assistance, although was non-weight-bearing, is considered full staff performance of the personal hygiene sub-task of brushing and styling her hair. Because this ADL sub-task was completed for the resident 3 times, but not every time during the last 7 days, it qualifies under the second criterion of the extensive assistance definition.
3	G0110	G-21 through G-41	Page number change.

**Track Changes
from Chapter 3, Section H V1.11
to Chapter 3, Section H V1.12**

Chapter	Section	Page	Change
3	H0200	H-6	<ul style="list-style-type: none"><li data-bbox="597 289 1344 363">— H0200A would be coded 1, yes, a trial-toileting program is attempted,<li data-bbox="597 380 1393 453">— H0200B would be coded 9, unable to determine or trial in progress, and<li data-bbox="597 470 1289 543">— H0200C would be coded 1, current-toileting program.yes.

**Track Changes
from Chapter 3, Section J V1.08
to Chapter 3, Section J V1.12**

Chapter	Section	Page	Change
3	J0100	J-2	<p>NON-MEDICATION PAIN INTERVENTION</p> <p>Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.</p>

**Track Changes
from Chapter 3, Section K V1.11
to Chapter 3, Section K V1.12**

Chapter	Section	Page	Change																								
3	K0510	K-10	<p>DEFINITIONS</p> <p>PARENTERAL/IV FEEDING Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).</p> <p>FEEDING TUBE Presence of any type of tube that can deliver food/ nutritional substances/ fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.</p>																								
3	K0710	K-16 & K-17	<p>3. Mr. K. has been able to take some fluids orally, however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="2" style="text-align: center;">While in the Hospital</th> <th colspan="2" style="text-align: center;">While in the Nursing Home</th> </tr> </thead> <tbody> <tr> <td>Mon.</td> <td>400 cc</td> <td>Mon.</td> <td>510 cc</td> </tr> <tr> <td>Tues.</td> <td>520 cc</td> <td>Tues.</td> <td>520 cc</td> </tr> <tr> <td>Weds.</td> <td>500 cc</td> <td>Weds.</td> <td>490 cc</td> </tr> <tr> <td>Thurs.</td> <td>480 cc</td> <td></td> <td></td> </tr> <tr> <td>Total</td> <td>1,900 cc</td> <td>Total</td> <td>1,520 cc</td> </tr> </tbody> </table> <p>Coding: K0710B1 would be coded 1, 500 cc/day or less. K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.</p> <p>Rationale: The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc =</p>	While in the Hospital		While in the Nursing Home		Mon.	400 cc	Mon.	510 cc	Tues.	520 cc	Tues.	520 cc	Weds.	500 cc	Weds.	490 cc	Thurs.	480 cc			Total	1,900 cc	Total	1,520 cc
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**Track Changes
from Chapter 3, Section K V1.11
to Chapter 3, Section K V1.12**

Chapter	Section	Page	Change
			<p>1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident.</p> <p>The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore code 2, 501 cc/day or more is correct for K0710B2, While a Resident.</p> <p>The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days.</p>

**Track Changes
from Chapter 3, Section M V1.11
to Chapter 3, Section M V1.12**

Chapter	Section	Page	Change
3	M0610	M-22	7. Considering only the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.

**Track Changes
from Chapter 3, Section N V1.11
to Chapter 3, Section N V1.12**

Chapter	Section	Page	Change
3	N0410	N-8	<p>Coding: Medications in N0410, would be checkedcoded as follows: A. Antipsychotic = 3, resperidone is an antipsychotic medication, B. Antianxiety = 7, lorazepam is an antianxiety medication, and D. Hypnotic = 2, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.</p>

**Track Changes
from Chapter 3, Section O V1.11
to Chapter 3, Section O V1.12**

Chapter	Section	Page	Change
3	O0100	O-2	<ul style="list-style-type: none"> • O0100A, Chemotherapy <p>Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment. For example, megestrol acetate is classified in the Physician's Desk Reference (PDR) as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. IV²s, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O0100I (Transfusions).</p>
3	O0100	O-3	<ul style="list-style-type: none"> • O0100F, Ventilator or respirator <p>Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.</p>
3	O0100	O-3	<ul style="list-style-type: none"> • The National Drug Code Directory, http://www.fda.gov/cder/ndc/database/Default.htm http://www.fda.gov/drugs/informationondrugs/ucm142438.htm
3	O0100	O-4	<ul style="list-style-type: none"> • O0100I, Transfusions <p>Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.</p> <ul style="list-style-type: none"> • O0100J, Dialysis <p>Code peritoneal or renal dialysis which that occurs at the nursing home or at another facility, in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during</p>

