Centers for Medicare & Medicaid Services

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

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Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

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

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.[1]

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

1.2 Content of the RAI for Nursing Homes

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

[1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf.

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

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

1.3 Completion of the RAI

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

1.8 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.75(l)(2)(3) and 483.75(l)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-16 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a multi-facility corporation, may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities;

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of Resident or Sponsor Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

- The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.*
- Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into QIES ASAP. Therefore, these assessments cannot be submitted to the QIES ASAP system.
- Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to QIES ASAP.
  - For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, Discharge, etc., the facility may receive a sequencing warning message, but should still submit the required assessment.
  - **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments.
- *NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.

- **Adding Certified Beds:**
  - If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - Medicare and Medicaid residents should not be placed in a bed until the facility has been notified that the bed has been certified.
- **Change In Ownership:** There are two types of change in ownership transactions:
  - The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.

- Staff with QIES user IDs continue to use the same QIES user IDs.
- **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare PPS assessment was combined with the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.

— There are also situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:

- The beds are no longer certified.
- There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, provider number, etc.
- The previous owner would complete a Discharge assessment - return not anticipated, thus code A0310F=10, A2000=date of ownership change, and A2100=02 for those residents who will remain in the facility.
- The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F=01, A1600=date of ownership change, A1700=1 (admission), and A1800=02.
- Staff who worked for the previous owner **cannot** use their previous QIES user IDs to submit assessments for the new owner as this is now a new facility. They **must** register for new user IDs for the new facility.
- Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.

• **Resident Transfers:**

— When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.

— When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within 14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-day Medicare-required PPS assessment.

— The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.

— When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating

facility should contact their Regional Office, State agency, and Medicare contractor for guidance.

- When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their Regional Office, State agency, and Medicare contractor for guidance.
- More information on emergency preparedness can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.

2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
  - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The15-month requirement for maintenance of the RAI data must be adhered to.
  - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
  - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.

- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.

  Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident.
- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a hand written **or** a computer-generated copy be maintained in the clinical record. Either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

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

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

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

Assessment Combination refers to the use of one assessment to satisfy both OBRA and Medicare PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. Sections 2.11 and 2.12 provide more detailed information on combining Medicare and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.

Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the

ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59PM should be included for MDS 3.0 coding.

Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

Assessment Submission refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

Assessment Timing refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the Medicare-required PPS assessment timing schedule is provided in Section 2.8.

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

- Early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.13).

Assessment Transmission refers to the electronic transmission of submission files to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

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

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

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

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.
- Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed.

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

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

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

Interdisciplinary Team (IDT[1]) is a group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident.

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

- Nursing Home
  - **Comprehensive (NC[2]) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment).
  - **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly Assessment). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.
  - **PPS (NP) Item Set.** This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day). This item set is used for a standalone scheduled PPS assessment or a scheduled PPS assessment combined with a PPS OMRA assessment and/or a Discharge assessment.
  - **OMRA - Start of Therapy (NS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
  - **OMRA - Start of Therapy and Discharge (NSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **OMRA (NO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and a change of therapy OMRA assessment. The code used is "NO" since this was the only type of OMRA when the code was initially assigned.
  - **OMRA - Discharge (NOD) Item Subset.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **Discharge (ND) Item Set.** This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).
  - **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

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

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

- **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day) or a Swing Bed Clinical Change assessment. This item set is used for a scheduled PPS assessment that is standalone or in any combination with other swing bed assessments (Swing Bed Clinical Change assessment, OMRA assessment, and/or Discharge assessment). This item set is also used for a Swing Bed Clinical Change assessment that is standalone or in any combination with other swing bed assessments (scheduled PPS assessment, OMRA assessment, and/or Discharge assessment).
  - **OMRA – Start of Therapy (SS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
  - **OMRA – Start of Therapy and Discharge Assessment (SSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **OMRA (SO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and change of therapy OMRA assessment.
  - **OMRA - Discharge Assessment (SOD) Item Set.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **Discharge (SD) Item Set.** This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).
  - **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

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

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

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

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

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

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

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

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

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)
- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA
- Change of Therapy (COT) OMRA

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

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

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

Tracking records

- Entry
- Death in facility

Assessments

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

Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

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

2.6 Required OBRA Assessments for the MDS

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

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

Comprehensive Assessments

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:

- Admission Assessment
- Annual Assessment
- Significant Change in Status Assessment
- Significant Correction to Prior Comprehensive Assessment

Each of these assessment types will be discussed in detail in this section. They are **not** required for residents in swing bed facilities.

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD (Item A2300) is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the timeframe in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[3] In closing the record, the nursing home should note why the RAI was not completed.

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

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

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

01. Admission Assessment (A0310A=01)

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:

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

- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.
- A SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
  - The resident's condition is not expected to return to baseline within two weeks.
  - For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from a Significant Change in Status Assessment during the intervening period, the staff must complete a SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- A SCSA may **not** be completed prior to an OBRA Admission assessment.
- A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident is admitted on the hospice benefit (i.e. the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by a SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
- A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD

must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by a SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.
- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for a SCSA are met (determination date + 14 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When a SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (CAA(s) completion date + 7 calendar days).

Guidelines for Determining a Significant Change in a Resident's Status: Note: this is not an exhaustive list

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

Some Guidelines to Assist in Deciding If a Change Is Significant or Not:

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a

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

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

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

- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
- Overall deterioration of resident's condition.

- **Improvement in two or more of the following:**
  - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
  - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - Resident's decision making changes for the better;
  - Resident's incontinence pattern changes for the better;
  - Overall improvement of resident's condition.

Examples (SCSA):

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

2. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.

3. Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. A SCSA will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status Is Not Significant: Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a SCSA)

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

Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:
Note: this is not an exhaustive list

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

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

Examples (SCSA):

1. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia, diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.

2. Mrs. K came into the nursing home with identifiable problems and has steadily responded to treatment. Her condition has improved over time and has recently hit a plateau. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need

not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if Mrs. K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if she is not discharged, an assessment is required by the end of the allotted 14-day period.

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

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

- If a SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability ("mental retardation" in the regulation), or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.[5]
- PASRR is not a requirement of the resident assessment process, but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at http://www.cms.gov/.
- The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

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

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (ASAP) system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).
- Is the first Medicare-required assessment to be completed when the resident is first admitted for SNF Part A stay.
- Is the first Medicare-required assessment to be completed when the Part A resident is re-admitted to the facility following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5 -day PPS assessment as the resident is now beginning a Medicare Part A stay.

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 13 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 18 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

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

- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

04. Medicare-required 60-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 57 through 59 of the Part A SNF covered stay.
- ARD may be extended up to day 63 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 61 through 90 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

05. Medicare-required 90-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 87 through 89 of the Part A SNF covered stay.
- ARD may be extended up to day 93 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 91 through 100 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled Assessments Used for PPS

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

Start of Therapy (SOT) OMRA

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

- May be combined with scheduled PPS assessments.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example if the 5-day assessment is performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued for any reason (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided whether therapy was scheduled or not scheduled for that day. For example:
  - If the resident was discharged from all therapy services on Tuesday, day 1 is Wednesday.
  - If the resident was discharged from all therapy services on Friday, Day 1 would be Saturday.
  - If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday.
- For purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.
- May be combined with any scheduled PPS assessment. In such cases, the item set for the scheduled assessment should be used.
- The ARD for the End of Therapy OMRA may not precede the ARD of the first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example: if the 5-day assessment is completed on day 8 and an EOT is completed in that window, the ARD for the EOT should be Day 8 as well.

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

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

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

  In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met.

  Finally, in cases where the date used to code A2400C is equal to the date used to code A2000—that is, cases where the discharge from Medicare Part A is the same day as the discharge from the facility—and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the Discharge assessment under the rules outlined for such combination in this chapter.
- The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's initial RUG-IV therapy classification in a Medicare Part A SNF stay.
- Except as described below, a COT OMRA may only be completed when a resident is currently classified into a RUG-IV therapy group (regardless of whether or not the resident is classified into this group for payment), based on the resident's most recent assessment used for payment.
- The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions are met*:

  1. Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and
  2. No discontinuation of therapy services (planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group.

  Under these circumstances, completing the COT OMRA to reclassify the resident into a therapy group may be considered optional. Additionally, the COT OMRA which classifies a resident into a non-therapy group or the COT OMRA which reclassifies the resident into a therapy group may be combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual.

  — Example 1: Mr. T classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount of therapy provided to Mr. T. and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to the

lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. T. did not qualify for a therapy RUG group. The facility completes a COT OMRA for Mr. T, with an ARD set for Day 37, on which he qualifies for LB1. Mr. T's rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 44, the facility checks the amount of therapy provided to Mr. T during the previous 7 days and finds that Mr. T again qualifies for the RUG-IV therapy group RUA.

In example 1 above, because Mr. T had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment) and no discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group (Day 31, in this scenario) and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (Day 44, in this scenario), the facility may complete a COT OMRA with an ARD of Day 44 to reclassify Mr. T. back into the RUG-IV therapy group RUA.

— Example 2: Mr. A classified into the RUG group RVA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount of therapy provided to Mr. A during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for a Very-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. A did not qualify for any RUG-IV therapy group. The facility completes a COT OMRA for Mr. A, with an ARD set for Day 37, on which he qualifies for LB1. Mr. A's rehabilitation regimen is intended to continue from that point, but Mr. A does not receive therapy on Days 36, 37 and 38. On Day 44, the facility checks the amount of therapy provided to Mr. A during the previous 7 days and finds that Mr. A again qualifies for the RUG-IV therapy group RVA.

In example 2 above, while Mr. A had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment), a discontinuation of therapy services occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (i.e., the discontinuation due to Mr. A missing therapy on Days 36-38). Therefore, the facility may not complete a COT OMRA with an ARD of Day 44 to reclassify Mr. A back into the RUG-IV therapy group RVA.

