

**MDS 3.0 RAI Manual (v1.08) Errata (v4)**  
**Effective April 1, 2012**

Issue IDs	Issue	Resolution
V4-01	In Chapter 2, under PPS Unscheduled Assessments for a Medicare Part A stay, Change of Therapy OMRA, instructions under bullet 6 needed clarification.	<p>In Chapter 2, page 2-50, bullet 4, instructions have been amended as follows:</p> <p>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 <b>alone only</b> by setting the ARD of the scheduled PPS assessment for an allowable day that is <b>on or before</b> <del>prior</del> 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. <b>Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.</b></p>
V4-02	Coding Tip is needed for policy related to coding for standalone unscheduled PPS assessment interviews.	<p>In Chapter 2, Section 2.9, page 2-51, the following information has been added:</p> <p><b>Coding Tips and Special Populations</b></p> <ul style="list-style-type: none"> <li>• <b>When coding a standalone unscheduled PPS assessment (COT, EOT, SOT), the interview items may be coded using the responses provided by the resident on a previous assessment <b>only</b> 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.</b></li> </ul>

Issue IDs	Issue	Resolution
V4-03	In Chapter 2, Section 2.10 Combining Medicare Scheduled and Unscheduled Assessments, instructions for PPS Scheduled Assessment and Change of Therapy OMRA on page 2-53 needed clarification.	<p>In Chapter 2, Section 2.10, page 2-54, PPS Scheduled Assessment and Change of Therapy OMRA instructions have been amended as follows:</p> <ul style="list-style-type: none"> <li>If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS assessment, <del>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.</del> then a SNF must elect to either combine the COT OMRA with the scheduled PPS assessment or may choose to complete the scheduled PPS assessment alone, as described in Section 2.9. If the scheduled PPS assessment is to be completed alone, then the ARD for the scheduled PPS assessment must be set for <b>on or prior</b> to Day 7 of the COT observation period. If the SNF chooses to combine the scheduled PPS assessment with the COT OMRA, then the ARD of the combined assessment must be set for Day 7 of the COT observation period.</li> </ul>
V4-04	In Chapter 3 Section A, page A-24, A2100 – code 9 is incorrect. This item refers to where residents are discharged, not where they were admitted from.	<p>In Chapter 3, Section A, on page A-24, Code 09 text has been amended as follows:</p> <ul style="list-style-type: none"> <li>Code 09, long term care hospital (LTCH): if <b>discharge location is an institution</b> <del>patient was admitted from a hospital</del> 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 I(PPS) 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.</li> </ul>

Issue IDs	Issue	Resolution
V4-05	Definition for the term “new normal” is needed in the RAI Manual, Section I, page I-3.	<p>In Chapter 3, Section I, page I-3, the term “new normal” has been removed and the entire bullet amended as follows:</p> <p>2. <b>Determine whether diagnoses are active:</b> Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a <b>direct relationship</b> to the resident’s current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident’s current status, or do not drive have no <b>longer</b> affected the resident’s current functioning or plan of care, or that the resident has adjusted to as their “new normal,” during the last 7-days look-back period, as these would be considered inactive diagnoses. Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific instructions for Item I2300 UTI.</p> <ul style="list-style-type: none"> <li>• <del>Active diagnoses have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.</del></li> </ul>
V4-06	In Chapter 3 Section K, on page K-16, the coding Rationale references K0500b. This should be replaced with K0700b.	<p>In Chapter 3, Section K, on page K-16, K0500b has been amended as follows:</p> <p>Coding: Coding: <b>K0700b</b> would be coded <b>1, 500 cc/day or less</b>.</p> <p>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 <b>code 1, 500 cc/day or less</b> is correct.</p>

