

SECTION A: IDENTIFICATION INFORMATION

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

A0050: Type of Record

A0050. Type of Record	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider

Coding Instructions for A0050, Type of Record

- Code 1, Add new record: if this is a **new record** that has not been previously submitted and accepted in the QIES ASAP system. If this item is **coded as 1**, continue to A0100 Facility Provider Numbers.

If there is an existing database record for the same resident, the same facility, the same reasons for assessment/tracking, and the same date (assessment reference date, entry date, or discharge date), then the current record is a duplicate and not a new record. In this case, the submitted record will be rejected and not accepted in the QIES ASAP system and a “fatal” error will be reported to the facility on the Final Validation Report.

- Code 2, Modify existing record: if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the QIES ASAP system.

If this item is coded as 2, continue to A0100, Facility Provider Numbers.

When a modification request is submitted, the QIES ASAP System will take the following steps:

1. The system will attempt to locate the existing record in the QIES ASAP database for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.
2. If the existing record is not found, the submitted modification record will be rejected and not accepted in the QIES ASAP system. A “fatal” error will be reported to the facility on the Final Validation Report.
3. If the existing record is found, then the items in all sections of the submitted modification record will be edited. If there are any fatal errors, the modification record will be rejected and not accepted in the QIES ASAP system. The “fatal” error(s) will be reported to the facility on the Final Validation Report.
4. If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP database. The prior record will be moved to a history file in the QIES ASAP database.

A0050: Type of Record (cont.)

- Code 3, Inactivate existing record: if this is a **request to inactivate** a record that already has been submitted and accepted in the QIES ASAP system.

If this item is **coded as 3**, skip to X0150, Type of Provider.

When an inactivation request is submitted, the QIES ASAP system will take the following steps:

1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.
2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a “fatal” error will be reported to the facility on the Final Validation Report.
3. All items in Section X of the submitted record will be edited. If there are any fatal errors, the current inactivation request will be rejected and no record will be inactivated in the QIES ASAP system.
4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file.

Identification of Record to be Modified/Inactivated

The Section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information **EXACTLY** as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the database.

Example: A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record: The encoder mistakenly entered “John” instead of “Joan” when entering a prior assessment for Joan L. Smith. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under Identification of Record to be Modified/Inactivated. When completing X0200A, the Resident First Name, “John” will be entered in this item. This will permit the MDS system to locate the previously submitted assessment that is being corrected. If the correct name “Joan” were entered, the QIES ASAP system would not locate the prior assessment.

The correction to the name from “John” to “Joan” will be made by recording “Joan” in the “normal” A0500A, Resident First Name in the modification record. The modification record must include all items appropriate for that assessment, not just the corrected name. This modification record will then be submitted and accepted into the QIES ASAP system, which causes the desired correction to be made.

A0100: Facility Provider Numbers

[illegible]

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 <input type="text"/>	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.

A0310: Type of Assessment

For Comprehensive, Quarterly, and PPS Assessments, Entry and OBRA Discharge Records, and Part A PPS Discharge Assessment.

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

Item Rationale

- Allows identification of needed assessment content.

Coding Instructions for A0310, Type of Assessment

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

If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B

A0310: Type of Assessment (cont.)

and A0310C) all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

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

Coding Tips and Special Populations

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

Coding Instructions for A0310B, PPS Assessment

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

DEFINITION

PROSPECTIVE
PAYMENT SYSTEM
(PPS)

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

A0310: Type of Assessment (cont.)

PPS Scheduled Assessments for a Medicare Part A Stay

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

PPS Unscheduled Assessments for Medicare Part A Stay

07. Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)
99. None of the above

Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA

- Code 0, no: if this assessment is not an OMRA.
- Code 1, Start of therapy assessment (OPTIONAL): with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a Short Stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.
- Code 2, End of therapy assessment: with an ARD that is 1 to 3 days after the last day therapy services were provided.
- Code 3, both the Start and End of therapy assessment: with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a Short Stay assessment, see Chapter 6).
- Code 4, Change of therapy assessment: with an ARD that is Day 7 of the COT observation period.

Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?

- Code 0, no: if this assessment is not a Swing Bed Clinical Change assessment.
- Code 1, yes: if this assessment is a swing bed clinical change assessment.

Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, Scheduled PPS, or OBRA Discharge) since the Most Recent Admission/Entry or Reentry?

- Code 0, no: if this assessment is not the first of these assessments since the most recent admission/entry or reentry.

A0310: Type of Assessment (cont.)

- Code 1, yes: if this assessment is the first of these assessments since the most recent admission/entry or reentry.

Coding Tips and Special Populations

- A0310E = 0 for:
 - Entry or Death in Facility tracking records (A0310F = 01 or 12);
 - A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or
 - A standalone unscheduled PPS assessment (A0310A = 99, A0310B = 07, and A0310F = 99).
- A0310E = 1 on the first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: the first submitted assessment may not be the Admission assessment.

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

- Enter the number corresponding to the reason for completing this assessment or tracking record. This item contains 2 digits. For code 01, enter “0” in the first box and place “1” in the second box. If the assessment is not coded as “01” or “10” or “11” or “12,” enter “99”:

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

DEFINITION

Part A PPS Discharge Assessment

A discharge assessment developed to inform current and future SNF QRP measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Coding Instructions for A0310G, Type of Discharge (*complete only if A0310F = 10 or 11*)

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

Coding Instructions for A0310H, Is this a Part A PPS Discharge Assessment?

- Code 0, no: if this is not a Part A PPS Discharge assessment.
- Code 1, yes: if this is a Part A PPS Discharge assessment.

A0310: Type of Assessment (cont.)

- A Part A PPS Discharge assessment (NPE Item Set) is required under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility.
- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

A0410: Unit Certification or Licensure Designation

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

Item Rationale

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

Steps for Assessment

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

A0410: Unit Certification or Licensure Designation (cont.)

Coding Instructions

- Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does **not** have authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any records are submitted under this certification designation, they will be rejected by the QIES ASAP system.
- Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State: if the nursing home resident is on a unit that is neither Medicare nor Medicaid certified, but the state has authority under state licensure to collect MDS information for residents on such units, the facility should submit the resident's MDS records per the state's requirement to QIES ASAP or directly to the state.

Note that this certification designation does not apply to swing-bed facilities.

Assessments for swing-bed residents on which A0410 is coded “2” will be rejected by the QIES ASAP system.

- Code 3, Unit is Medicare and/or Medicaid certified: if the resident is on a Medicare and/or Medicaid certified unit, regardless of payer source (i.e., even if the resident is private pay or has his/her stay covered under e.g., Medicare Advantage, Medicare HMO, private insurance, etc.), the facility is required to submit MDS records (OBRA and SNF PPS only) to QIES ASAP for these residents. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.

A0500: Legal Name of Resident

A0500. Legal Name of Resident	
<p>A. First name:</p> <div style="border: 1px solid black; width: 100px; height: 25px; margin: 5px 0;"></div> <p>C. Last name:</p> <div style="border: 1px solid black; width: 250px; height: 25px; margin: 5px 0;"></div>	<p>B. Middle initial:</p> <div style="border: 1px solid black; width: 30px; height: 25px; margin: 5px 0;"></div> <p>D. Suffix:</p> <div style="border: 1px solid black; width: 50px; height: 25px; margin: 5px 0;"></div>

Item Rationale

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

Steps for Assessment

1. Ask resident, family, significant other, guardian, or legally authorized representative.

DEFINITION

LEGAL NAME

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

A0500: Legal Name of Resident (cont.)

2. Check the resident's name on his or her Medicare card, or if not in the program, check a Medicaid card or other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

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

A0600: Social Security and Medicare Numbers

A0600. Social Security and Medicare Numbers																
	<p>A. Social Security Number:</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></tr></table>					-			-							
				-			-									
	<p>B. Medicare number (or comparable railroad insurance number):</p> <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															

Item Rationale

- Allows identification of the resident.
- Allows records for resident to be matched in system.