- A COT OMRA may be used to reclassify a resident into a RUG-IV therapy group only when the resident was classified into a RUG-IV non-therapy by a previous COT OMRA (which may have been combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual).

  — For example: Mr. E classified into the RUG group RUA on his 14-day assessment with an ARD set for Day 15 of his stay. No unscheduled assessments were required or completed between Mr. E's 14-day assessment and his 30-day assessment. On Day

29, the facility checked the amount of therapy provided to Mr. E during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. E did not qualify for any RUG-IV therapy group. The facility completes a 30-day assessment for Mr. E, with an ARD set for Day 29, on which he qualifies for LB1, but opts not to combine this 30-day assessment with a COT OMRA (as permitted under the COT rules outlined in Section 2.9 of the MDS 3.0 manual). Mr. E.'s rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 36, the facility checks the amount of therapy provided to Mr. E during the previous 7 days and finds that Mr. E again qualifies for the RUG-IV therapy group RUA.

In the scenario above, although Mr. E had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (e.g., the 14-day assessment), the assessment which classified Mr. E into a RUG-IV non-therapy group was not a COT OMRA. Therefore, the facility may not complete a COT OMRA with an ARD of Day 36 to reclassify Mr. E back into the RUG-IV therapy group RUA.

If a resident is classified into a non-therapy RUG on a COT OMRA and the facility subsequently decides to discontinue therapy services for that resident, an EOT OMRA is not required for this resident.

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

Significant Change in Status Assessment (SCSA)

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

For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.

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

Swing Bed Clinical Change Assessment

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

Significant Correction to Prior Comprehensive Assessment

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

Coding Tips and Special Populations

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

unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).

2.10 Combining Medicare Scheduled and Unscheduled Assessments

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

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

DEFINITION

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

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in this chapter and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software the coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that

the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15).

In cases when a facility fails to combine a scheduled and unscheduled PPS assessment as required by the combined assessment policy, the payment is controlled by the unscheduled assessment. For example: if the ARD of an EOT OMRA is set for Day 14 and the ARD of a 14-day assessment is set for Day 15, this would violate the combined assessment policy. Consequently, the EOT OMRA would control the payment. The EOT would begin payment on Day 12, and continue paying into the 14-day payment window until the next scheduled or unscheduled assessment used for payment.

PPS Scheduled Assessment and Start of Therapy OMRA

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

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 1
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and End of Therapy OMRA

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

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 2
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 3
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Change of Therapy OMRA

- The ARD must be set within the window for the scheduled assessment and on day 7 of the COT observation period. If both ARD requirements are not met, the assessments may not be combined.
- Must complete the scheduled PPS assessment item set.
- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current standard payment period and the next payment period appropriate to the given scheduled assessment, assuming no intervening assessments. For example:
  - Based on her 14-day assessment, Mrs. T is currently classified into group RVB. Based on the ARD set for the 14-day assessment, a change of therapy evaluation for Mrs. T is necessary on Day 28. The change of therapy evaluation reveals that the therapy services Mrs. T received during that COT observation period were only sufficient to qualify Mrs. T for RHB. Therefore, a COT OMRA is required. Since the facility has not yet completed a 30-day assessment for Mrs. T, the facility must combine the 30-day assessment with the required COT OMRA. The combined assessment confirms Mrs. T's appropriate classification into RHB. The payment for the revised RUG classification will begin on Day 22 and, assuming no intervening assessments, will continue until Day 60.

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the

patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.

- If the ARD for the Swing Bed Clinical Change Assessment falls within the ARD (including grace days) of a PPS scheduled assessment that has not been completed yet, the assessments MUST be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99 (only value allowed for Swing Beds)
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 0
  A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

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

  A0310A = 99
  A0310B = 07
  A0310C = 1
  A0310D = 1

Swing Bed Clinical Change Assessment and End of Therapy OMRA

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

  A0310A = 99
  A0310B = 07
  A0310C = 2
  A0310D = 1

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

ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of

therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 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[7]

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

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

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.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly/ PPS* Item Sets	Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities
Stand-alone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day)	• Entry Tracking Record • Discharge assessments • Death in Facility Tracking Record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • Change of Therapy OMRA • OMRA • OMRA and Discharge
Combined Assessment Types	• OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required • Annual and any OMRA • SCSA and any Medicare-required • SCSA and any OMRA • SCPA and any Medicare-required • SCPA and any OMRA • Any OBRA comprehensive and any Discharge	• Quarterly and any Medicare-scheduled • Quarterly and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Discharge and any Medicare-required • Quarterly and any Discharge • Significant Correction to Prior Quarterly and any Discharge • Any Medicare-required and any Discharge	N/A

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

3.2 Becoming Familiar with the MDS-recommended Approach

1. **First, reading the Manual is essential.**
   - The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the primary source of information for completing an MDS assessment.
   - Notice how the manual is organized.
   - Using it correctly will increase the accuracy of your assessments.
   - While it is important to understand and apply the information in Chapter 3, facilities should also become familiar with Chapters 1, 2, 4, 5 and 6. These Chapters provide the framework and supporting information for data collected on the item set as well as the process for further assessment and care planning.
   - It is important to understand the entire process of the RAI in conjunction with the intent and rationale for coding items on the MDS 3.0 item set.
   - Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
   - If you require further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
2. **Second, review the MDS item sets.**
   - Notice how sections are organized and where information should be recorded.
   - Work through one section at a time.
   - Examine item definitions and response categories as provided on the item sets, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.
   - There are several item sets, and depending on which item set you are completing, the skip patterns and items active for each item set may be different.
3. **Complete a thorough review of Chapter 3.**
   - Review procedural instructions, time frames, and general coding conventions.
   - Become familiar with the intent of each item, rationale and steps for assessment.
   - Become familiar with the item itself with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
   - Do the definitions and instructions differ from current practice at your facility?
   - Do your facility processes require updating to comply with MDS requirements?
   - Complete a test MDS assessment for a resident at your facility. Enter the appropriate codes on the MDS.

- Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.
- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.
- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete your initial case differently?
- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

4. **Use of information in this chapter:**
   - Keep this chapter with you during the assessment process.
   - Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

3.3 Coding Conventions

There are several standard conventions to be used when completing the MDS assessment, as follows.

- The standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.
- **With the exception of certain items (e.g., some items in Sections K and O), the look-back period generally does not include hospital stay.**
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, directs the assessor to skip to item G0110, **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes.** The intervening items from B0200-F0800 would not be coded (i.e. left blank). If B0100 was recorded as **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200).
- Use a check mark for boxes where the instructions state to "check all that apply," if specified condition is met; otherwise these boxes remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).

A0100: Facility Provider Numbers

A0100. Facility Provider Numbers	
	A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐ B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐ C. State Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Allows the identification of the facility submitting the assessment.

Coding Instructions

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

DEFINITIONS

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

CMS CERTIFICATION NUMBER (CCN)
Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE PROVIDER NUMBER
Medicaid Provider Number established by a state.

A0200: Type of Provider

A0200. Type of Provider	
Enter Code ☐	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed

Item Rationale

- Allows designation of type of provider.

Coding Instructions

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

DEFINITION

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

A2400: Medicare Stay (cont.)

Item Rationale

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

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

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

Coding Instructions for A2400B, Start of Most Recent Medicare Stay

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

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

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

DEFINITIONS

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

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

CURRENT MEDICARE STAY
NEW ADMISSION: Day 1 of Medicare Part A stay.
READMISSION: Day 1 of Medicare Part A coverage after readmission following a discharge.

A2400: Medicare Stay (cont.)

Coding Tips and Special Populations

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

Examples

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

    - A2000 = 11-24-2010
    - A2400A = 1
    - A2400B = 10-14-2010
    - A2400C = 11-23-2010

C1300: Signs and Symptoms of Delirium

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

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Item Rationale

Health-related Quality of Life

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

Planning for Care

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

F0500: Interview for Activity Preferences (cont.)

Item Rationale

Health-related Quality of Life

- Activities are a way for individuals to establish meaning in their lives, and the need for enjoyable activities and pastimes does not change on admission to a nursing home.
- A lack of opportunity to engage in meaningful and enjoyable activities can result in boredom, depression, and behavior disturbances.
- Individuals vary in the activities they prefer, reflecting unique personalities, past interests, perceived environmental constraints, religious and cultural background, and changing physical and mental abilities**.**

Planning for Care

- These questions will be useful for designing individualized care plans that facilitate residents' participation in activities they find meaningful.
- Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing informal dialogue between the care provider and resident.
- As with daily routines, responses may provide insights into perceived functional, emotional, and sensory support needs.

Coding Instructions

- See Coding Instructions on page F-4.
  Coding approach is identical to that for daily preferences.

Coding Tips and Special Populations

- See Coding Tips on page F-5.
  Coding tips include those for daily preferences.
- Include Braille and or audio recorded material when coding items in F0500A.

Interviewing Tips and Techniques

- See Interview Tips and Techniques on page F-5.
  Coding tips and techniques are identical to those for daily preferences.

DEFINITIONS

READ
Script, Braille, or audio recorded written material.

NEWS
News about local, state, national, or international current events.

KEEP UP WITH THE NEWS
Stay informed by reading, watching, or listening.

NEWSPAPERS AND MAGAZINES
Any type, such as journalistic, professional, and trade publications in script, Braille, or audio recorded format.

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

Examples for G0110J, Personal Hygiene

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

   Coding: G0110J1 would be coded 1, supervision.
   G0110J2 would be coded 1, setup help only.

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

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

   Coding: G0110J1 would be coded 3, extensive assistance.
   G0110J2 would be coded 2, one person physical assist.

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

Scenario Examples

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

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

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, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure 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 and on the left.)
- If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050855.hcsp?dDocName=bok1_050855.