Issue IDs	Issue	Resolution
V4-07	<p>In Chapter 3, Section M, on page M-30, the definitions box for item M1040 reads: "Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused <b>would</b> edges".</p> <p>The word "would" should be replaced with the word "wound".</p>	<p>In Chapter 3, Section M, on page M-30, the definitions box for item M1040 has been amended as follows:</p> <p>"Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused <b>wound</b> edges".</p>
V4-08	<p>In Chapter 3 Section X, on page X-1, it does not include Item A0050 for inactivation requests. It currently reads: "Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Section X items. All other MDS sections are skipped."</p>	<p>In Chapter 3, Section X, on page X-1, the fifth paragraph has been amended as follows:</p> <p>"An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes <b>Item A0050 and the</b> Section X items. All other MDS sections are skipped."</p>
V4-09	<p>Coding Instructions for Chapter 3, Section X, on page X-5, under section "Coding Instructions for X0600A, Federal OBRA Reason for Assessment", require clarification.</p>	<p>In Chapter 3, Section X, page X-5, the second coding instruction bullet under section "Coding Instructions for X0600A, Federal OBRA Reason for Assessment" has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>• Note that the Federal OBRA reason for assessment/tracking code in X0600A <del>does not have to</del> <b>must</b> match the current value of A0310A on a modification request. <del>The entries may be different if the modification is correcting the Federal OBRA reason for assessment/tracking code.</del></li> <li>• <b>If item A0310A was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new event date must be submitted.</b></li> </ul>

Issue IDs	Issue	Resolution
V4-10	Coding Instructions for Chapter 3, Section X, on page X-5, under section “Coding Instructions for X0600B, PPS Assessment”, require clarification.	<p>In Chapter 3, Section X, on page X-5, the second coding instruction bullet under section “Coding Instructions for X0600B, PPS Assessment”, has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>Note that the PPS assessment code in X0600B <del>does not have to</del> <b>must</b> match the current value of A0310B on a modification request. <del>The entries may be different if the modification is correcting the Federal OBRA reason for assessment/tracking code.</del></li> <li><b>If item A0310B was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and new record with a new event date must be submitted.</b></li> </ul>
V4-11	Coding Instructions for Chapter 3, Section X, on page X-5, under section “PPS Other Medicare Required Assessment—OMRA”, require clarification.	<p>In Chapter 3, Section X, on page X-5, the second coding instruction bullet under section “Coding PPS Other Medicare Required Assessment—OMRA” has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>Note that the PPS OMRA code in X0600C <del>does not have to</del> <b>must</b> match the current value of A0310C on a modification request. <del>The entries may be different if the modification is correcting the PPS OMRA code.</del></li> <li><b>If item A0310C was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new event date must be submitted.</b></li> </ul>
V4-12	Coding Instructions for Chapter 3, Section X, on page X-6, under section “Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)”, require clarification.	<p>In Chapter 3, Section X, on page X-6, the fourth coding instruction bullet under section “Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)” has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>Note that the code in X0600D <del>does not have to</del> <b>must</b> match the current value of A0310D on a modification request. <del>The entries may be different if the modification is correcting the Swing Bed clinical change assessment code.</del></li> <li><b>If item A0310D was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new event date must be submitted.</b></li> </ul>

Issue IDs	Issue	Resolution
V4-13	Coding Instructions for Chapter 3, Section X, on page X-6, under section “Coding Instructions for X0600F, Entry/discharge reporting”, require clarification.	<p>In Chapter 3, Section X, on page X-6, the second coding instruction bullet under section “Coding Instructions for X0600F, Entry/discharge reporting”, has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>Note that the Entry/discharge code in X0600F <del>does not have to</del> <b>must</b> match the current value of A0310F on a modification request. <del>The entries may be different if the modification is correcting the Entry/discharge reason for completing the assessment or tracking record.</del></li> <li><b>If item A0310F was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new event date must be submitted.</b></li> </ul>
V4-14	Coding Instructions for Chapter 3, Section X, on page X-7, under section “Coding Instructions for X0700A, Assessment Reference Date—Complete Only if X0600F = 99”, require clarification.	<p>In Chapter 3, Section X, on page X-7, the second coding instruction bullet under section “Coding Instructions for X0700A, Assessment Reference Date—Complete Only if X0600F = 99”, has been amended as follows:</p> <ul style="list-style-type: none"> <li>Note that the assessment reference date in X0700A <del>does not have to</del> <b>must</b> match the current value of A2300 on a modification request. <del>The entries may be different if the modification is correcting the assessment reference date. The entries may also be different if the type of assessment/tracking record is being changed. For example, if the incorrect QIES ASAP database record indicates an admission assessment but the record should have been an entry record, then the assessment reference date for the prior record is entered in Item X0700A (Assessment Reference Date). However, the new assessment reference date in A2300 would be blank. The assessment reference date is not active on an entry record. Instead, the entry date would be entered in item A1600.</del></li> </ul>
V4-15	Coding Instructions for Chapter 3, Section X, on page X-7, under section “Coding Instructions for X0700B, Discharge Date—Complete Only If X0600F = 10, 11, or 12”, require clarification.	<p>In Chapter 3, Section X, on page X-7, the second coding instruction bullet under section “Coding Instructions for X0700B, Discharge Date—Complete Only If X0600F = 10, 11, or 12”, has been amended as follows:</p> <ul style="list-style-type: none"> <li>Note that the discharge date in X0700B <del>does not have to</del> <b>must</b> match the current value of A2000 on a modification request. <del>The entries may be different if the modification is correcting the discharge date. The entries may also be different if the type of assessment/tracking record is being changed.</del></li> </ul>