A0600: Social Security and Medicare Numbers (cont.)

Coding Instructions

- Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no social security number is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank.
- Enter Medicare number in A0600B exactly as it appears on the resident's documents.
- If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the leftmost space followed by one letter/digit per space. If no Medicare number or RRB number is known or available, the item may be left blank.
- For PPS assessments (A0310B = 01, 02, 03, 04, 05, and 07), either the Medicare or Railroad Retirement Board (RRB) number (A0600B) must be present (i.e., may not be left blank). Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.
- A0600B can only be a Medicare (HIC) number or a Railroad Retirement Board number.

DEFINITIONS

SOCIAL SECURITY NUMBER

A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER (OR COMPARABLE RAILROAD INSURANCE NUMBER)

An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may be different from the resident's social security number (SSN), and may contain both letters and numbers. For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.

A0700: Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Item Rationale

- Assists in correct resident identification.

A0700: Medicaid Number (cont.)

Coding Instructions

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

Coding Tips and Special Populations

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

A0800: Gender

A0800. Gender	
Enter Code <input type="checkbox"/>	1. Male 2. Female

Item Rationale

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

Coding Instructions

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

Coding Tips and Special Populations

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

A0900: Birth Date

A0900. Birth Date										
		<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Month			Day			Year		

Item Rationale

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

Coding Instructions

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

A1000: Race/Ethnicity

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

Item Rationale

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

A1000: Race/Ethnicity (cont.)

Steps for Assessment: Interview Instructions

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

Coding Instructions

Check all that apply.

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

DEFINITIONS

RACE/ETHNICITY

AMERICAN INDIAN OR ALASKA NATIVE

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

ASIAN

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

BLACK OR AFRICAN AMERICAN

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

HISPANIC OR LATINO

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

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

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

WHITE

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

A1100: Language

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions for A1100A

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

A1100: Language (cont.)

Coding Instructions for A1100B

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

Coding Tips and Special Populations

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

A1200: Marital Status

A1200. Marital Status	
Enter Code <input type="text"/>	<ol style="list-style-type: none">1. Never married2. Married3. Widowed4. Separated5. Divorced

Item Rationale

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

Steps for Assessment

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

Coding Instructions

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

A1300: Optional Resident Items

[illegible]

Item Rationale

- Some facilities prefer to include the nursing home medical record number on the MDS to facilitate tracking.
- Some facilities conduct unit reviews of MDS items in addition to resident and nursing home level reviews. The unit may be indicated by the room number.
- Preferred name and lifetime occupation help nursing home staff members personalize their interactions with the resident.
- Many people are called by a nickname or middle name throughout their life. It is important to call residents by the name they prefer in order to establish comfort and respect between staff and resident. Also, some cognitively impaired or hearing impaired residents might have difficulty responding when called by their legal name, if it is not the name most familiar to them.
- Others may prefer a more formal and less familiar address. For example, a physician might appreciate being referred to as “Doctor.”
- Knowing a person’s lifetime occupation is also helpful for care planning and conversation purposes. For example, a carpenter might enjoy pursuing hobby shop activities.
- These are optional items because they are not needed for CMS program function.

Coding Instructions for A1300A, Medical Record Number

- Enter the resident's medical record number (from the nursing home medical record, admission office or Health Information Management Department) if the nursing home chooses to exercise this option.

Coding Instructions for A1300B, Room Number

- Enter the resident's room number if the nursing home chooses to exercise this option.

Coding Instructions for A1300C, Name by Which Resident Prefers to Be Addressed

- Enter the resident's preferred name. This field captures a preferred nickname, middle name, or title that the resident prefers staff use.
- Obtained from resident self-report or family or significant other if resident is unable to respond.

A1300: Optional Resident Items (cont.)