Cancer

- I0100, cancer (with or without metastasis)

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

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])
- I0500, deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)
- I0600, heart failure (e.g., congestive heart failure [CHF], pulmonary edema)
- I0700, hypertension
- I0800, orthostatic hypotension
- I0900, peripheral vascular disease or peripheral arterial disease

Gastrointestinal

- I1100, cirrhosis
- I1200, gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)
- I1300, ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

- I1400, benign prostatic hyperplasia (BPH)
- I1500, renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- I1550, neurogenic bladder
- I1650, obstructive uropathy

Infections

- I1700, multidrug resistant organism (MDRO)
- I2000, pneumonia
- I2100, septicemia
- I2200, tuberculosis
- I2300, urinary tract infection (UTI) (last 30 days)
- I2400, viral hepatitis (e.g., hepatitis A, B, C, D, and E)
- I2500, wound infection (other than foot)

Metabolic

- I2900, diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)

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

- I3100, hyponatremia
- I3200, hyperkalemia
- I3300, hyperlipidemia (e.g., hypercholesterolemia)
- I3400, thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Musculoskeletal

- I3700, arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])
- I3800, osteoporosis
- I3900, hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)
- I4000, other fracture

Neurological

- I4200, Alzheimer's disease
- I4300, aphasia
- I4400, cerebral palsy
- I4500, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- I4800, dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- I4900, hemiplegia or hemiparesis
- I5000, paraplegia
- I5100, quadriplegia
- I5200, multiple sclerosis (MS)
- I5250, Huntington's disease
- I5300, Parkinson's disease
- I5350, Tourette's syndrome
- I5400, seizure disorder or epilepsy
- I5500, traumatic brain injury (TBI)

Nutritional

- I5600, malnutrition (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- I5700, anxiety disorder

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

- I5800, depression (other than bipolar)
- I5900, manic depression (bipolar disease)
- I5950, psychotic disorder (other than schizophrenia)
- I6000, schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- I6100, post-traumatic stress disorder (PTSD)

Pulmonary

- I6200, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- I6300, respiratory failure

Vision

- I6500, cataracts, glaucoma, or macular degeneration

None of Above

- I7900, none of the above active diagnoses within the past 7 days

Other

- I8000, additional active diagnoses

Coding Tips

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
  - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
  - For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.
- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
  - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

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

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.
- Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

- **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.
- **Item I2300 Urinary tract infection (UTI):**
  - The UTI has a look-back period of 30 days for active disease instead of 7 days.
  - **Code only if all the following are met:**
    1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,
    2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),
    3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and
    4. Current medication or treatment for a UTI in the last 30 days.

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

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTIs and many other issues related to infections in LTC.
http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html

Examples of Active Disease

1. A resident is prescribed hydrochlorothiazide for hypertension. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.

   Coding: **Hypertension** item (I0700), would be checked.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for a resident with atrial fibrillation to decrease the risk of embolic stroke. The resident requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

   Coding: **Atrial fibrillation** item (I0300), would be checked.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

3. A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

   Coding: **Arthritis** item (I3700), would be checked.
   Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

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

4. The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. The resident is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.

   Coding: **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be checked.

   Rationale: The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

1. The admission history states that the resident had pneumonia 2 months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look back period.

   Coding: **Pneumonia** item (I2000), would not be checked**.**

   Rationale: The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

   Coding: **CAD** item (I0400), would not be checked**.**

   Rationale: The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.

   Coding: **Hip Fracture** item (I3900), would not be checked**.**

   Rationale: Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

K0510: Nutritional Approaches (cont.)

- IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

- **The following items are NOT to be coded in K0510A:**
  - IV Medications—**Code these when appropriate in O0100H, IV Medications.**
  - IV fluids used to reconstitute and/or dilute medications for IV administration.
  - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
  - IV fluids administered solely as flushes.
  - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Enteral feeding formulas:
  - Should not be coded as a mechanically altered diet.
  - Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

Coding Tips for K0510D

- Therapeutic diets are not defined by the content of what is provided or when it is served, but ***why*** the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***part*** of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B columns 2 and 3 would be coded **2, 501cc/day or more**.

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc
6,300 cc divided by 7 days = 900 cc/day
900 cc is greater than 500 cc, therefore **code 2**, **501 cc/day or more** is correct.

2. **Calculation for Average Daily Fluid Intake**

Mrs. G. received 1 liter of IV fluids in the hospital on the Tuesday prior to her admission to the nursing home on Saturday afternoon. She received no other intake via IV or tube feeding during the last 7 days.

IV Fluid Intake	
Sun.	0 cc
Mon.	0 cc
Tues.	1,000 cc
Wed.	0 cc
Thurs.	0 cc
Fri.	0 cc
Sat.	0 cc
Total	1,000 cc

Coding: K0710B column 1 would be coded **1, 500 cc/day or less**.

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc
1000 cc divided by 7 days = 142.9 cc/day
142.9 cc is less than 500 cc, therefore **code 1**, **500 cc/day or less** is correct.

3. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

While in the Hospital		While in the Nursing Home	
Mon.	400 cc	Fri.	510 cc
Tues.	520 cc	Sat.	520 cc
Wed.	500 cc	Sun.	490 cc
Thurs.	480 cc		
Total	1,900 cc	Total	1,520 cc

M0210: Unhealed Pressure Ulcer(s) (cont.)

Coding Instructions

Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days.

- Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period.

  Then skip Items M0300–M0800.
- Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).

Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a resident had a pressure ulcer that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment, **code 0**.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg.
3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg.
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

M0300A: Number of Stage 1 Pressure Ulcers (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code here.
3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature (warmth or coolness); tissue consistency (firm or boggy).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes.

DEFINITIONS

STAGE 1 PRESSURE ULCER
An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

NON-BLANCHABLE
Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

Coding Instructions for M0300A

- Enter the number of Stage 1 pressure ulcers that are currently present.
- Enter 0 if no Stage 1 pressure ulcers are present.

M1200: Skin and Ulcer Treatments (cont.)

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-hour turning/repositioning program that is organized, planned, documented, monitored and evaluated based on an individualized assessment of her needs. The physician documents

M1200: Skin and Ulcer Treatments (cont.)

that after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, dietician's nutritional assessment and laboratory results, that the resident has protein-calorie undernutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients and micronutrients. All mattresses in the nursing home are pressure reducing (redistribution) mattresses.

Coding: Check items M1200A, M1200B, M1200C, M1200D, and M1200E.

Rationale: Interventions include pressure reducing (redistribution) pad in the wheelchair (M1200A) and pressure reducing (redistribution) mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the past 7 days the resident has had a three layer compression bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure redistributing mattress and pad for the wheelchair.

   Coding: Check items M1200A, M1200B, and M1200G.

   Rationale: Treatments include pressure reducing (redistribution) mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression bandaging system (M1200G).

3. Mrs. S. has a diagnosis of right-sided hemiplegia from a previous stroke. As part of her assessment, it was noted that while in bed Mrs. S. is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every 3 hours while in bed. When she is in her wheelchair, it is difficult for her to offload the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when she is sitting, and therefore, Mrs. S. is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions.

   Coding: Check M1200C.

   Rationale: Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident's unique needs.

N0410: Medications Received (cont.)

- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
  - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at http://www.cms.gov/Manuals/IOM/list.asp]), which may
    - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
    - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.

Example

1. The Medication Administration Record for Mrs. P. reflects the following:
   - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
   - Lorazepam 1 mg PO QAM: Received every day.
   - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

   Coding: Medications in N0410, would be coded as follows: A. Antipsychotic = 3, resperidone is an antipsychotic medication, B. Antianxiety = 7, lorazepam is an antianxiety medication, and D. Hypnotic = 2, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

N0410: Medications Received (cont.)

Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition** (**DSM-5**) (or subsequent editions) (http://www.psychiatry.org/practice/dsm), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (http://www.cms.gov/Manuals/IOM/list.asp)].

Additional information on medications can be found in:

The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/

The National Drug Code Directory,
http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100C, Oxygen therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

- **O0100F, Ventilator or respirator**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

- **O0100G, BiPAP/CPAP**

Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask.

- **O0100H, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:

- The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/
- The National Drug Code Directory, http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

O0300: Pneumococcal Vaccine (cont.)

- Individuals living in environments or social settings (e.g., nursing homes and other long-term care facilities) with an identified increased risk of invasive pneumococcal disease or its complications should be considered for vaccination populations.
- If vaccination status is unknown or the resident/family is uncertain whether or not the vaccine was received, the resident should be vaccinated.

- Pneumococcal vaccine is given once in a lifetime, with certain exceptions. Revaccination is recommended for the following:
  - Individuals 2 years of age or older who are at highest risk for serious pneumococcal infection and for those who are likely to have a rapid decline in pneumococcal antibody levels. Those at highest risk include individuals with asplenia (functional or anatomic), sickle-cell disease, HIV infections or AIDS, cancer, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression (e.g., organ or bone marrow transplant, medication regimens that lower immunity (such as chemotherapy or long-term steroids).
  - Persons 65 years or older should be administered a second dose of pneumococcal vaccine if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.
- If the resident has had a severe allergic reaction to vaccine components or following a prior dose of the vaccine, they should not be vaccinated.

  If the resident has a moderate to severe acute illness, he or she should not be vaccinated until his or her condition improves. However, someone with a minor illness (e.g., a cold) should be vaccinated since minor illnesses are not a contraindication to receiving the vaccine.

[Centers for Disease Control and Prevention. (2012, May). *The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (12th ed.).* Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/index.html]

Note: Please refer to the algorithm below for pneumococcal vaccine administration ONLY.

O0400: Therapies (cont.)

Coding values for Mr. T's 30-day assessment are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

General Coding Example:

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

Speech-language pathology services that were provided over the 7-day look-back period:

- Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

  Coding:
  O0400A1 would be coded 190; O0400A2 would be coded 70; O0400A3 would be coded 75; O0400A4 would be coded 5; O0400A5 would be coded 10062011; and O0400A6 would be coded with dashes.