Issue IDs	Issue	Resolution
V4-16	Coding Instructions for Chapter 3, Section X, on page X-7, under section “Coding Instruction for X0700C, Entry Date—Complete Only If X0600F = 01”, require clarification.	<ul style="list-style-type: none"> <li>In Chapter 3, Section X, on page X-7, the second coding instruction bullet under section “Coding Instructions for X0700C, Entry Date—Complete Only If X0600F = 01”, has been amended as follows:</li> <li>Note that the entry date in X0700C <del>does not have to</del> <b>must</b> match the current value of A1600 on a modification request. <del>The entries may be different if the modification is correcting the entry date. The entries may also be different if the type of assessment/tracking record is being changed.</del></li> </ul>
V4-17	Coding Instructions for Chapter 3, Section X, on page X-9, under section “Coding Instructions for X0900D, Item Coding Error”, require clarification.	<p>In Chapter 3, Section X, on page X-9, the second coding instruction bullet under section “Coding Instructions for X0900D, Item Coding Error”, has been amended as follows:</p> <ul style="list-style-type: none"> <li>An item coding error includes any error made coding an MDS item <b>(for exceptions when certain items may not be modified see Chapter 5)</b>, such as choosing an incorrect code for the Activities of Daily Living (ADL) bed mobility self-performance item G0110A1 (e.g., choosing a code of “4” for a resident who requires limited assistance and should be coded as “2”). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.</li> </ul>
V4-18	Coding Instructions for Chapter 3, Section X, on page X-9, under section “for X0900E, End of Therapy-Resumption (EOT-R) date”, require clarification.	<p>In Chapter 3, Section X, on page X-9, the first coding instruction bullet under section “for X0900E, End of Therapy-Resumption (EOT-R) date”, has been amended and an additional bullet added as follows:</p> <ul style="list-style-type: none"> <li>Check the box if <b>the End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not indicating a resumption of therapy date in item O0450B)</b> <del>error in the prior QIES ASAP record was caused by an erroneous End of Therapy Resumption (EOT-R) date.</del></li> <li><b>Do not check this box if the modification is correcting the End of Therapy Resumption date (item O0450B) in a previous EOT-R assessment. In this case, the reason for modification is an item Coding Error and box X0900D should be checked.</b></li> </ul>

Issue IDs	Issue	Resolution
V4-19	Clarification is needed for CMS policy for inactivations involving incorrect submission of ARD or Type of Assessment items.	<p>In Chapter 5, on page 5-12, the following paragraphs have been added to the “Inactivation Requests” section:</p> <p>If the ARD or Type of Assessment is entered incorrectly, and the provider does not correct it within the encoding period, the provider must complete and submit a new MDS 3.0 record.</p> <p>Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid</p> <p>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.</p>
V4-20	In Appendix B, the hyperlink sends providers to MDS 3.0 training materials. It should send providers to Appendix B list for State Agency and CMS Regional Office RAI/MDS Contacts.	<p>In Appendix B, page B-1, the hyperlink to State RAI/MDS contacts has been amended as follows:</p> <p><a href="https://www.cms.gov/NursingHomeQualityInits/20_MDS30RAIManual.asp#TopOfPage">https://www.cms.gov/NursingHomeQualityInits/20_MDS30RAIManual.asp#TopOfPage</a>.</p>
V4-21	In Appendix E, on page E-7, the calculation in Example 2 is incorrect and needs to be corrected.	<p>In Appendix E, on page E-7, the calculation for Example 2 has been amended as follows:</p> <p>In this example, one of the items in Column 2 (D0500E2) has a missing value (it is equal to dash) and the other 9 items have non-missing values. D0600 is computed as follows:</p> <ol style="list-style-type: none"> <li>1. Compute the sum of the 9 items with non-missing values. This sum is 12.</li> <li>2. Multiply this sum by 1.111 (See bullet 5 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 12. Therefore, the calculation is: <math>912 \times 1.111286 = 44.25013.332</math>.</li> <li>3. Round the result to the nearest integer. In the example, 13.332 rounds to 13.</li> <li>4. Place the rounded result in D0600.</li> </ol>