Coding Instructions for A1300D, Lifetime Occupation(s)

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

A1500: Preadmission Screening and Resident Review (PASRR)

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

Item Rationale

Health-related Quality of Life

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

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

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

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

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

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

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

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

Steps for Assessment

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

Coding Instructions

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

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

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

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

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

Coding Instructions

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

DEFINITIONS

DOWN SYNDROME

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

AUTISM

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

EPILEPSY

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

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

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

DEFINITION

OTHER ORGANIC
CONDITION RELATED
TO ID/DD

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

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

Most Recent Admission/Entry or Reentry into this Facility	
A1600. Entry Date	
	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div> <div style="font-size: 12px;">Month</div> <div style="font-size: 12px;">–</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div> <div style="font-size: 12px;">Day</div> <div style="font-size: 12px;">–</div> <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div> <div style="font-size: 12px;">Year</div> </div>
A1700. Type of Entry	
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div>	1. Admission 2. Reentry
A1800. Entered From	
Enter Code <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other

A1600: Entry Date

Most Recent Admission/Entry or Reentry into this Facility											
A1600. Entry Date											
		<div> <div></div> <div></div> </div> <div>Month</div>		<div> <div></div> <div></div> </div> <div>Day</div>		<div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>					

Item Rationale

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

Coding Instructions

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

DEFINITION

ENTRY DATE

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

A1700: Type of Entry

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

Item Rationale

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

Coding Instructions

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

A1800: Entered From

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

Item Rationale

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

Steps for Assessment

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

Coding Instructions

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

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

DEFINITIONS

PRIVATE HOME OR APARTMENT

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

BOARD AND CARE/ ASSISTED LIVING/ GROUP HOME

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

A1800: Entered From (cont.)

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

Coding Tips and Special Populations

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

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

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

Item Rationale

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

Coding Instructions

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

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

Examples

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

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

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

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

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

Coding Tips and Special Populations

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

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

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

A2000: OBRA Discharge Date

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

Item Rationale

- Closes case in system.

Coding Instructions

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

Coding Tips and Special Populations

- A Part A PPS Discharge assessment (NPE Item Set) is required under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) when the resident's Medicare Part A stay ends, but the resident does not leave the facility.
- If a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), then both an OBRA Discharge assessment and a Part A PPS Discharge assessment are required; but these two assessments may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

A2100: OBRA Discharge Status

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

Item Rationale

- Demographic and outcome information.

Steps for Assessment

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

Coding Instructions

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

- Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
- Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- Code 07, hospice: if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and

A2100: OBRA Discharge Status (cont.)

related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient hospice programs.

- Code 08, deceased: if resident is deceased.
- Code 09, long term care hospital (LTCH): if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
- Code 99, other: if discharge location is none of the above.

A2200: Previous Assessment Reference Date for Significant Correction

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

Item Rationale

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

Coding Instructions

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

A2300: Assessment Reference Date

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

A2300: Assessment Reference Date (cont.)

Item Rationale

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

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the look-back period, the 2 leave days are still considered part of the look-back period.
- When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to the physician during the leave, the visit would be counted in Item 00600, **Physician Examination** (if criteria are otherwise met).

DEFINITION

ASSESSMENT REFERENCE DATE (ARD)

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

A2300: Assessment Reference Date (cont.)

This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

A2400: Medicare Stay

A2400. Medicare Stay																																	
Enter Code <input type="checkbox"/>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <p>0. No → Skip to B0100, Comatose</p> <p>1. Yes → Continue to A2400B, Start date of most recent Medicare stay</p> <p>B. Start date of most recent Medicare stay:</p> <table border="1" style="margin-left: 40px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <table border="1" style="margin-left: 40px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month		Day		Year												Month		Day		Year			
Month		Day		Year																													
Month		Day		Year																													

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.

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.)

- 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).