  Rationale:
  Individual minutes totaled 190 over the 7-day look-back period [(30 × 5) + (20 × 2) = 190]; concurrent minutes totaled 70 over the 7-day look-back period (35 × 2 = 70); and group minutes totaled 75 over the 7-day look-back period (25 × 3 = 75). Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.

O0400: Therapies (cont.)

- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.
  Coding:
  O0400B1 would be coded 113, O0400B2 would be coded 0, O0400B3 would be coded 80, O0400B3A would be coded 60, O0400B4 would be coded 5, O0400B5 would be coded 10092011, and O0400B6 would be coded with dashes.
  Rationale:
  Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 2) + 23 + 18 + 12 = 113]; concurrent minutes totaled 0 over the 7-day look-back period (0 × 0 = 0); and group minutes totaled 80 over the 7-day look-back period (20 × 4 = 80). Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.
  Coding:
  O0400C1 would be coded 287, O0400C2 would be coded 100, O0400C3 would be coded 0, O0400C3A would be coded 60, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes.
  Rationale:
  Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 0 = 0). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

- Respiratory therapy services; Sunday-Thursday for 10 minutes each day.
  Coding:
  O0400D1 would be coded 50, O0400D2 would be coded 0.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code ☐	A. Resident participated in assessment 0. No 1. Yes
Enter Code ☐	B. Family or significant other participated in assessment 0. No 1. Yes 9. Resident has no family or significant other
Enter Code ☐	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process and in developing their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved-except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.15 Quality of Life).

DEFINITION

RESIDENT'S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspective during assessment.

Q0600: Referral (cont.)

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Steps for Assessment: Interview Instructions

1. If Item Q0400A is coded 1, yes, then complete this item.
2. If Item Q0490B is coded 1, yes, then complete this item,
3. If Item Q0500B is coded 1, yes, then complete this item.

DEFINITION

DESIGNATED LOCAL CONTACT AGENCY
Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

Coding Instructions

- Code 0, No - referral not needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family, etc. responded no to Q0500B.
- Code 1, No - referral is or may be needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.
- Code 2, Yes - referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

  Section Q Point of Contact list for Local Contact Agencies:
  http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf

Q0600: Referral (cont.)

Coding Tips

- State Medicaid Agencies have designated Local Contact Agencies and a State point of contact (POC) to coordinate efforts to implement Section Q and designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.
- Several resources are available at the Return to Community web site at: http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/community-living-initiative.html.
  - The State-by-State list of Local Contact Agencies and POC Section Q Coordinator Information
  - MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
  - The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q.
- Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident's return to their community. The nursing home and local agency staff members should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
- Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.
- The local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transitions back to the community is possible.
- Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.
- When Q0600 is answered 1, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0600A, Federal OBRA Reason for Assessment

- Fill in the boxes with the Federal OBRA reason for assessment/tracking code exactly as submitted for item A0310A "Federal OBRA Reason for Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the Federal OBRA reason for assessment/tracking code in X0600A must match the current value of A0310A on a modification request.
- If item A0310A was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600B, PPS Assessment

- Fill in the boxes with the PPS assessment type code exactly as submitted for item A0310B "PPS Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the PPS assessment code in X0600B must match the current value of A0310B on a modification request.
- If item A0310B was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600C, PPS Other Medicare Required Assessment—OMRA

- Fill in the boxes with the PPS OMRA code exactly as submitted for item A0310C "PPS—OMRA" on the prior erroneous record to be modified/inactivated.
- Note that the PPS OMRA code in X0600C must match the current value of A0310C on a modification request.
- If item A0310C was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)

- Enter the code exactly as submitted for item A0310D "Is this a Swing Bed clinical change assessment?" on the prior erroneous record to be modified/inactivated.
- Code 0, no: if the assessment submitted was not coded as a swing bed clinical change assessment.
- Code 1, yes: if the assessment submitted was coded as a swing bed clinical change assessment.

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)

- Note that the code in X0600D must match the current value of A0310D on a modification request.
- If item A0310D was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600F, Entry/discharge reporting

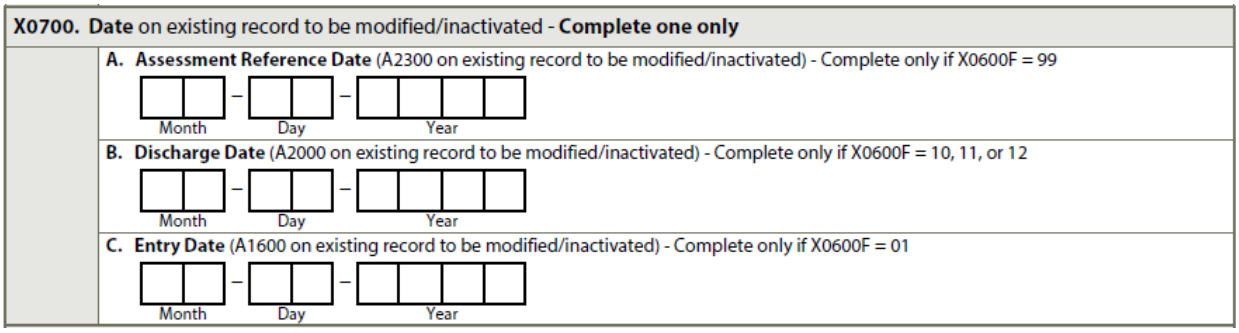
- Enter the number corresponding to the entry/discharge code exactly as submitted for item A0310F "Entry/discharge reporting" on the prior erroneous record to be modified/inactivated.

  01. Entry tracking record
  10. Discharge assessment-return not anticipated
  11. Discharge assessment-return anticipated
  12. Death in facility tracking record
  99. None of the above

- Note that the Entry/discharge code in X0600F must match the current value of A0310F on a modification request.
- If item A0310F was incorrect on an assessment that was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

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.



16. Pressure Ulcer

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Pressure Ulcer CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) OR

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

   H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

   K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

   M0150 = 1

6. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

   M0300A > 0 AND M0300A <= 9

Once communication is established with the QIES ASAP system, the provider can access the Welcome to the CMS QIES Systems for Providers page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 web site at https://www.qtso.com/mds30.html.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
  - For all non-Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
  - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).
  - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).
  - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively.
  - For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000 for a Death in Facility tracking record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of State RAI Coordinators.)

- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:
  - For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
  - For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).
  - For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- **Submission Format:** For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Each MDS record must be a separate file in a required XML format. The submission file is a compressed ZIP file that may contain multiple XML files. See the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site for details concerning file and record formats, XML structure, and ZIP files.
- **Transmitting Data:** Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted.
  - **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
  - **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Submission Time Frame for MDS Records

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Admission Assessment	01	All values	10, 11, 99	V0200C2	V0200C2 + 14
Annual Assessment	03	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Change in Status Assessment	04	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Correction to Prior Comprehensive Assessment	05	All values	10, 11, 99	V0200C2	V0200C2 + 14

(continued)

Submission Time Frame for MDS Records (continued)

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Quarterly Review Assessment	02	All values	10, 11, 99	Z0500B	Z0500B +14
Sign. Correction Prior Quarterly Assessment	06	All values	10, 11, 99	Z0500B	Z0500B + 14
PPS Assessment	99	01 through 07	10, 11, 99	Z0500B	Z0500B + 14
Discharge Assessment	All values	All values	10 or 11	Z0500B	Z0500B + 14
Death in Facility Tracking	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	1	A1600	A1600 + 14
Correction Request (Modification or Inactivation)	N/A	N/A	N/A	X1100E	X1100E + 14

Table Legend:

Item	Description
V0200C2	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the CAA Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
Z0500B	MDS Assessment Completion Date: Date of the RN assessment coordinator's signature, indicating that the MDS assessment is complete.
A2000	Date of discharge or death
A1600	Date of entry
X1100E	Date of the RN coordinator's signature on the Correction Request (Section X) certifying completion of the correction request information and the corrected assessment or tracking information.

- **Assessment Schedule:** An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 2 for details.

5.3 Validation Edits

The QIES ASAP system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.

Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation

information includes the file submission identification number (ID), the date and time the file was received for processing as well as the file name.

Validation and Editing Process. Each time a user accesses the QIES ASAP system and transmits an MDS file, the QIES ASAP system performs three types of validation:

1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.

2. **Fatal Record Errors.** If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:

   - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).
   - Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600).

     Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening Discharge assessment (A0310F = 10 or 11). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

Storage to the QIES ASAP System. If there are any Fatal Record Errors, the record will be rejected and not stored in the QIES ASAP system. If there are no Fatal Record Errors, the record is loaded into the QIES ASAP system, even if the record has Non-Fatal Errors (Warnings).

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide* on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 web site.

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS "are required to submit the resident assessment data described at §483.20…. in the manner necessary to administer the payment rate methodology described in §413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments in specified windows near the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. The first three positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident, and the last two positions are an Assessment Indicator (AI) code indicating which type of assessment was completed. Standard "grouper" logic and software for RUG-IV and the AI code are provided by CMS on the MDS 3.0 web site.

The standard grouper uses MDS 3.0 items to determine both the RUG-IV group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the RUG-IV group and AI code. Detailed logic for determining the RUG-IV group and AI code is provided in Chapter 6.

The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes.

1. The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The RUG version code in Item Z0100B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare Part A HIPPS code.
2. The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS. An example when the non-therapy HIPPS is to be billed is when the resident has been receiving rehabilitation therapy (physical therapy, occupational therapy, and/or speech-language pathology services), all rehabilitation therapy ends, and the resident continues on Part A (see Chapter 6 for details, including other instances when this HIPPS code is used for billing purposes). The RUG version code in Item Z0150B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare non-therapy Part A HIPPS code.