Track Changes
from Chapter 3, Section O V1.11
to Chapter 3, Section O V1.12

Chapter	Section	Page	Change
			dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.
3	O0250	O-5	<p>Replaced screen shot.</p> <p>OLD</p> <div style="border: 1px solid black; padding: 5px;"> <p>O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period</p> <p>Enter Code <input type="checkbox"/></p> <p>A. Did the resident receive the influenza vaccine in this facility for this year's influenza season?</p> <p>0. No → Skip to O0250C, If influenza vaccine not received, state reason</p> <p>1. Yes → Continue to O0250B, Date vaccine received</p> <p>B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?</p> <p style="text-align: center;"> <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>Enter Code <input type="checkbox"/></p> <p>C. If influenza vaccine not received, state reason:</p> <p>1. Resident not in facility during this year's flu season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible - medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain vaccine due to a declared shortage</p> <p>9. None of the above</p> </div> <p>NEW</p> <div style="border: 1px solid black; padding: 5px;"> <p>O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period</p> <p>Enter Code <input type="checkbox"/></p> <p>A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?</p> <p>0. No → Skip to O0250C, If influenza vaccine not received, state reason</p> <p>1. Yes → Continue to O0250B, Date influenza vaccine received</p> <p>B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?</p> <p style="text-align: center;"> <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>Enter Code <input type="checkbox"/></p> <p>C. If influenza vaccine not received, state reason:</p> <p>1. Resident not in this facility during this year's influenza vaccination season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible - medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain influenza vaccine due to a declared shortage</p> <p>9. None of the above</p> </div>
3	O0250	O-6 through O-9	<p style="text-align: center;">Planning for Care</p> <ul style="list-style-type: none"> • Influenza vaccines have been proven effective in preventing hospitalizations. • A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. • Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine. <ul style="list-style-type: none"> — Mild problems: soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days. — Severe problems: <ul style="list-style-type: none"> ◦ Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few

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			<p>minutes to a few hours after the shot.</p> <ul style="list-style-type: none"> ◦ In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination. • People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine. • Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine. <p>O0250: Influenza Vaccine (cont.)</p> <ul style="list-style-type: none"> • The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC: http://www.cdc.gov/vaccinesafety/vaccine_monitoring/ • Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23) national goal of increasing to 90 percent, the percentage of adults aged 18 years or older in long-term care nursing homes who are vaccinated annually against seasonal influenza residents. <p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Review the resident’s medical record to determine whether an influenza vaccine was received in the facility for this year’s influenza vaccination season. If vaccination status is unknown, proceed to the next step. 2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year’s influenza vaccination season. If vaccination status is still unknown, proceed to the next step. 3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care

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			<p>physician. If influenza vaccination status is still unknown, proceed to the next step.</p> <p>4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.</p> <p>Coding Instructions for O0250A, Did the Resident Receive the Influenza Vaccine in This Facility for This Year's Influenza Vaccination Season?</p> <ul style="list-style-type: none"> • Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza vaccination season. Proceed to If influenza vaccine not received, state reason (O0250C). • Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to Date Influenza Vaccine Received (O0250B). <p>Coding Instructions for O0250B, Date Influenza Vaccine Received</p> <ul style="list-style-type: none"> • Enter the date that the influenza vaccine was received. Do not leave any boxes blank. <ul style="list-style-type: none"> — If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2012 should be entered as 01-017-2012. — If the day only contains a single digit, then fill the first box of the day with the "0". For example, May October 6, 2012 should be entered as 0510-06-2012. A full 8 character date is required. — A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box. <p>O0250: Influenza Vaccine (cont.)</p> <p>Coding Instructions for O0250C, If Influenza Vaccine Not Received, State Reason</p> <p><i>If the resident has not received the influenza vaccine for this</i></p>

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			<p><i>year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:</i></p> <ul style="list-style-type: none"> • Code 1, Resident not in this facility during this year's influenza vaccination season: resident was not in the facility during this year's influenza vaccination season. • Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season. • Code 3, Not eligible—medical contraindication: if influenza vaccine not received due to medical contraindications. Contraindications include, but are not limited to including: allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe or an acute febrile illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination is present. However, the resident should be vaccinated if contraindications end. • Code 4, Offered and declined: resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine what is being offered and chooses not to accept the influenza vaccination. • Code 5, Not offered: resident or responsible party/legal guardian not offered the influenza vaccine. • Code 6, Inability to obtain influenza vaccine due to a declared shortage: influenza vaccine is unavailable at the facility due to a declared influenza vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. • Code 9, None of the above: if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is