Issue IDs	Issue	Resolution
V4-22	In Appendix E, on page E-7, the calculation in Example 3 is incorrect and needs to be corrected.	<p>In Appendix E, on page E-7, the calculation for Example 3 has been amended as follows:</p> <p>In this example, two of the items in Column 2 have missing values: D0500E2 and D0500H2 are equal to dash. The other 8 items have non-missing values. D0600 is computed as follows:</p> <ol style="list-style-type: none"> <li>1. Compute the sum of the 8 items with non-missing values. This sum is 9.</li> <li>2. Multiply this sum by 1.250 (See bullet 6 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 9. Therefore, the calculation is: <math>8 \times 9 \times 1.250 = 11.250</math>.</li> <li>3. Round the result to the nearest integer. In the example, 11.250 rounds to 11.</li> <li>4. Place the rounded result in D0600.</li> </ol>

- 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 before* 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.
- 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 RUG-IV therapy classification.
- 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 unscheduled PPS assessment (COT, EOT, 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.

## 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 Chapter 2 of this manual 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).

### ***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**

- If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS Assessment, then a SNF must elect to either combine the COT OMRA with the scheduled PPS assessment or choose to complete the scheduled PPS assessment alone, as described in Section 2.9. If the scheduled PPS assessment is to be completed alone, then the ARD for the scheduled PPS assessment must be set for **on or prior** to Day 7 of the COT observation period. If the SNF chooses to combine the scheduled PPS assessment with the COT OMRA, then the ARD of the combined must be set for Day 7 of the COT observation period.
- 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 Assessments<sup>1</sup>

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 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.

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<sup>1</sup> 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.



**Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities**

	<b>Comprehensive Item Set</b>	<b>Quarterly/ PPS* Item Sets</b>	<b>Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities</b>
Stand-alone Assessment Types	<ul style="list-style-type: none"> <li>• OBRA Admission</li> <li>• Annual</li> <li>• Significant Change in Status (SCSA)</li> <li>• Significant Correction to Prior Comprehensive (SCPA)</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly</li> <li>• Significant Correction to Prior Quarterly</li> <li>• PPS 5-Day (5-Day)</li> <li>• PPS 14-Day (14-Day)</li> <li>• PPS 30-Day (30-Day)</li> <li>• PPS 60-Day (60-Day)</li> <li>• PPS 90-Day (90-Day)</li> <li>• PPS Readmission/Return</li> </ul>	<ul style="list-style-type: none"> <li>• Entry Tracking Record</li> <li>• Discharge assessments</li> <li>• Death in Facility Tracking Record</li> <li>• Start of Therapy OMRA</li> <li>• Start of Therapy OMRA and Discharge</li> <li>• Change of Therapy OMRA</li> <li>• OMRA</li> <li>• OMRA and Discharge</li> </ul>

(continued)

**Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities (continued)**

	<b>Comprehensive Item Set</b>	<b>Quarterly/ PPS* Item Sets</b>	<b>Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities</b>
Combined Assessment Types	<ul style="list-style-type: none"> <li>• OBRA Admission and 5-Day</li> <li>• OBRA Admission and 14-Day</li> <li>• OBRA Admission and any OMRA</li> <li>• Annual and any Medicare-required</li> <li>• Annual and any OMRA</li> <li>• SCSA and any Medicare-required</li> <li>• SCSA and any OMRA</li> <li>• SCPA and any Medicare-required</li> <li>• SCPA and any OMRA</li> <li>• Any OBRA comprehensive and any Discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly and any Medicare-scheduled</li> <li>• Quarterly and any OMRA</li> <li>• Significant Correction to Prior Quarterly and any Medicare-required</li> <li>• Significant Correction to Prior Quarterly and any OMRA</li> <li>• Any Discharge and any Medicare-required</li> <li>• Quarterly and any Discharge</li> <li>• Significant Correction to Prior Quarterly and any Discharge</li> <li>• Any Medicare-required and any Discharge</li> </ul>	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**