There is also a Medicare Short Stay indicator (Item Z0100C) on the MDS. For a qualifying Medicare short stay, the RUG-IV grouper uses alternative rehabilitation classification logic when there has been insufficient time to establish a full rehabilitation regime. The standard grouper uses MDS 3.0 items to determine the Medicare short stay indicator. See Chapter 6 for details.

Both HIPPS codes (Z0100A and Z0150A), the RUG version codes (Z0100B and Z0150B), and the Medicare Short Stay indicator (Z0100C) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B= 01, 02, 03, 04, 05, or 07). All of these values are validated by the QIES ASAP system. The Final Validation Report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare-Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP system calculated value for the Medicare Part A HIPPS code (Z0100A) is not a group that begins with 'R', i.e., Rehabilitation Plus Extensive Services or Rehabilitation group.

The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in the QIES ASAP system. The claim must include the correct HIPPS code for the assessment. If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3616a).

5.5 MDS Correction Policy

Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay—the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Corrections made to the electronic record after QIES ASAP acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in the QIES ASAP system:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the QIES ASAP system.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip

pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.

- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures **must** be implemented by the provider to assure that the QIES ASAP system information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.

5.6 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the QIES ASAP System

If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the QIES ASAP system. The paper copy should be corrected according to standard procedures detailed below.

Errors Identified During the Encoding Period

Facilities have up to 7 days to encode (enter into the software) and edit an MDS assessment after the MDS has been completed. Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a provider may correct item responses to meet required edits.

Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as was used for the original item completion (i.e., the same ARD (A2300) and look-back period). Both the electronic and paper copies of the MDS must be corrected.

Errors Identified After the Encoding Period

Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record in error is an OBRA comprehensive or Quarterly assessment record (i.e., Item A0310A = 01 through 06).

Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**.

If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.

The correction process is more complicated for nursing home OBRA comprehensive or Quarterly assessments with ***any significant errors*** identified after the end of the 7-day encoding and editing period but before the records have been accepted into the QIES ASAP system. First, the nursing home must correct the original OBRA comprehensive or Quarterly assessment to reflect the resident's actual status as of the ARD for that original assessment and submit the record. Second, to insure an up-to-date view of the resident's status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident's status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.

In summary, the nursing home must take the following actions for an OBRA comprehensive or Quarterly assessment that has ***not*** been submitted to the QIES ASAP system when it contains significant errors:

- Correct the errors in the original OBRA comprehensive or Quarterly assessment.
- Submit the corrected assessment.
- Perform a ***new*** assessment – a Significant Change in Status Assessment or a Significant Correction to Prior Assessment and update the care plan as necessary.

If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 through 07) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare-only and Discharge assessments.

5.7 Correcting Errors in MDS Records That Have Been Accepted Into the QIES ASAP System

Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within 3 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

Errors identified in QIES ASAP system records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. The following two processes have been established to correct MDS records (assessments, Entry tracking records or Death in Facility tracking records) that have been accepted into the QIES ASAP system:

- Modification
- Inactivation

A Modification request moves the inaccurate record into history in the QIES ASAP system and replaces it with the corrected record as the active record. An Inactivation request also moves the inaccurate record into history in the QIES ASAP system, but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0.

The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable location of the erroneous MDS record previously submitted and accepted into the QIES ASAP system. Section X items are defined in the MDS 3.0 Data Submission Specifications posted on the CMS MDS 3.0 web site.

When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. In addition, the facility would keep a hard copy of the Correction Request items (Section X) with an inactivated record. For details on electronic records, see Chapter 2, Section 2.4.

Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include:

- Target Date
  - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
  - Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),
  - Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)

*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013). This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.
- An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done. Consider the following examples:

- A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.

- An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

- An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
  - Unit Certification or Licensure Designation (Item A0410),
  - State-assigned facility submission ID (FAC_ID),
  - Test record submitted as a production record.

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in Section 5.8) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in a nursing home OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06) in the QIES ASAP system, then the nursing home must determine if there are any significant errors. If the ***only errors are minor errors***, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any ***significant error*** is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if correction of the MDS item(s) revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Discharge Date (Item A2000) on a Discharge assessment record (Item A0310F = 10, 11) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that the Type of Provider is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct Type of Provider, ensuring that the clinical information is accurate.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the

look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system cannot be corrected with an automated Modification or Inactivation request. These errors are:

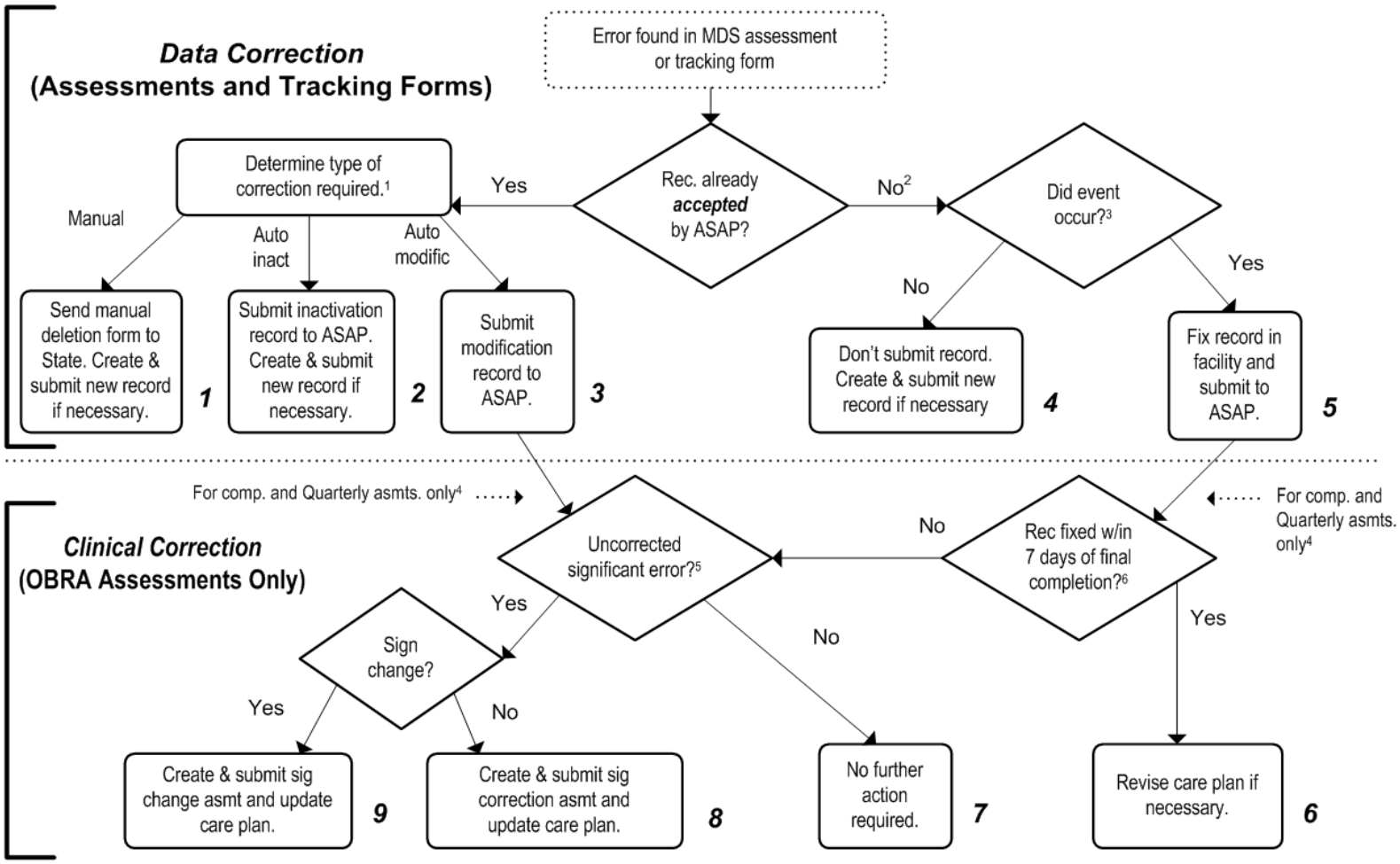
1. The record is a test record inadvertently submitted as production.
2. The record has the wrong unit certification or licensure designation in Item A0410.
3. The record has the wrong state code or facility ID in the control Items STATE_CD or FAC_ID.

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the appropriate MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility must submit the completed form to the State Agency. Completed forms with privacy information must be sent via certified mail through the United States Postal Service (USPS). The State Agency will review the request for completion and accuracy. After approving the provider's request, the state must sign the form and send it to the QTSO Help Desk. Completed forms with privacy data must be sent via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be evaluated and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual deletion is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect unit certification or licensure designation in Item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (Unit is Medicare and/or Medicaid certified) when actually the unit is neither Medicare nor Medicaid certified and MDS data is not required by the State (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual deletion is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 indicating that the Unit is Medicare and/or Medicaid certified but actually the unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.

If a QIES ASAP system record has the wrong state code or facility ID (control item STATE_CD, FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct STATE_CD and FAC_ID value.



[1] Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an incorrect Unit Certification or Licensure Designation (A0410), for example sent in as Unit is Medicare and/or Medicaid certified (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 = 2). Otherwise, automated inactivation or modification required: (a) if event did not occur (see note #3 below), submit automated inactivation, (b) if event occurred, submit automated modification.

[2] Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP.