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			<p>unknown.</p> <p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins. • The influenza season varies annually. Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area. • Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm • Facilities can also contact their local health department website for their local influenza surveillance information. The influenza season ends when influenza is no longer active in your geographic area. <p>O0250: Influenza Vaccine (cont.)</p> <ul style="list-style-type: none"> • The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine. • A “high dose” inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident’s primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident. • Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins. <p>Examples</p> <p>1. Mrs. J. received the influenza vaccine in the facility during this</p>

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			<p>year's influenza vaccination season, on January 7, 20104.</p> <p>Coding: O0250A would be coded 1, yes; O0250B would be coded 01-07-20104, and O0250C would be skipped.</p> <p>Rationale: Mrs. J. received the vaccine in the facility on January 7, 20104, during this year's influenza vaccination season.</p> <p>2. Mr. R. did not receive the influenza vaccine in the facility during this year's influenza vaccination season due to his known allergy to egg protein.</p> <p>3. Resident Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season. Her doctor provided documentation of Mrs. T.'s receipt of the vaccine to the facility to place in Mrs. T.'s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks forof the influenza vaccine prior to administration.</p> <p>Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.</p> <p>Rationale: Mrs. T. received the influenza vaccine at her doctor's office during this year's influenza vaccination season.</p> <p>4. Mr. K. wanted to receive the influenza vaccine if it arrived prior to his scheduled discharge on October 5th. Mr. K. was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Mr. K. did not receive the influenza vaccine in the facility.</p>
3	-	O-10	Page number change.
3	O0300	O-11	[Centers for Disease Control and Prevention. (2009 2012 , May). <i>The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (112th ed.)</i> . Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters]
3	-	O-12 through O-17	Page number change.
3	O0400	O-18	Co-treatment minutes —Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Skip the item Enter 0 if none were provided.
3	-	O-19	Page number change.
3	O0400	O-20	When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the

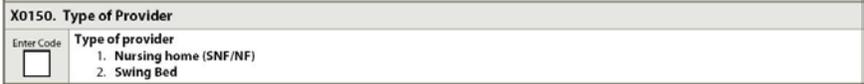
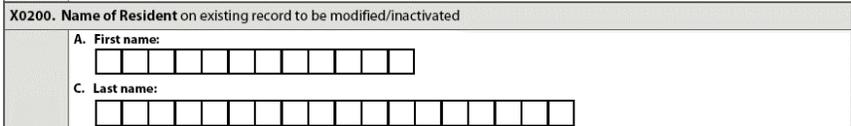
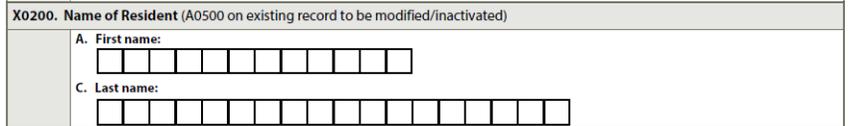
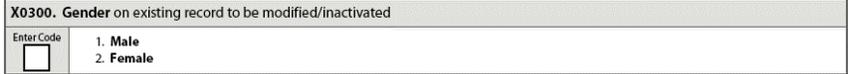
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			MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.
3	-	O-21 through O-23	Page number change.
3	O0400	O-24	A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.'s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.'s therapy may be coded as 30 minutes of individual therapy on the MDS. MDS.
3	-	O-25 & O-26	Page number change.
3	O0400	O-27	Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B are joined by Mr. T. and Mr. E., whose stays are also covered by Medicare Part A., and the therapist begins working with all of them on the same therapy goals- as part of a group session. After 15 minutes in this group session, Mr. A. becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
3	O0400	O-27	<u>Therapy Modalities</u> Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met, see page O-17) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot

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			pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the patient's plan of care.
3	-	O-28 through O-40	Page number change.
3	O0500	O-41	5. Mrs. J. had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J. has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J.'s overall care plan goal is to maximize her independence in ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro hook and loop fasteners . The nursing assistants have been instructed in how to verbally guide Mrs. J. as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. It takes approximately 20 minutes per day for Mrs. J. to complete this task (dressing and undressing).
3	O0500	O-42	6. Mr. W.'s cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed.
3	-	O-43 through O-45	Page number change.