	<b>Swing Bed PPS</b>	<b>Other Required Assessments/Tracking Item Sets for Swing Bed Providers</b>
Assessment Type	<ul style="list-style-type: none"> <li>• PPS 5-Day (5-Day)</li> <li>• PPS 14-Day (14-Day)</li> <li>• PPS 30-Day (30-Day)</li> <li>• PPS 60-Day (60-Day)</li> <li>• PPS 90-Day (90-Day)</li> </ul>	<ul style="list-style-type: none"> <li>• Entry Record</li> <li>• Discharge assessments</li> <li>• Death in Facility record</li> <li>• Start of Therapy OMRA</li> <li>• Start of Therapy OMRA and Discharge</li> </ul>

	<ul style="list-style-type: none"> <li>• PPS Readmission/Return</li> <li>• Clinical Change Assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Change of Therapy OMRA</li> <li>• OMRA</li> <li>• OMRA and Discharge</li> </ul>
Assessment Type Combinations	<ul style="list-style-type: none"> <li>• Clinical Change and any Medicare-required</li> <li>• Any Medicare-required and any Discharge</li> </ul>	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 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).

### *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 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 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 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 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 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 on a day of discharge (Item A2000) **and** the date of discharge falls 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 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 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 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 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 on day of discharge (Item A2000) **and** the date of discharge falls within 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) 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 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 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 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 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 on day of discharge (Item A2000) **and** the date of discharge falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).



- 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 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 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 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 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 on the day of discharge (Item A2000) and the date of discharge falls 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).
- 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 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 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 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 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***

- EOT OMRA and Discharge item set.
- ARD (Item A2300) must be set on day of discharge (Item A2000) **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.
- Must be completed (Item Z0500B) within 14 days after the ARD.

## **2.13 Factors Impacting the SNF Medicare Assessment Schedule<sup>2</sup>**

### ***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

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<sup>2</sup> These requirements/policies also apply to swing bed providers.

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. The type of entry on the Entry Tracking record (as described in Section 2.6) completed by the provider determines whether a Medicare-required 5-day or a Medicare Readmission/Return assessment should be completed.

When the Medicare resident returns to the SNF and the entry type on the Entry Tracking record is a Reentry (Item A1700=2), the first required Medicare assessment is the Medicare Readmission/Return assessment (Item A0310B = 06) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

When the Medicare resident returns to the SNF and the entry type on the Entry Tracking record is an Admission (Item A1700=1), the first required Medicare assessment is the Medicare-required 5-Day assessment (Item A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

For 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.

### ***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 Leaves the Facility and Returns During an Observation Period***

The ARD is not altered if the beneficiary is out of the facility for a 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.



### ***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.

### ***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 omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for the Medicare-required assessment that was missed, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the Health Insurance Prospective Payment System (HIPPS) code

established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of day 41 would be paid the default rate for days 31 through 40 and at the HIPPS code from the assessment beginning on day 41.

If the ARD of the late assessment is set after the end of the payment period for the Medicare-required assessment that was missed and the resident is still on Part A, the provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period 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 the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment which covers days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services.

### ***Missed PPS Assessment***

If the SNF fails to set the ARD 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 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 when specific circumstances are met may be used to bill for some Part A days. See chapter 6, Section 6.8 for greater detail.

### ***Errors on a Medicare 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 or readmission/return					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	01,02,06	0,1,2,3,4	10,11,99	NC	Comprehensive
01,03	99	0	10,11,99	NC	Comprehensive
01,03,04,05	07	1,2,3,4	10,11,99	NC	Comprehensive
03,04,05	01 thru 06	0,1,2,3,4	10,11,99	NC	Comprehensive
04,05	07,99	0	10,11,99	NC	Comprehensive
02,06	01 thru 06	0,1,2,3,4	10,11,99	NQ	Quarterly
02,06	99	0	10,11,99	NQ	Quarterly
02,06	07	1,2,3,4	10,11,99	NQ	Quarterly
99	01 thru 06	0,1,2,3,4	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 2 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 06	0,1,2,3,4	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3,4	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	0	99	SO	EOT , EOT-R or COT OMRA
99	07	2,3	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.

## A2100: Discharge Status (cont.)

### Item Rationale

- Demographic and outcome information.

### Steps for Assessment

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

### Coding Instructions

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

- Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
- Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental delay 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

## I: Active Diagnoses in the Last 7 Days (cont)

### Item Rationale

#### Health-Related Quality of Life

- Disease processes can have a significant adverse affect on an individual's health status and quality of life.

#### Planning for Care

- This section identifies active diseases and infections that drive the current plan of care.

### Steps for Assessment

*There are two look-back periods for this section:*

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).