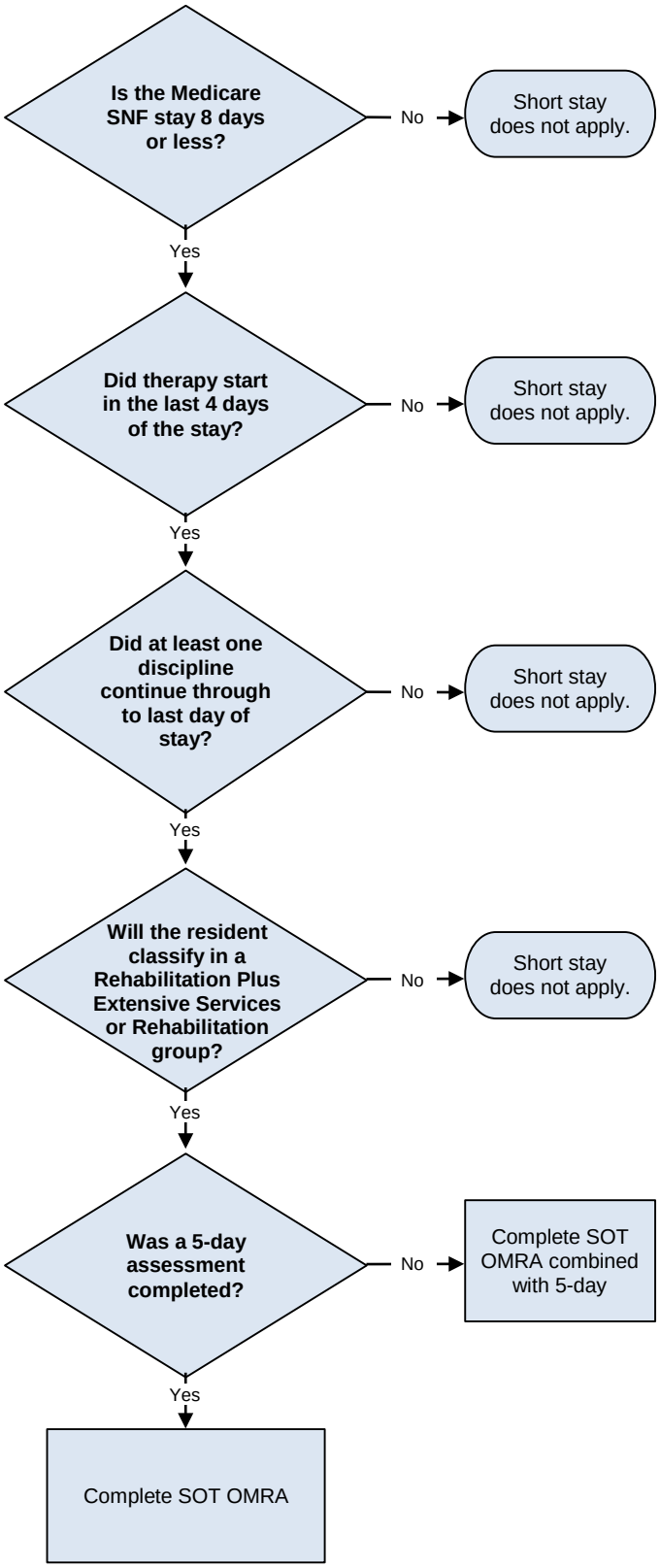
[3] The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a Discharge assessment was created for a resident who was not actually discharged), then the event did not occur.

[4] OBRA comprehensive assessments with A0310A = 01, 03, 04, 05 and Quarterly assessments with A0310A = 02, 06.

[5] The assessment contains a significant error which has not been corrected by a subsequent assessment.

[6] Final completion date is item V0200C2 for a comprehensive and Z0500B for all other assessments.

Medicare Short Stay Assessment Algorithm



Medicare Short Stay Assessment Requirements:
All 8 must be true

Assessment Requirements:
1. Must be SOT OMRA
2. 5-day assessment must be completed (may be combined with the SOT OMRA)

ARD Requirements:
3. Must be Day 8 or earlier of Part A stay
4. Must be last day of Part A stay (see Item A2400C instructions)
5. Must be no more than 3 days after the start of therapy, not including the start of therapy date

Rehabilitation Requirements:
6. Must have started in last 4 days of Part A stay
7. Must continue through last day of Part A stay

RUG Requirement:
8. Must classify resident into a Rehabilitation Plus Extensive Services or Rehabilitation group

Note: When the earliest start of therapy is 1st day of stay, then the Part A stay must be 4 days or less

CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

STEP # 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, **go to Step #2.**

If the ADL score is less than 2, skip to Category II now.

STEP # 2

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Infection isolation while a resident

If the resident does not receive one of these treatments or services, skip to Category II now.

STEP # 3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

- **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
    1. In the past 7 days:
       Total Therapy Minutes (calculated on pages 6-26–6-29) of 720 minutes or more
       and
       One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
       and
       A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
       Medicare Short Stay Average Therapy Minutes (see page 6-20) of 144 minutes or more

RUG-IV ADL Score	RUG-IV Class
11-16	RUX
2-10	RUL

- **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
       Total Therapy Minutes (calculated on pages 6-26–6-29) of 500 minutes or more
       and
       At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days

    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
       Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 100 and 143 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RVX
2-10	RVL

- **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
       Total Therapy Minutes (calculated on pages 6-26–6-29) of 325 minutes or more
       and
       At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days

    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
       Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 65 and 99 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RHX
2-10	RHL

- **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
       Total Therapy Minutes (calculated on pages 6-26–6-29) of 150 minutes or more
       and
       At least 5 distinct calendar days of any combination of the three disciplines (as documented in O0420)

    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
       Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 30 and 64 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RMX
2-10	RML

- **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

  1. In the last 7 days:
     Total Therapy Minutes (calculated on pages 6-26–6-29) of 45 minutes or more
     and
     At least 3 distinct calendar days of any combination of the three disciplines (as documented in O0420)
     and
     Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

  2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
     Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 15 and 29 minutes

*Restorative Nursing Services
H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
O0500C Splint or brace assistance
O0500D,F** Bed mobility and/or walking training
O0500E Transfer training
O0500G Dressing and/or grooming training
O0500H Eating and/or swallowing training
O0500I Amputation/prostheses care
O0500J Communication training

**Count as one service even if both provided

RUG-IV ADL Score	**RUG-IV Class**
2-16	RLX

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

CATEGORY II: REHABILITATION
RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

STEP # 1

Determine whether the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for one Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on pages 6-26–6-29) of 720 minutes or more
   and
   One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
   and
   A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-20) of 144 minutes or more

RUG-IV ADL Score	RUG-IV Class
11-16	RUC
6-10	RUB
0-5	RUA

B. **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on pages 6-26–6-29) of 500 minutes or more
   and
   At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 100 and 143 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RVC
6-10	RVB
0-5	RVA

C. **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on pages 6-26–6-29) of 325 minutes or more
   and
   At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 65 and 99 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RHC
6-10	RHB
0-5	RHA

D. **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on pages 6-26–6-29) of 150 minutes or more
   and
   At least 5 distinct calendar days of any combination of the three disciplines (as documented in O0420)
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 30 and 64 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RMC
6-10	RMB
0-5	RMA

E. **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:
   Total Therapy Minutes (calculated on pages 6-26–6-29) of 45 minutes or more
   and
   At least 3 distinct calendar days of any combination of the three disciplines (as documented in O0420)
   and
   Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-21) is "Yes":**

   Medicare Short Stay Average Therapy Minutes (see page 6-20) of between 15 and 29 minutes

*Nursing Restorative Services

H0200C, H0500** Urinary toileting program and/or bowel toileting program

O0500A,B** Passive and/or active ROM

O0500C Splint or brace assistance

O0500D,F** Bed mobility and/or walking training

O0500E Transfer training

O0500G Dressing and/or grooming training

O0500H Eating and/or swallowing training

O0500I Amputation/prostheses care

O0500J Communication training

**Count as one service even if both provided

RUG-IV ADL Score	**RUG-IV Class**
11-16	RLB
0-10	RLA

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Category, proceed to Category III.

CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

***NOTE**: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.*

- Advancing Excellence in America's Nursing Homes Resources: https://www.nhqualitycampaign.org/;
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: http://www.ahrq.gov/clinic/;
- Alzheimer's Association Resources: http://www.alz.org/professionals_and_researchers_14899.asp;
- American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version): http://www.eatright.org/About/Content.aspx?id=8373;
- American Geriatrics Society Clinical Practice Guidelines and Tools: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_programs_products/;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: http://www.amda.com/tools;
- American Pain Society: http://americanpainsociety.org/;
- American Society of Consultant Pharmacists Practice Resources: https://ascp.com/practice-resources;
- Association for Professionals in Infection Control and Epidemiology Practice Resources: http://www.apic.org/Resources/Overview;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/longtermcare/prevention/index.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf;
- Emerging Solutions in Pain Tools: http://www.emergingsolutionsinpain.com/;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools: http://www.hartfordign.org/resources;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: http://www.hartfordign.org/practice/consultgerirn/;
- Improving Nursing Home Culture (CMS Special Study): http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf;
- Institute for Safe Medication Practices: http://www.ismp.org/;

CARE AREA GENERAL RESOURCES (cont.)

- Quality Improvement Organizations: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793;
- University of Missouri's Geriatric Examination Tool Kit: http://web.missouri.edu/~proste/tool/; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: http://www.guideline.gov/.

APPENDIX G: REFERENCES

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Centers for Disease Control and Prevention: The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases, 12th ed. Available from http://www.cdc.gov/vaccines/pubs/pinkbook/index.html

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Track Changes
from Title Page v1.12
to Title Page v1.13

Chapter	Section	Page	Change
—	—	—	Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version ~~3.0~~ 1.13 October 2015

Track Changes
from TOC v1.12
to TOC v1.13

Chapter	Section	Page	Change
TOC	—	i	Page numbers changed in Chapter 2.
TOC	—	i–ii	Removed version numbers from chapters, sections, and appendices.