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 Most Recent Medicare Stay (A2400C) may be **earlier** than the actual Discharge Date (A2000) from the facility. If this occurs, the Part A PPS Discharge assessment is required. If the resident subsequently physically leaves the facility, the OBRA Discharge assessment would be required.
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the same day** that the resident dies, a Death in Facility Tracking Record is completed, with the Discharge Date (A2000) equal to the date the resident died. In this case, a Part A PPS Discharge assessment is **not** required.
- For a **standalone** Part A PPS Discharge assessment, the End Date of the Most Recent Medicare Stay (A2400C) must be equal to the ARD (Item A2300).

A2400: Medicare Stay (cont.)

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2016. 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 began planning her discharge. An Advanced Beneficiary Notice (ABN) and an NOMNC with the last day of coverage as November 23, 2016 were issued. Mrs. G. was discharged home from the facility on November 24, 2016. Code the following on her combined OBRA and Part A PPS Discharge assessment:

- A0310F = 10
- A0310G = 1
- A0310H = 1
- A2000 = 11-24-2016
- A2100 = 01
- A2300 = 11-24-2016
- A2400A = 1
- A2400B = 10-14-2016
- A2400C = 11-23-2016

Rationale: Because Mrs. G's last day covered under Medicare was one day before her physical discharge from the facility, a combined OBRA and Part A PPS Discharge was completed.

2. Mr. N began receiving services under Medicare Part A on December 11, 2016. He was unexpectedly sent to the ER on December 19, 2016 at 8:30pm and was not admitted to the hospital. He returned to the facility on December 20, 2016, at 11:00 am. The facility completed his 14-day PPS assessment with an ARD of December 23, 2016. Code the following on his 14-day PPS assessment:

- A2400A = 1
- A2400B = 12-11-2016
- A2400C = -----

Rationale: Mr. N was out of the facility at midnight but returned in less than 24 hours and was not admitted to the hospital, so was considered LOA. Therefore, no Discharge assessment was required. His Medicare Part A Stay is considered ongoing; therefore, the date in A2400C is dashed.

A2400: Medicare Stay (cont.)

3. Mr. R. began receiving services under Medicare Part A on October 15, 2016. Due to complications from his recent surgery, he was unexpectedly discharged to the hospital for emergency surgery on October 20, 2016, but is expected to return within 30 days. Code the following on his OBRA Discharge assessment:

- A0310F = 11
- A0310G = 2
- A0310H = 0
- A2000 = 10-20-2016
- A2100 = 03
- A2300 = 10-20-2016
- A2400A = 1
- A2400B = 10-15-2016
- A2400C = 10-20-2016

Rationale: Mr. R's physical discharge to the hospital was unplanned, yet it is anticipated that he will return to the facility within 30 days. Therefore, only an OBRA Discharge was required.

4. Mrs. K began receiving services under Medicare Part A on October 4, 2016. She was discharged from Medicare Part A services on December 17, 2016. She and her family had already decided that Mrs. K would remain in the facility for long-term care services, and she was moved into a private room (which was dually certified) on December 18, 2016. Code the following on her Part A PPS Discharge assessment:

- A0310F = 99
- A0310G = ^
- A0310H = 1
- A2000 = ^
- A2100 = ^
- A2300 = 12-17-2016
- A2400A = 1
- A2400B = 10-04-2016
- A2400C = 12-17-2016

Rationale: Because Mrs. K's Medicare Part A stay ended, and she remained in the facility for long-term care services, a **standalone** Part A PPS Discharge was required.

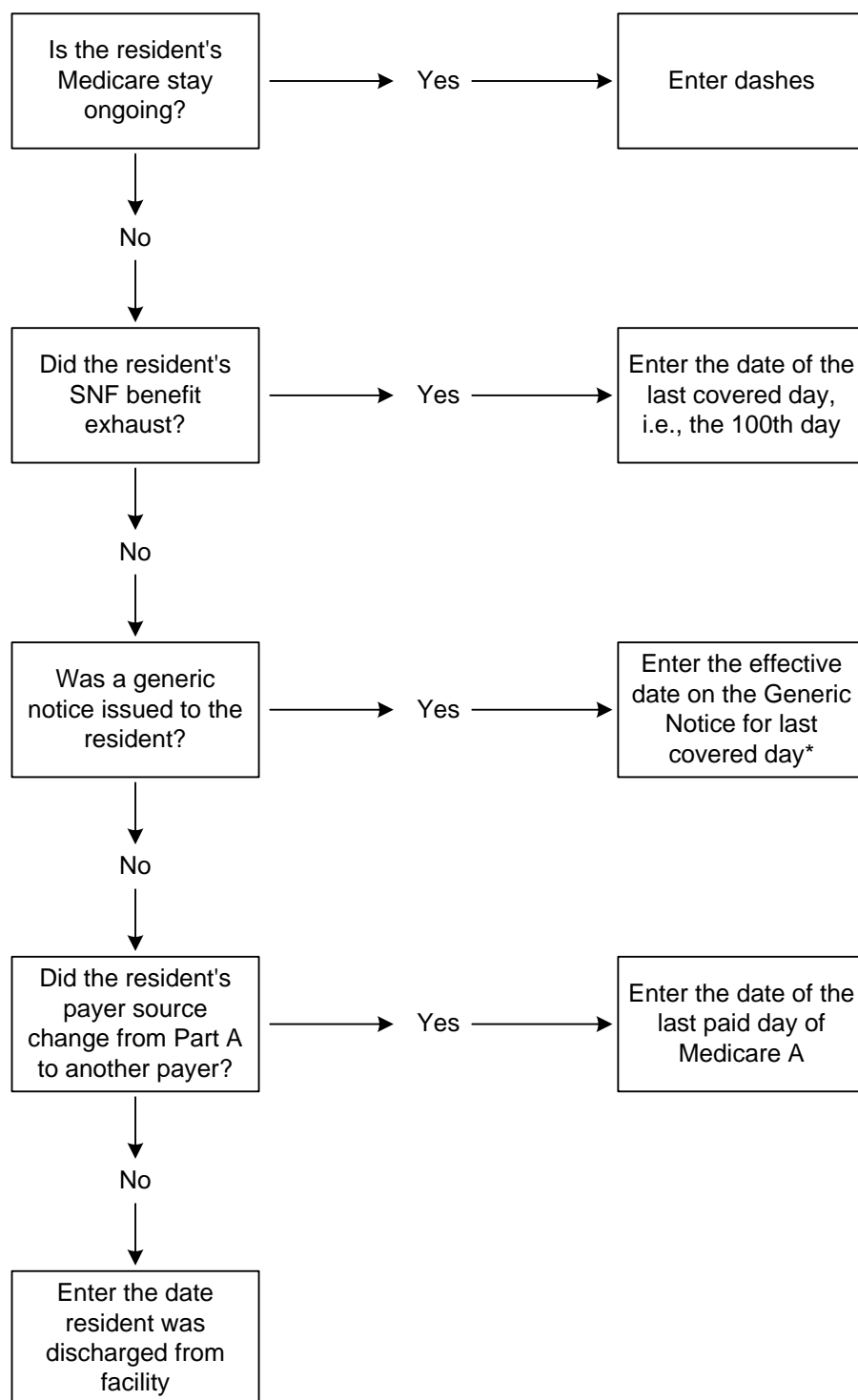
A2400: Medicare Stay (cont.)

5. Mr. W began receiving services under Medicare Part A on November 15, 2016. His Medicare Part A stay ended on November 25, 2016, and he was unexpectedly discharged to the hospital on November 26, 2016. However, he is expected to return to the facility within 30 days. Code the following on his OBRA Discharge assessment:

- A0310F = 11
- A0310G = 2
- A0310H = 0
- A2000 = 11-26-2016
- A2100 = 03
- A2300 = 11-26-2016
- A2400A = 1
- A2400B = 11-15-2016
- A2400C = 11-25-2016

Rationale: Mr. W's Medicare stay ended the day before discharge and he is expected to return to the facility within 30 days. Because his discharge to the hospital was unplanned, only an OBRA Discharge assessment was required.

Medicare Stay End Date Algorithm A2400C



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