1. **Identify diagnoses:** The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the **last 60 days**.

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries,

diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

- Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
- Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

### DEFINITIONS

#### ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..

#### FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform, ADLs, paresis, or paralysis.

#### NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).

## I: Active Diagnoses in the Last 7 Days (cont)

Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300, UTI.

- Check the following information sources in the medical record for the last 7 days to identify “active” diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor’s orders, consults and official diagnostic reports, and other sources as available.

### Coding Instructions

*Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-8 for specific coding instructions).*

- Document active diagnoses on the MDS as follows:
  - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
  - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia**, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).
- Check off each active disease. Check all that apply.
- If a disease or condition is **not** specifically listed, check the “Other” box (I8000) and write in the ICD code and name for that diagnosis.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to insure that the ICD code’s decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes are on the left.)
- If a diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000.

### Cancer

- I0100, cancer (with or without metastasis)

### Heart/Circulation

- I0200, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- I0300, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- I0400, coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])

## K0700: Percent Intake by Artificial Route (cont.)

Coding: K0700b 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.



## M1040: Other Ulcers, Wounds and Skin Problems (cont.)

### Item Rationale

#### Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

#### Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

### Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
  - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

### Coding Instructions

*Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above. Pressure ulcers coded in M0200 through M0900 should NOT be coded here.*

- M1040A, infection of the foot (e.g., cellulitis, purulent drainage)
- M1040B, diabetic foot ulcer(s)
- M1040C, other open lesion(s) on the foot (e.g., cuts, fissures)

#### DEFINITIONS

##### DIABETIC FOOT ULCERS

Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

##### SURGICAL WOUNDS

Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

##### OPEN LESION OTHER THAN ULCERS, RASHES, CUTS

Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

##### BURNS (SECOND OR THIRD DEGREE)

Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

## SECTION X: CORRECTION REQUEST

**Intent:** The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

A modification request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

The modification request record contains correct values for all MDS items (not just the values previously in error), including the Section X items. The corrected record will replace the prior erroneous record in the QIES ASAP database.

In some cases, an incorrect MDS record requires a completely new assessment of the resident in addition to a modification request for that incorrect record. Please refer to Chapter 5 of this manual, Submission and Correction of the MDS Assessments, to determine if a new assessment is required in addition to a modification request.

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Item A0050 and the Section X items. All other MDS sections are skipped.

The modification and inactivation processes are automated and neither completely removes the prior erroneous record from the QIES ASAP database. The erroneous record is archived in a history file. In certain cases, it is necessary to delete a record and not retain any information about the record in the QIES ASAP database. This requires a request from the facility to the facility's state agency to manually delete all traces of a record from the QIES ASAP database. The policy and procedures for a Manual Correction/Deletion Request are provided in Chapter 5 of this manual.

A Manual Deletion Request is required **only** in the following three cases:

1. **Item A0410 Submission Requirement is incorrect.** Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Only records required by the State and/or the Federal governments may be stored in the QIES ASAP database. If a record has been submitted with the incorrect Submission Requirement value in Item A0410, then that record must be manually deleted and, in some cases, a new record with a corrected A0410 value submitted. Item A0410 cannot be corrected by modification or inactivation. See Chapter 5 of this manual for details.

## X0600: Type of Assessment/Tracking (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 a record that was previously submitted and accepted by the ASAP system, then the original record must be inactivated and a new record with a new event 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 a record that was previously submitted and accepted by the ASAP system, then the original record must be inactivated and a new record with a new event 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 a record that was previously submitted and accepted by the ASAP system, then the original record must be inactivated and a new record with a new event 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 O, no: if the assessment submitted was not coded as a swing bed clinical change assessment.

### X0600: Type of Assessment/Tracking (cont.)

- Code 1, yes: if the assessment submitted was coded as a swing bed clinical change assessment.
- Note that the code in X0600D must match the current value of A0310D on a modification request.
- If item A0310D was incorrect on a record that was previously submitted and accepted by the ASAP system, then the original record must be inactivated and a new record with a new event 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 a record that was previously submitted and accepted by the ASAP system, then the original record must be inactivated and a new record with a new event 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><b>A. Assessment Reference Date</b> - Complete only if X0600F = 99</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><b>B. Discharge Date</b> - Complete only if X0600F = 10, 11, or 12</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><b>C. Entry Date</b> - Complete only if X0600F = 01</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>

## X0700: Date on Existing Record to Be Modified/Inactivated (cont.)

### Coding Instructions for X0700A, Assessment Reference Date— 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—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—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.