Track Changes
from Chapter 1 v1.12
to Chapter 1 v1.13

Chapter	Section	Page	Change
1	—	1-3	**Hendall Inc.** • Terresita Gayden • Anne Jones • Galen Snowden
1	—	1-3	Marianne Culihan, RN added to CMS Acknowledgements
1	—	1-4	Brandy Barnette, MBA, RN, CCM added to CMS Acknowledgements
1	—	1-3–1-4	Page length changed.
1	1.1	1-5	Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from ~~http://healthcentricadvisors.org/images/stories/documents/inhc.pdf~~ http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf
1	1.2	1-6	The required subsets of data items for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, Discharge, Entry Tracking, PPS item sets) can be found in Appendix H.
1	1.3	1-6	While its primary purpose ~~is~~ as an assessment tool is ~~used~~ to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents.
1	1.8	1-15	The notice shown on page 1-~~14~~16 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities.
1	1.8	1-18	**Legal Notice Regarding MDS 3.0** - Copyright 2011 United States of America and interRAI. This work may be freely used and distributed solely within the United States. Portions of the MDS 3.0 are under separate copyright protections; Pfizer Inc. holds the copyright for the PHQ-9 ~~and the Annals of Internal Medicine holds the copyright for the CAM. Both Pfizer Inc. and the Annals of Internal Medicine~~; Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Both Pfizer Inc. and the Hospital Elder Life Program, LLC have granted permission to ~~freely~~ use these instruments in association with the MDS 3.0.

Track Changes
from Chapter 2 v1.12R
to Chapter 2 v1.13

Chapter	Section	Page	Change
2	2.3	2-4	— The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities~~; therefore,~~. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments ~~are conducted~~ prior to certification as if the beds were already certified.* — Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into QIES ASAP. Therefore, these assessments cannot be submitted to the QIES ASAP system. — ~~Then a~~Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to QIES ASAP.

Track Changes
from Chapter 2 v1.12R
to Chapter 2 v1.13

Chapter	Section	Page	Change
2	2.3	2-4	~~— NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.~~ o For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, i~~I~~f a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue~~s~~ with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, Discharge, etc., the facility may receive a sequencing warning message, but should still submit the required assessment. o **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments. — *NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.
2	2.3	2-5	o The assessment schedule for existing residents continues, and the facility continues to use the existing provider number. o Staff with QIES user IDs continue to use the same QIES user IDs.

Track Changes
from Chapter 2 v1.12R
to Chapter 2 v1.13

Chapter	Section	Page	Change
2	2.3	2-5	○ The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F=01, A1600=date of ownership change, A1700=1 (admission), and A1800=02. ○ Staff who worked for the previous owner **cannot** use their previous QIES user IDs to submit assessments for the new owner as this is now a new facility. They **must** register for new user IDs for the new facility.
2	2.3–2.6	2-4–2-14	Page length changed.
2	2.6	2-17	• ~~If a resident goes to the hospital prior to completion of the OBRA Admission assessment, when the resident returns, the nursing home must consider the resident as a new admission.~~ The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
2	2.6	2-17–2-18	Page length changed.
2	2.6	2-21	A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program ~~(Medicare Hospice or other structured hospice)~~(Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home.
2	2.6	2-24	The following text was moved from *Examples (SCSA)* to *Some Guidelines to Assist in Deciding If a Change Is Significant or Not*. • **Improvement in two or more of the following:** – Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment; – Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; – Resident's decision making changes for the better; – Resident's incontinence pattern changes for the better; – Overall improvement of resident's condition.

Track Changes
from Chapter 2 v1.12R
to Chapter 2 v1.13

Chapter	Section	Page	Change
2	2.6	2-21–2-26	Page length changed.
2	2.9	2-46–2-49	Page length changed due to revised page formatting.
2	2.9	2-52	• In cases where a resident is discharged from the SNF ***on or prior to*** Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the Discharge assessment. In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met. Finally, in cases where the date used to code A2400C is equal to the date used to code A2000—that is, cases where the discharge from Medicare Part A is the same day as the discharge from the facility—and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the Discharge assessment under the rules outlined for such combination in this chapter.
2	2.9	2-52–2-61	Page length changed due to revised content on 2-52.

Track Changes
from Chapter 3 Intro v1.10
to Chapter 3 Intro v1.13

Chapter	Section	Page	Change
3	3.2	3-2	• Check the MDS 3.0 Web site regularly for updates at: ~~http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp~~ http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
3	3.2	3-2	• If you require further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: ~~http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp~~ http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
3	3.2	3-3	• It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website: ~~http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp~~ http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).
3	3.3	3-3	• ~~Unlike the MDS 2.0,~~ The standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.

Track Changes
from Chapter 3 Section A v1.12R
to Chapter 3 Section A v1.13

Chapter	Section	Page	Change
3	A0100	A-3	• Facilities must have a National Provider Identifier (NPI) and a CMS ~~Certified~~ Certification Number (CCN). • Enter the facility provider numbers: A. National Provider Identifier (NPI). B. CMS ~~Certified~~ Certification Number (CCN).
3	A2400	A-31	— Date of last day covered as recorded on the effective date from the ~~Generic Notice~~ Notice of Medicare Non-Coverage (NOMNC); or
3	A2400	A-32	**Examples** 1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and an ~~Generic Notice~~ NOMNC with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her Discharge assessment:

Track Changes
from Chapter 3 Section C v1.12
to Chapter 3 Section C v1.13

Chapter	Section	Page	Change
3	C1300	C-26	~~*Disclaimer: This protocol contains unauthorized portions, unauthorized modifications of, and incorrect references to the short Confusion Assessment Method (CAM) contained in "The Confusion Assessment Method (CAM) Training Manual and Coding Guide," © Hospital Elder Life Program, LLC 1988-2014. All Rights Reserved. This protocol was not approved, authorized, endorsed or reviewed by Hospital Elder Life Program, LLC or the original author of the CAM, Dr. Sharon K. Inouye, M.D., M.P.H., Institute for Aging Research at Hebrew SeniorLife, and all such parties disclaim all responsibility for and liabilities with respect to any use, publication, or implementation of this protocol.*~~ *Disclaimer: Adapted from Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission. All rights reserved.*

Track Changes
from Chapter 3 Section F v1.05
to Chapter 3 Section F v1.13

Chapter	Section	Page	Change
3	F0500	F-9	See Coding Instructions on page F-~~5~~4.

Track Changes
from Chapter 3 Section G v1.12
to Chapter 3 Section G v1.13

Chapter	Section	Page	Change
3	G0110	G-20	Added underline to "second criterion." 2. Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her. Coding: G0110J1 would be coded 3, extensive assistance. G0110J2 would be coded 2, one person physical assist. Rationale: A staff member had to complete part of the activity of personal hygiene for the resident 3 out of 7 days during the look-back period. The assistance, although non-weight-bearing, is considered full staff performance of the personal hygiene sub-task of brushing and styling her hair. Because this ADL sub-task was completed for the resident 3 times, but not every time during the last 7 days, it qualifies under the second criterion of the extensive assistance definition.

Track Changes
from Chapter 3 Section I v1.10
to Chapter 3 Section I v1.13

Chapter	Section	Page	Change
3	I	I-4	• If an individual is receiving aftercare following a hospitalization, ~~diagnosis is~~ a ~~V~~Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050855.hcsp?dDocName=bok1_050855.
3	I	I-10	Coding: **Cerebrovascular ~~Vascular~~ Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be checked.
3	I	I-4–I-10	Page length changed due to revised content on I-4.

Track Changes
from Chapter 3 Section K v1.12R
to Chapter 3 Section K v1.13

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>K0510</td><td>K-12</td><td>• ~~Guidelines on basic fluid and electrolyte replacement can be found online at http://guidelines.gov/content.aspx?id=15590&search=fluid+and+electrolyte+replacement+amda.~~</td></tr>
<tr><td>3</td><td>K0710</td><td>K-16</td><td>3. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.
<table>
<tr><th colspan="2">While in the Hospital</th><th colspan="2">While in the Nursing Home</th></tr>
<tr><td>Mon.</td><td>400 cc</td><td>~~Mon.~~ Fri.</td><td>510 cc</td></tr>
<tr><td>Tues.</td><td>520 cc</td><td>~~Tues.~~ Sat.</td><td>520 cc</td></tr>
<tr><td>Wed~~s~~.</td><td>500 cc</td><td>~~Weds~~ Sun.</td><td>490 cc</td></tr>
<tr><td>Thurs.</td><td>480 cc</td><td></td><td></td></tr>
<tr><td>Total</td><td>1,900 cc</td><td>Total</td><td>1,520 cc</td></tr>
</table></td></tr>
</table>

Track Changes
from Chapter 3 Section M v1.12
to Chapter 3 Section M v1.13

Chapter	Section	Page	Change
3	M0210	M-5	• If a resident had a pressure ulcer that healed during the look-back period of the current assessment, ~~and was not present~~ but there was no documented pressure ulcer on the prior assessment, **code 0**.
3	M0300	M-6	4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at ~~http://www.npuap.org/images/NPUAP-SuspectDTI.jpg~~ http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg.
3	M0300A	M-8	~~**Coding Tips**~~ • ~~If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).~~ • ~~If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.~~
3	M1200	M-40, M-41	Revised page break at the bottom of page M-40 so that the sentence no longer breaks across pages midsentence.

Track Changes
from Chapter 3 Section N v1.12
to Chapter 3 Section N v1.13

Chapter	Section	Page	Change
3	N0410	N-8	Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website ~~http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm~~ http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.
3	N0410	N-9	Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, ~~Fourth~~Fifth Edition** (**DSM-~~IV~~5**) (or subsequent editions) (~~http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1~~http://www.psychiatry.org/practice/dsm)
3	N0410	N-9	The Orange Book, ~~http://www.fda.gov/cder/ob/default.htm~~ http://www.accessdata.fda.gov/scripts/cder/ob/
3	N0410	N-9	The National Drug Code Directory, ~~http://www.fda.gov/cder/ob/default.htm~~ http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

Track Changes
from Chapter 3 Section O v1.12
to Chapter 3 Section O v1.13

Chapter	Section	Page	Change
3	O0100	O-3	The Orange Book, ~~http://www.fda.gov/cder/ob/default.htm~~ http://www.accessdata.fda.gov/scripts/cder/ob/
3	O0300	O-11	[Centers for Disease Control and Prevention. (2012, May). *The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (12th ed.).* Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/index.html~~#chapters~~]
3	O0400	O-29–O-30	Page length changed due to formatting change on O-29.