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Chapter	Section	Page	Change
3	X0150	X-2	<p>X0150: Type of Provider (A0200 on existing record to be modified/inactivated)</p> <p>This item contains the type of provider identified from the prior erroneous record to be modified/ inactivated.</p>
3	X0150	X-2	<p>Replaced screen shot.</p> <p>OLD</p>  <p>NEW</p> 
3	X0150	X-2	<p>Coding Instructions for X0150, Type of Provider</p> <p>This item contains the type of provider identified from the prior erroneous record to be modified/ inactivated. Enter the type of provider code 1 “Nursing Home (SNF/NF)” or code 2 (Swing Bed” exactly as submitted for item A0200 “Type of Provider” on the prior erroneous record to be modified/inactivated.</p>
3	X0200	X-2	<p>X0200: Name of Resident (A0500 on existing record to be modified/inactivated)</p>
3	X0200	X-2	<p>Replaced screen shot.</p> <p>OLD</p>  <p>NEW</p> 
3	X0200	X-3	<p>X0200: Name of Resident (A0500 on existing record to be modified/inactivated) (cont.)</p>
3	X0300	X-3	<p>X0300: Gender (A0800 on existing record to be modified/inactivated)</p>
3	X0300	X-3	<p>Replaced screen shot.</p> <p>OLD</p>  <p>NEW</p>

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Chapter	Section	Page	Change
			<p>X0300. Gender (A0800 on existing record to be modified/inactivated)</p> <p>Enter Code <input type="checkbox"/> 1. Male 2. Female</p>
3	X0400	X-3	<p>X0400: Birth Date (A0900 on existing record to be modified/inactivated)</p>
3	X0400	X-3	<p>Replaced screen shot.</p> <p>OLD</p> <p>X0400. Birth Date on existing record to be modified/inactivated</p> <p><input type="text"/> - <input type="text"/> - <input type="text"/></p> <p>Month Day Year</p> <p>NEW</p> <p>X0400. Birth Date (A0900 on existing record to be modified/inactivated)</p> <p><input type="text"/> - <input type="text"/> - <input type="text"/></p> <p>Month Day Year</p>
3	X0500	X-4	<p>X0500: Social Security Number (A0600A on existing record to be modified/inactivated)</p>
3	X0500	X-4	<p>Replaced screen shot.</p> <p>OLD</p> <p>X0500. Social Security Number on existing record to be modified/inactivated</p> <p><input type="text"/> - <input type="text"/> - <input type="text"/></p> <p>NEW</p> <p>X0500. Social Security Number (A0600A on existing record to be modified/inactivated)</p> <p><input type="text"/> - <input type="text"/> - <input type="text"/></p>
3	X0600	X-4	<p>X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated)</p>
3	X0600	X-4	<p>Replaced screen shot.</p> <p>OLD</p> <p>X0600. Type of Assessment on existing record to be modified/inactivated</p> <p>Enter Code <input type="checkbox"/> A. Federal OBRA Reason for Assessment</p> <p>01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above</p> <p>Enter Code <input type="checkbox"/> B. PPS Assessment</p> <p>PPS Scheduled Assessments for a Medicare Part A Stay</p> <p>01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment</p> <p>PPS Unscheduled Assessments for a Medicare Part A Stay</p> <p>07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) Not PPS Assessment 99. None of the above</p> <p>Enter Code <input type="checkbox"/> C. PPS Other Medicare Required Assessment - OMRA</p> <p>0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment</p> <p>Enter Code <input type="checkbox"/> D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2</p> <p>0. No 1. Yes</p> <p>Enter Code <input type="checkbox"/> F. Entry/discharge reporting</p> <p>01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above</p>

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Chapter	Section	Page	Change
			<p>NEW</p> <p>X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)</p> <p>Enter Code <input type="checkbox"/> <input type="checkbox"/></p> <p>A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above</p> <p>Enter Code <input type="checkbox"/> <input type="checkbox"/></p> <p>B. PPS Assessment PPS Scheduled Assessments for a Medicare Part A Stay 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment PPS Unscheduled Assessments for a Medicare Part A Stay 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) Not PPS Assessment 99. None of the above</p> <p>Enter Code <input type="checkbox"/></p> <p>C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment</p> <p>Enter Code <input type="checkbox"/></p> <p>D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes</p> <p>Enter Code <input type="checkbox"/> <input type="checkbox"/></p> <p>F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above</p>
3	X0600	X-5	X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)
3	X0600	X-6	X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)
3	X0700	X-6	<p>Replaced screen shot.</p> <p>OLD</p> <p>X0700. Date on existing record to be modified/inactivated - Complete one only</p> <p>A. Assessment Reference Date - Complete only if X0600F = 99 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p> <p>B. Discharge Date - Complete only if X0600F = 10, 11, or 12 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p> <p>C. Entry Date - Complete only if X0600F = 01 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p> <p>NEW</p> <p>X0700. Date on existing record to be modified/inactivated - Complete one only</p> <p>A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p> <p>B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p> <p>C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>Month Day Year</small></p>
3	X0700	X-7	Coding Instructions for X0700A, Assessment Reference Date (A2300 on existing record to be modified/inactivated)—Complete

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			Only if X0600F = 99
3	X0700	X-7	Coding Instructions for X0700B, Discharge Date (A2000 on existing record to be modified/inactivated)—Complete Only If X0600F = 10, 11, or 12
3	X0700	X-7	Coding Instructions for X0700C, Entry Date (A1600 on existing record to be modified/inactivated)—Complete Only If X0600F = 01

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Chapter	Section	Page	Change
3	Z0400	Z-6	— quality monitoring activities, such as the quality indicator /quality measure reports
3	Z0400	Z-8	<p>Steps for Assessment</p> <p>1. Verify that all items on this assessment or tracking record are complete.</p>

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Chapter	Section	Page	Change
5	-	5-1	Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required (OBRA)–Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).
5	5.1	5-1	http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.aspx http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html
5	5.1	5-1	<p>The provider indicates the submission authority for a record certification or licensure of the unit on which the resident resides in item A0410, Unit Certification or Licensure Designation Submission Requirement. In addition to reflecting certification or licensure of the unit, this item indicates the submission authority for a record.</p> <ul style="list-style-type: none"> • Value = 1 Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State. Neither federal nor state required submission. • Value = 2 Unit is neither Medicare nor Medicaid certified but MDS data is required by the State but not federal required submission (FOR NURSING HOMES ONLY). • Value = 3 Unit is Medicare and/or Medicaid certified Federal required submission. <p>See Chapter 3 for details concerning the coding of item A0410, Unit Certification or Licensure Designation Submission Requirement. Note: CMS certified Swing Bed unit assessments are always Value 3, Unit is Medicare and/or Medicaid certified. Federal required submission.</p>
5	5.2	5-2	<ul style="list-style-type: none"> • Completion Timing: <ul style="list-style-type: none"> — For all non-admission Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300). — For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000

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			<p>for a death Death in In facility Facility tracking record).</p> <ul style="list-style-type: none"> • State Requirements: Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state State RAI eoordinators Coordinators.) • Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking information record, the provider should must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:
5	5.2	5-3	<ul style="list-style-type: none"> • Transmitting Data: Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both Federal and state requirements. Care plans are not required to be transmitted.
5	5.2	5-3	Sign. Correction to Prior Comprehensive Assessment- Quarterly Review Assessment-
5	5.2	5-4	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the Care Area Assessment (CAA) Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
5	5.2	5-4	Assessment Schedule: An OBRA assessment (comprehensive or quarterly Quarterly) is due every quarter unless the resident is no longer in the facility. There should must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There should must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 6 2 for details.
5	5.3	5-4	Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the MDS QIES ASAP system. This confirmation information includes the file submission number as well as the date and time the file was received for processing.
5	5.3	5-5	3. Non-Fatal Errors (Warnings). The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.

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			<p>Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening discharge Discharge record assessment (A0310F = 10, or 11 or 12). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.</p>
5	5.4	5-6	<p>Both HIPPS codes (Z0100A and Z0150A), the RUG version codes (Z0100B and Z0150B), and the Medicare Short Stay indicator (Z0100C) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B= 01, 02, 03, 04, 05, 06, or 07). All of these values are validated by the QIES ASAP system. The Final Validation Report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare-Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP system calculated value for the Medicare Part A HIPPS code (Z0100A) is not a group that begins with 'R', i.e., Rehabilitation Plus Extensive Services or Rehabilitation group.</p>
5	5.5	5-7 & 5-8	<ul style="list-style-type: none"> Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.
5	5.6	5-9	<p>Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may</p>

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			be more complex if the record in error is an OBRA comprehensive or quarterly Quarterly assessment record (i.e., Item A0310A = 01 through 06).
5	5.6	5-9	<ul style="list-style-type: none"> Correct the errors in the original OBRA comprehensive or quarterly Quarterly assessment.
5	5.7	5-10	Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record; within 3 years of the target date of the record for facilities that are still open. If a facility is closed/terminated, then corrections must be submitted within 2 years of the facility closed termination date, regardless of the age of the original record. A record may be corrected even if subsequent records have been accepted for the resident.
5	5.7	5-10	The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include most MDS items, including:
5	-	5-11	Page length change.
5	5.7	5-12	— Unit Certification or Licensure Designation Submission Requirement (Item A0410),
5	5.7	5-13	<p>Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1) when the look-back period and/or clinical assessment would change had the MDS been modified</p> <p>Discharge Date (Item A2000) on a Discharge/Death in Facility assessment record (Item A0310F = 10, 11, 12) when the look-back period and/or clinical assessment would change had the MDS been modified</p>
5	5.8	5-14	<ol style="list-style-type: none"> The record has the wrong unit certification or licensure designation submission requirement in Item A0410. The record has the wrong state_cd or facility ID in the control Items STATE_CD or FAC_ID. <p>In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the appropriate MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility must submit the completed form to the State Agency; Completed forms with privacy information must be sent via certified mail through the United States Postal Service (USPS). The State Agency will review the request for completion and accuracy. After approving the provider's request, the state must sign the form and send it to the QTSO Help Desk. Completed forms with privacy data must approve the provider's request and</p>

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			<p>submit a signed form to the QIES Help Desk be sent via certified mail through the USPS.</p> <p>When a test record is in the QIES ASAP system, the problem must be manually evaluated in the QIES ASAP system and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual deletion correction is necessary to completely remove the test record and associated information.</p> <p>A QIES ASAP system record with an incorrect unit certification or licensure designation submission requirement in Item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (Unit is Medicare and/or Medicaid certified federal submission requirement) but there was when actually the unit is neither Medicare nor Medicaid certified and MDS data is not required by the State no state or federal requirement for the record (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual correction deletion is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 (indicating that the Unit is Medicare and/or Medicaid certified federal submission requirement) but the record actually the unit is neither Medicare nor Medicaid certified but MDS data is only required by the sState (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.</p> <p>If a QIES ASAP system record has the wrong main state code or facility ID (control item STATE_CD, FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct</p>

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			STATE_CD and FAC_ID value, when indicated.
5	5.8	5-15	<p>Edits to diagram:</p> <p style="text-align: right;">For comp. and Quarterly asmts. only⁴</p> <p>For comp. and QQuarterly asmts. only⁴</p> <p>¹Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an incorrect Unit Certification or Licensure Designation submission requirement value (A0410), for example sent in as Unit is Medicare and/or Medicaid certified federally required (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State state required (A0410 = 2). Otherwise, automated inactivation or modification required: (a) if event did not occur (see note #3 below), submit automated inactivation, (b) if event occurred, submit automated modification.</p> <p>²Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP.</p> <p>³The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a DDischarge assessment was created for a resident who was not actually discharged), then the event did not occur.</p> <p>⁴OBRA comprehensive assessments with A0310 A=01,03,04,05 and QQuarterly assessments with A0310B=02,06.</p>

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6	6.3	6-5	— difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale ≥ 3),
6	6.4	6-7	The first digit of the AI code identifies scheduled PPS assessments that establish the RUG payment rate for the standard PPS scheduled payment periods. These assessments are PPS 5-day, 14-day, 30-day, 60-day, and 90-day, and readmission/return . The Omnibus Budget Reconciliation Act (OBRA 1987) required assessments are also included, because they can be used under certain circumstances for payment (see Section 6.8). Table 2 displays the first AI
6	6.4	6-8	PPS 5-day or readmission/return (5d-or-readm)
6	6.4	6-11	<ul style="list-style-type: none"> EXAMPLE 5. The End of Therapy OMRA assessment is performed with an ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25 through Day 30. The Medicare Non-Therapy RUG (Z0150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.
6	6.4	6-12	<ul style="list-style-type: none"> EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30-Day assessment is then performed with an ARD on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and the EOT-R items (O0450A; and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.
6	6.4	6-12	7. In all cases where an EOT-R would be completed, the resident must resume therapy at the same RUG-IV therapy level as had been in effect prior to the break in therapy. However, it is

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			<p>possible that the ARD for an EOT OMRA reporting resumption may be set for the first grace day of the allowable grace days for a scheduled PPS assessment, while the ARD for the scheduled assessment was set for a day within the normal ARD window. In this limited subset of cases, the resumption of therapy should occur using the previous RUG-IV therapy level (which should be the same as the therapy level determined on the scheduled PPS assessment if the resumption is appropriate) but using the Activities of Daily Living (ADL) score from the most recent PPS assessment. Consider the following example.</p> <ul style="list-style-type: none"> • EXAMPLE 7. A resident, Mr. P, is admitted on 10/01/11. The ARD of the 5-day assessment for Mr. P is set for 10/07/11 (Day 7) and the RUG assigned to Mr. P is RVB. The ARD of the 14-day assessment is set for 10/14/11 (Day 14) and the RUG assigned to Mr. P is again RVB. The ARD of the 30-day assessment is set for 10/28/11 (Day 28) and the RUG assigned to Mr. P is now RVA. Due to an acute illness, Mr. P is unable to receive therapy services from 10/29/11 through 10/31/11, but is expected to resume therapy on 11/2/11 under the same therapy regimen. The facility completes an EOT for Mr. P with an ARD of 10/31/11 and reports that the resumption of therapy will occur on 11/2/11. The EOT OMRA assigns Mr. P a non-therapy RUG of CE2. Mr. P is discharged from the facility on 11/12/11. <p>In the case described above, assuming no intervening assessments were necessary, the facility would bill in the following manner. Days 1-14 would be billed under HIPPS code RVB10. Days 15-28 would be billed under HIPPS code RVB20. Days 29-32 would be billed under HIPPS code CE20A. Days 33-41 would be billed under HIPPS code RVA0A.</p> <p>This represents the one and only occasion where the three character RUG-IV therapy RUG code may differ from that which was billed prior to the break in therapy, and the difference may only be in the third character in the therapy RUG code related to the resident's ADL score.</p>
6	6.4	6-13 & 6-14	<p>7.8. Example 78 presents a case where a Change of Therapy OMRA is performed.</p> <ul style="list-style-type: none"> • EXAMPLE 78. The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were reflective of the RUG-IV

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			<p>classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed with an ARD set for Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different Rehabilitation category results and a Change of Therapy OMRA is performed with an ARD set for Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the COT observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA.</p> <p>8-9. If a new PPS assessment used for payment occurs with an ARD set for on or prior to the last day of a COT observation period, then a Change of Therapy OMRA is not required for that observation period. Example 89 illustrates this case.</p> <ul style="list-style-type: none"> • EXAMPLE 89. An SCSA is performed with an ARD of Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed with an ARD on Day 17. Rather, the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22. <p>9-10. Example 910 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a COT observation period.</p> <ul style="list-style-type: none"> • EXAMPLE 910. The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No Change of Therapy OMRA is performed with an ARD on Day 21 and the change of therapy evaluation process is discontinued.
6	6.4	6-15	Page number change.
6	6.4	6-16	Page number change.
6	6.4	6-17	Page number change.
6	6.4	6-18	<ul style="list-style-type: none"> • Note that a Change in Therapy OMRA cannot be combined with a 5-day PPS or readmission/return assessment.
6	6.4	6-19	1. The assessment must be a Start of Therapy OMRA (A0310C = 1). This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or

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			<p>readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but not combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.</p> <p>2. A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed. The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.</p>
6	6.4	6-20	If all eight of these conditions are met, then MDS Item Z0100C (Medicare Short Stay Assessment indicator) is coded "Yes." T he assignment of the RUG-IV rehabilitation therapy classification is calculated based on average daily minutes actually provided (when there is a fraction, the total therapy minutes is not rounded and only the whole number is used), and the resulting RUG-IV group is recorded in MDS Item Z0100A (Medicare Part A HIPPS Code).
6	6.4	6-21	<p>Edited image.</p> <p>ARD Requirements:</p> <ol style="list-style-type: none"> 3. Must be Day 8 or earlier of Part A stay 4. Must be last day of Part A stay (see Item 2400 A2400C instructions) 5. Must be no more than 3 days after the start of therapy, not including the start of therapy date
6	6.4	6-22	<p>a. If a 5-day or readmission/return assessment was completed prior to Medicare Short Stay assessment, use the Medicare Part A RUG (Z0100A) from that assessment for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the Medicare Short Stay assessment from the day therapy started through the end of the short stay; or</p> <p>b. If the Start of Therapy OMRA is combined with a 5-day or readmission/return assessment, use the Medicare Part A non-therapy RUG (Z0150A) for the first day of the short stay through the day before therapy started; then use the Medicare Part A RUG (Z0100A) from the day therapy started through the end of the short stay.</p>
6	-	6-23 through	Page number change.

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		6-27	
6	6.6	6-28	Total Rehabilitation Therapy Minutes Calculation Example Mrs. D., whose stay is covered under SNF PPS, received the following rehabilitation services during FY2012 (group therapy time is allocated) as follows:
6	-	6-29	Page number change.
6	6.6	6-30	1. The assessment must be a Start of Therapy OMRA (Item A0310C = 1). This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility. 2. A PPS 5-day (Item A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed. The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
6	-	6-31	Page number change.
6	-	6-32	Page number change.
6	6.6	6-33	At least 5 distinct calendar days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4 as documented in O0420)
6	6.6	6-34	At least 3 distinct calendar days of any combination of the 3 three disciplines (O0400A4, plus O0400B4 plus O0400C4 as documented in O0420)
6	-	6-35	Page number change.
6	6.6	6-36	At least 5 distinct calendar days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4 as documented in O0420)
6	6.6	6-36	At least 3 distinct calendar days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4 as documented in O0420)
6	-	6-37 through 6-39	Page number change.
6	6.6	6-40	Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9 [®]) or the Staff Assessment of Resident Mood (PHQ-9-OV [®]). Instructions for completing the PHQ-9 [®] are in Chapter 3, Section D. Refer to Appendix E for cases in which the

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			PHQ-9 [®] or (PHQ-9-OV [®]) is complete but all questions are not answered. The following items comprise the PHQ-9 [®] :
6	6.6	6-41	M1200E Pressure ulcers care
6	6.6	6-42	STEP # 3 Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9 [®]) or the Staff Assessment of Resident Mood (PHQ-9-OV [®]). Instructions for completing the PHQ-9 [®] are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9 [®] or (PHQ-9-OV [®]) is complete but all questions are not answered. The following items comprise the PHQ-9 [®] :
6	-	6-43	Page number change.
6	6.6	6-44	STEP # 2 Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-9 [®]) or the Staff Assessment of Resident Mood (PHQ-9-OV [®]). Instructions for completing the PHQ-9 [®] are in Chapter 3, section D. Refer to Appendix E for cases in which the PHQ-9 [®] or (PHQ-9-OV [®]) is complete but all questions are not answered. The following items comprise the PHQ-9 [®] :
6	-	6-45 through 6-56	Page number change.

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—	—	G-1 thru G-3	<p>Centers for Disease Control and Prevention: <u>2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings</u>. Available from http://www.cdc.gov/longtermcare/http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf.</p> <p>Centers for Medicare & Medicaid Services: <u>HIPPS Codes</u>. Jun. 22, 2009 April 2012; retrieved Nov. 18, 2009, available from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Prosper Medicare Fee Svc Pmt Gen/HIPPS Codes.htmlhttp://www.cms.hhs.gov/Prosper Medicare Fee Svc Pmt Gen/02_HIPPS Codes.asp#TopOfPage</p> <p>Centers for Medicare & Medicaid Services: <u>MDS 3.0 Data Submission Specifications</u>. Available from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHOIMDS30TechnicalInformation.htmlhttp://www.cms.gov/NursingHomeQualityInits/30-NHOIMDS30TechnicalInformation.asp#TopOfPage</p> <p>Centers for Medicare & Medicaid Services: <u>MDS 3.0 for Nursing Home</u>. Available from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHOIMDS30.htmlhttp://www.cms.gov/NursingHomeQualityInits/30_NHOIMDS30TechnicalInformation.asp#TopOfPage</p> <p>Centers for Medicare & Medicaid Services: <u>Medicare Benefit Policy Manual (Pub. 100-2)</u>. Available from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html?DLPage=1&DLSort=0&DLSortDir=ascendinghttp://www.cms.hhs.gov/manuals/iom/List.asp</p> <p>Centers for Medicare & Medicaid Services: <u>Medicare Claims Processing Manual (Pub. 100-4)</u>. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascendinghttp://www.cms.hhs.gov/manuals/iom/List.asp</p> <p>Centers for Medicare & Medicaid Services: <u>Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1)</u>. Available from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascendinghttp://www.cms.hhs.gov/manuals/iom/List.asp</p>

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			<p data-bbox="597 281 1453 390">Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html?DLPage=1&DLSort=0&DLSortDir=ascendinghttp://www.ems.hhs.gov/manuals/iom/List.asp</p> <p data-bbox="597 422 1422 642">National Pressure Ulcer Advisory Panel: <u>Suspected Deep Tissue Injury</u> [image of cross-sectioned suspected deep tissue injury]. Retrieved November 18, 2009, from http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTL.jpghttp://www.npuap.org/images/NPUAP-SuspectDTL.jpg</p> <p data-bbox="597 674 1433 856">National Pressure Ulcer Advisory Panel: <u>Unstageable</u> [image of cross-sectioned unstageable pressure ulcer]. Retrieved November 18, 2009, from http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpghttp://www.npuap.org/images/NPUAP-Unstage2.jpg</p>