<b>Correction Attestation Section</b> - Complete this section to explain and attest to the modification/inactivation request	
<b>X0800. Correction Number</b>	
Enter Number <input type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one

## X0800: Correction Attestation Section (cont.)

### Coding Instructions for X0800, Correction Number

- Enter the total number of correction requests to modify/inactivate the QIES ASAP record that is in error. Include the present modification/inactivation request in this number.
- For the first correction request (modification/inactivation) for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, X0800 is incremented by one. For values between one and nine, a leading zero should be used in the first box. For example, enter “01” into the two boxes for X0800.
- This item identifies the total number of correction requests following the original assessment or tracking record, including the present request. Note that Item X0800 is used to track successive correction requests in the QIES ASAP database.

## X0900: Reasons for Modification

The items in this section indicate the possible reasons for the modification request of the record in the QIES ASAP database. Check all that apply. These items should only be completed when A0050 = 2, indicating a modification request. If A0050 = 3, indicating an inactivation request, these items should be skipped.

<b>X0900. Reasons for Modification</b> - Complete only if Type of Record is to modify a record in error (A0050 = 2)	
↓ Check all that apply	
<input type="checkbox"/>	<b>A. Transcription error</b>
<input type="checkbox"/>	<b>B. Data entry error</b>
<input type="checkbox"/>	<b>C. Software product error</b>
<input type="checkbox"/>	<b>D. Item coding error</b>
<input type="checkbox"/>	<b>E. End of Therapy - Resumption (EOT-R) date</b>
<input type="checkbox"/>	<b>Z. Other error requiring modification</b> If "Other" checked, please specify: _____

### Coding Instructions for X0900A, Transcription Error

- Check the box if any errors in the prior QIES ASAP record were caused by data transcription errors.
- A transcription error includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the resident’s weight (e.g., recording “191” rather than the correct weight of “119” that appears in the medical record).

### Coding Instructions for X0900B, Data Entry Error

- Check the box if any errors in the prior QIES ASAP record were caused by data entry errors.
- A data entry error includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is an error where the response to the individual minutes of physical therapy O0400C1 is incorrectly encoded as “3000” minutes rather than the correct number of “0030” minutes.



## X0900: Reasons for Modification (cont.)

### Coding Instructions for X0900C, Software Product Error

- Check the box if any errors in the prior QIES ASAP record were caused by software product errors.
- A software product error includes any error created by the encoding software, such as storing an item in the wrong format (e.g., storing weight as “020” instead of “200”).

### Coding Instructions for X0900D, Item Coding Error

- Check the box if any errors in the prior QIES ASAP record were caused by item coding errors.
- An item coding error includes any error made coding an MDS item (for exceptions when certain items may not be modified see Chapter 5), such as choosing an incorrect code for the Activities of Daily Living (ADL) bed mobility self-performance item G0110A1 (e.g., choosing a code of “4” for a resident who requires limited assistance and should be coded as “2”). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

### Coding Instructions for X0900E, End of Therapy-Resumption (EOT-R) date

- Check the box if the End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not indicating a resumption of therapy date in item O0450B).
- Do not check this box if the modification is correcting the End of Therapy Resumption date (item O0450B) in a previous EOT-R assessment. In this case, the reason for modification is an item Coding Error and box X0900D should be checked.

### Coding Instructions for X0900Z, Other Error Requiring Modification

- Check the box if any errors in the prior QIES ASAP record were caused by other types of errors not included in Items X0900A through X0900E.
- Such an error includes any other type of error that causes a QIES ASAP record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the “other error” in the space provided with the item.

## X1050: Reasons for Inactivation

The items in this section indicate the possible reasons for the inactivation request. Check all that apply. These items should only be completed when A0050 = 3, indicating an inactivation request. If A0050 = 2, indicating a modification request, these items should be skipped.



## X1050: Reasons for Inactivation (cont.)

<b>X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)</b>	
↓ Check all that apply	
<input type="checkbox"/>	<b>A. Event did not occur</b>
<input type="checkbox"/>	<b>Z. Other error requiring inactivation</b> If "Other" checked, please specify: _____

### Coding Instructions for X1050A, Event Did Not Occur

- Check the box if the prior QIES ASAP record does not represent an event that actually occurred.
- An example would be a discharge record submitted for a resident, but there was no actual discharge. There was **no event**.

### Coding Instructions for X1050Z, Other Reason Requiring Inactivation

- Check the box if any errors in the prior QIES ASAP record were caused by other types of errors not included in Item X1050A.
- Facility staff should describe the “other error” in the space provided with the item.

## X1100: RN Assessment Coordinator Attestation of Completion

The items in this section identify the RN coordinator attesting to the correction request and the date of the attestation.

<b>X1100. RN Assessment Coordinator Attestation of Completion</b>	
<b>A. Attesting individual's first name:</b>	<input type="text"/>
<b>B. Attesting individual's last name:</b>	<input type="text"/>
<b>C. Attesting individual's title:</b>	<input type="text"/>
<b>D. Signature</b>	<input type="text"/>
<b>E. Attestation date</b>	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

### Coding Instructions for X1100A, Attesting Individual’s First Name

- Enter the first name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

### Coding Instructions for X1100B, Attesting Individual’s Last Name

- Enter the last name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

## X1100: RN Assessment Coordinator Attestation of Completion (cont.)

### Coding Instructions for X1100C, Attesting Individual's Title

- Enter the title of the facility staff member attesting to the completion of the corrected information on the line provided.

### Coding Instructions for X1100D, Signature

- The attesting individual must sign the correction request here, certifying the completion of the corrected information. The entire correction request should be completed and signed within 14 days of detecting an error in a QIES ASAP record. The correction request, including the signature of the attesting facility staff, must be kept with the modified or inactivated MDS record and retained in the resident's medical record or electronic medical record.

### Coding Instructions for X1100E, Attestation Date

- Enter the date the attesting facility staff member attested to the completion of the corrected information.
- Do not leave any boxes blank. For a one-digit month or day, place a zero in the first box. For example, January 2, 2011, should be entered as:

0	1	0	2	2	0	1	1
---	---	---	---	---	---	---	---

### Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion

- If an inactivation is being completed, Z0400 must also be completed.

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 A0130A = 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), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.

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 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 an event date (ARD, entry date, and discharge date) or type of assessment item (A0310) 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 event date or type of assessment, ensuring that the clinical information is accurate.

If the ARD or Type of Assessment is entered incorrectly, and the provider does not correct it within the encoding period, the provider must complete and submit a new MDS 3.0 record.

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.
1. The record has the wrong submission requirement in item A0410.
2. The record has the wrong facility ID in the control item 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 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 via certified mail through the United States Postal Service (USPS). The State Agency **must** approve the provider's request and submit a signed form to the QIES Help Desk via certified mail through the USPS.

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 correction is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect 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 (federal submission requirement) but there was actually 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 is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 (federal submission requirement) but the record is only 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 main facility ID (control item 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 FAC\_ID value when indicated.

## **APPENDIX B: STATE AGENCY AND CMS REGIONAL OFFICE RAI/MDS CONTACTS**

Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts is located on the following website: [https://www.cms.gov/NursingHomeQualityInits/20\\_MDS30RAIManual.asp#TopOfPage](https://www.cms.gov/NursingHomeQualityInits/20_MDS30RAIManual.asp#TopOfPage).

## Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600 (cont.)

In this example, one of the items in Column 2 (D0500E2) has a missing value (it is equal to dash) and the other 9 items have non-missing values. D0600 is computed as follows:

1. Compute the sum of the 9 items with non-missing values. This sum is 12.
2. Multiply this sum by 1.111 (See bullet 5 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 12. Therefore, the calculation is:  $12 \times 1.111 = 13.332$ .
3. Round the result to the nearest integer. In the example, 13.332 rounds to 13.
4. Place the rounded result in D0600.

### Example 3: Two Missing Values in Column 2

The following example shows how to score the resident interview when two of the items in Column 2 have missing values:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	-
D0500F2	0
D0500G2	1
D0500H2	-
D0500I2	2
D0500J2	1
<b>D0600</b>	<b>11</b>

In this example, two of the items in Column 2 have missing values: D0500E2 and D0500H2 are equal to dash. The other 8 items have non-missing values. D0600 is computed as follows:

1. Compute the sum of the 8 items with non-missing values. This sum is 9.
2. Multiply this sum by 1.250 (See bullet 6 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 9. Therefore, the calculation is:  $9 \times 1.250 = 11.250$ .
3. Round the result to the nearest integer. In the example, 11.250 rounds to 11.
4. Place the rounded result in D0600.