Track Changes
from Chapter 3 Section Q v1.11
to Chapter 3 Section Q v1.13

Chapter	Section	Page	Change
3	Q	Q-1	Section Q of the MDS uses a person-centered approach ~~and~~ to ~~insure~~ ensure that all individuals have the opportunity to learn about home~~-~~ and community~~-~~based services and ~~have an opportunity~~ to receive long term care in the least restrictive setting possible.
3	Q0600	Q-20	**Section Q Point of Contact list for Local Contact Agencies:** ~~http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-~~ ~~Services-and-Support/Balancing/Money-Follows-the-Person.html~~ http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf
3	Q0600	Q-21	• Several resources are available at the Return to Community web site at: ~~http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage~~ http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/community-living-initiative.html.

Track Changes
from Chapter 3 Section X v1.12R
to Chapter 3 Section X v1.13

Chapter	Section	Page	Change
3	X0600	X-5	• If item A0310A was incorrect on an assessment that ~~we~~ was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7)~~and a new record with a new date must be submitted~~.
3	X0600	X-5	• If item A0310B was incorrect on an assessment that ~~we~~ was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7)~~and a new record with a new date must be submitted~~.
3	X0600	X-5	• If item A0310C was incorrect on an assessment that ~~we~~ was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7)~~and a new record with a new date must be submitted~~.
3	X0600	X-6	• If item A0310D was incorrect on an assessment that ~~we~~ was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7)~~and a new record with a new date must be submitted~~.
3	X0600	X-6	• If item A0310F was incorrect on an assessment that ~~we~~ was previously submitted and accepted by the ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7)~~and a new record with a new date must be submitted~~.

Track Changes
from Chapter 4 v1.10
to Chapter 4 v1.13

Chapter	Section	Page	Change
4	4.10	4-35	3. Frequent bowel incontinence as indicated by: **H0400 = 2 OR H0400 = 3**

Track Changes
from Chapter 5 v1.12R
to Chapter 5 v1.13

Chapter	Section	Page	Change
5	5.1	5-2	Once communication is established with the QIES ASAP system, the provider can access the ~~CMS MDS Welcome Page~~ Welcome to the CMS QIES Systems for Providers page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 web site at https://www.qtso.com/mds30.html. When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.
5	5.1–5.8	5-2–5-16	Page length changed.
5	5.3	5-4	**Initial Submission Feedback.** For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the file submission identification number (ID) ~~as well as~~, the date and time the file was received for processing as well as the file name.
5	5.4	5-5	Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and in Section 5 of the *Minimum Data Set (MD S) 3.0 Provider User's Guide* on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 web site.

Track Changes
from Chapter 5 v1.12R
to Chapter 5 v1.13

Chapter	Section	Page	Change
5	5.6	5-8	If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, ~~production records that were inadvertently submitted as test records,~~ or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the QIES ASAP system. The paper copy should be corrected according to standard procedures detailed below.
5	5.7	5-12	• An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct: — Unit Certification or Licensure Designation (Item A0410), — State-assigned facility submission ID (FAC_ID), — ~~Production/test code (PRODN_TEST_CD)~~ Test record submitted as a production record.
5	5.8	5-14	3. The record has the wrong ~~state_cd~~ state code or facility ID in the control Items STATE_CD or FAC_ID.
5	5.8	5-16	[1]Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an incorrect Unit Certification or Licensure Designation (A0410), for example sent in as Unit is Medicare and/or Medicaid certified (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 = 2). [2]Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP. [3]The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a Discharge assessment was created for a resident who was not actually discharged), then the event did not occur. [4]OBRA comprehensive assessments with A0310A = 01, 03, 04, 05 and Quarterly assessments with A0310~~B~~A = 02, 06.

Track Changes
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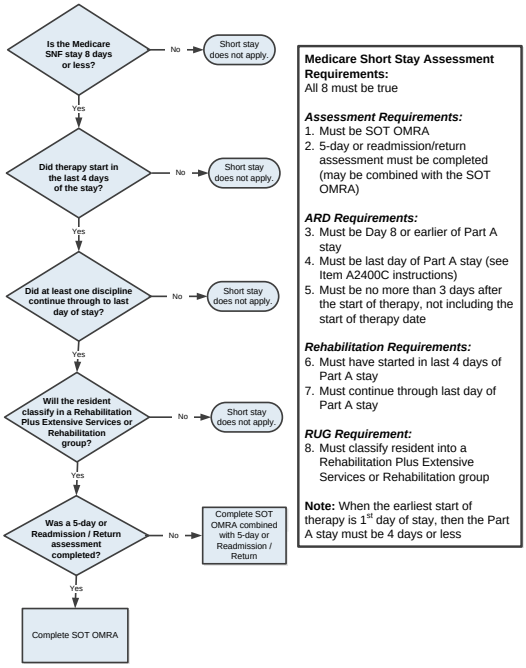
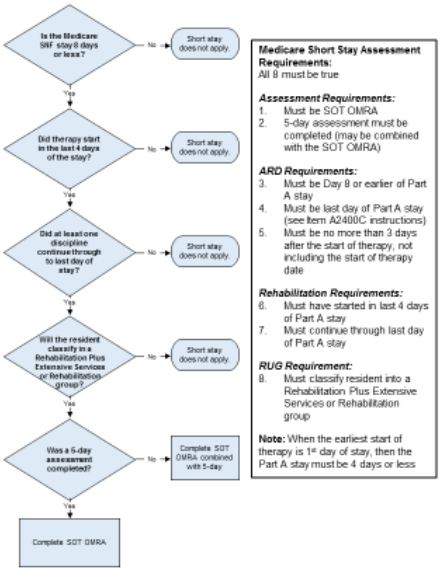
Chapter	Section	Page	Change
6	6.4	6-21	Removed all references to the Readmission/Return assessment from the Medicare Short Stay Assessment Algorithm. OLD:  NEW: 

Track Changes
from Chapter 6 v1.12R
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Chapter	Section	Page	Change
6	6.6	6-32–6-36	• [pg. 6-32] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 720 minutes or more • [pg. 6-33] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 500 minutes or more • [pg. 6-33] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 325 minutes or more • [pg. 6-33] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 150 minutes or more • [pg. 6-34] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 45 minutes or more • [pg. 6-35] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 720 minutes or more • [pg. 6-35] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 500 minutes or more • [pg. 6-36] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 325 minutes or more • [pg. 6-36] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 150 minutes or more • [pg. 6-36] Total Therapy Minutes (calculated on pages ~~6-25 – 6-28~~6-26–6-29) of 45 minutes or more
6	6.6	6-32–6-37	• [pg. 6-32] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of 144 minutes or more • [pg. 6-33] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 100 and 143 minutes • [pg. 6-33] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 65 and 99 minutes • [pg. 6-33] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 30 and 64 minutes • [pg. 6-34] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 15 and 29 minutes • [pg. 6-35] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of 144 minutes or more • [pg. 6-35] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 100 and 143 minutes • [pg. 6-36] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 65 and 99 minutes • [pg. 6-36] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 30 and 64 minutes • [pg. 6-37] Medicare Short Stay Average Therapy Minutes (see page ~~6-19~~6-20) of between 15 and 29 minutes

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Chapter	Section	Page	Change
6	6.6	6-32–6-37	2. [pg. 6-32] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-33] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-33] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-33] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-34] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-35] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-35] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-36] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-36] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":** 2. [pg. 6-37] **If the Medicare Short Stay Assessment Indicator (determined on page ~~6-206~~6-21) is "Yes":**

Track Changes
from Appendix C v1.09
to Appendix C v1.13

Chapter	Section	Page	Change
Ap. C	—	Ap. C-84	• Advancing Excellence in America's Nursing Homes Resources: ~~http://www.nhqualitycampaign.org/star_index.aspx?controls=resImplementationGuides~~ https://www.nhqualitycampaign.org/
Ap. C	—	Ap. C-84	• Alzheimer's Association Resources: http://www.alz.org/professionals_and_researchers_14899.asp~~#professional~~
Ap. C	—	Ap. C-84	• American Pain Society: ~~http://www.ampainsoc.org/pub/cp_guidelines.htm~~ http://americanpainsociety.org/
Ap. C	—	Ap. C-84	• American Society of Consultant Pharmacists Practice Resources: ~~http://www.ascp.com/articles/professional-development/clinical-practice-resources~~ https://ascp.com/practice-resources
Ap. C	—	Ap. C-84	• Association for Professionals in Infection Control and Epidemiology Practice Resources: ~~http://www.apic.org/AM/Template.cfm?Section=Practice~~ http://www.apic.org/Resources/Overview
Ap. C	—	Ap. C-84	• Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: ~~http://www.cdc.gov/HAI/settings/ltc_settings.html~~ http://www.cdc.gov/longtermcare/prevention/index.html
Ap. C	—	Ap. C-84	• Improving Nursing Home Culture (CMS Special Study): ~~http://www.healthcentricadvisors.org/images/stories/documents/inhc.pdf~~ http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf
Ap. C	—	Ap. C-85	Page break position changed due to revised hyperlinks on page Ap. C-84.

Track Changes
from Appendix G v1.12R
to Appendix G v1.13

Chapter	Section	Page	Change
Ap. G	—	Ap. G-1	Centers for Disease Control and Prevention: The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases, 12th ed. Available from http://www.cdc.gov/vaccines/pubs/pinkbook/index.html~~#chapters~~
Ap. G	—	Ap. G-2	Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from ~~http://healthcentricadvisors.org/images/stories/documents/inhc.pdf.~~ http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf.