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.

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, OBRA 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.

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

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

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

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

(1) who should participate in the assessment process

(2) how the assessment process is completed

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

CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Medicare assessments in nursing homes and the mandated Medicare assessments in non-critical access hospitals with a swing bed agreement.

2.1 Introduction to the Requirements for the RAI

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.

The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.

MDS assessments are also required for Medicare payment (Prospective Payment System [PPS]) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF QRP required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

It is important to note that when the OBRA and Medicare PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement 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. (Refer to Sections 2.11 and 2.12 for combining OBRA and Medicare assessments).

2.2 State Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by the State and approved by CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items. As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.

- CMS' approval of a State's RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.
- CMS' approval of a State's RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
- All comprehensive RAIs authorized by States must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-approved State's RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI).

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

2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

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

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

through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
  - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-") (See Chapter 3 for more information).
  - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet those needs upon admission.
  - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g. pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level of care in order to be reimbursed under the SNF PPS. CMS collects MDS data for quality monitoring purposes of swing bed facilities effective October 1, 2010. Therefore, swing bed providers must also complete the Entry record, PPS assessments, Discharge assessments, and Death in Facility record. Requirements for the Medicare-required PPS assessments, Entry record, Discharge assessments and Death in Facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.

Skilled Nursing Facility Quality Reporting Program: The IMPACT Act of 2014 established the Skilled Nursing Facility Quality Reporting Program (SNF QRP). Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that skilled nursing facilities are to collect and report on standardized patient assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year.

- Section GG: Functional Abilities and Goals assesses the need for assistance with self-care and mobility activities; it is collected at the start of a Medicare Part A stay on the 5-Day PPS assessment and is also collected at the end of the Medicare Part A stay on the Part A PPS Discharge assessment. Section GG was added to the MDS 3.0 in order to be able to collect the data required to calculate the functional status process-based quality measure,

Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). An adapted version of this LTCH measure was finalized for skilled nursing facilities in the Fiscal Year (FY) 2016 SNF PPS final rule for FY 2018 payment determination. Data collected for the SNF QRP is submitted through the QIES ASAP system as it currently is for other MDS assessments.

It is important to note that data collection for Section GG **does not substitute** for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for both Section GG and Section G.

Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html.

The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - 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, OBRA 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 an OBRA 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 OBRA 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. No Discharge assessment is required.

Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in 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 three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Section 2.6 provides detailed instructions regarding return anticipated and return not anticipated types, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. 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.
- Resident's Medicare Part A stay ends, but the resident remains in the facility.

Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. 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 a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, 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 11 different item subsets for nursing homes and 8 for swing bed providers as follows:

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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;"

- 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 OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
  - **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
  - **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.
- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day) or a Swing Bed Clinical Change assessment.

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

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 swing bed 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 Type of Provider, Item A0200 (indicating nursing home or swing bed), and the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H). 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.

Item Set Codes are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

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.

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), A0310C (PPS Other Medicare Required Assessment – OMRA), and A0310H (Is this a Part A PPS Discharge Assessment?). 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
- Part A PPS Discharge Assessment

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 an OBRA 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.

RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A= 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5- and 14-day PPS; or Part A PPS Discharge assessment
Annual (Comprehensive)	A0310A= 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or PPS assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A= 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or PPS assessment

(continued)

RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A= 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or PPS assessment
Quarterly (Non-Comprehensive)	A0310A= 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with another assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A=06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or PPS assessment
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F= 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or PPS assessment
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F= 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or PPS assessment

(continued)

RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Entry tracking record	A0310F= 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F= 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

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) or any Discharge assessment type.

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.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 am or 11:59 pm, is considered day "1" of admission.
- The ARD (Item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (Item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (Item V0200B2) must be no later than day 14.
- 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).
- For a resident who goes in and out of the facility on a relatively frequent basis and return 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 an OBRA Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

02. Annual Assessment (A0310A=03)

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

Assessment Management Requirements and Tips for Annual Assessments:

- The ARD (Item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or Significant Correction to Prior Quarterly assessment (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- 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).

03. Significant Change In Status Assessment (SCSA) (A0310A=04)

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

A **"significant change"** is a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only);
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.
A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

Assessment Management Requirements and Tips for Significant Change in Status Assessments:

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

- 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 an OBRA 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.

Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

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

Example (PASRR & SCSA):

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

Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

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

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

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

A **"significant error"** is an error in an assessment where:

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

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

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

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- A SCPA is appropriate when:
  - the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (CAA(s) completion date + 7 calendar days).

Non-Comprehensive Assessments and Entry and Discharge Reporting

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

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

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

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

- Entry Tracking Record
- Death in Facility Tracking Record

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

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

  For example:

  — Resident A has a Quarterly assessment with an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3rd (which is day 14 after the ARD).

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

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

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[6] In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[6] When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and a SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into the MDS system and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, determine if a revision to the resident's care plan is necessary, and make the applicable revision.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

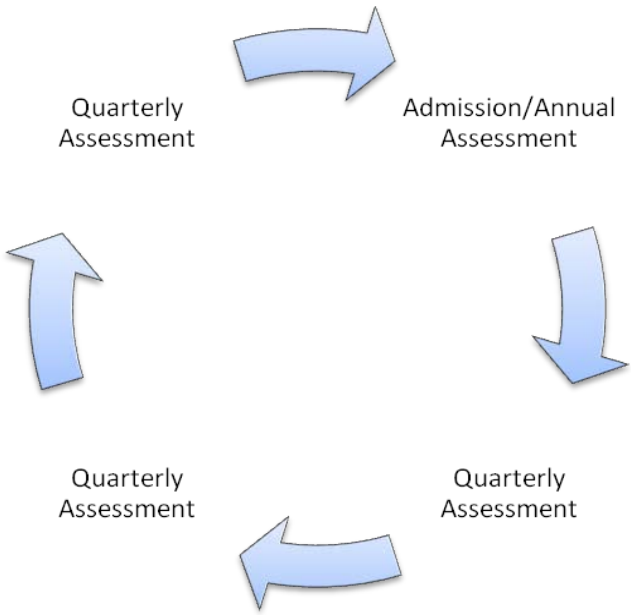
[6] The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

05. Quarterly Assessment (A0310A=02)

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

Assessment Management Requirements and Tips:

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



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

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

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

A **"significant error"** is an error in an assessment where:

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

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

Assessment Management Requirements and Tips:

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

Tracking Records and Discharge Assessments (A0310F)

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

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

OBRA-required Tracking Records and Discharge Assessments include the following types (Item A0310F):

07. Entry Tracking Record (Item A0310F=01)

There are two types of entries – admission and reentry.

Admission (Item A1700=1)

- Entry tracking record is coded an Admission every time a resident:
  - is admitted for the first time to this facility; or
  - is readmitted after a discharge return not anticipated; or
  - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

Example (Admission):

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

   A0310F = 01
   A1600 = 08-27-2011
   A1700 = 1

Reentry (Item A1700=2)

- Entry tracking record is coded Reentry every time a person:
  - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

Example (Reentry):

1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, Mr. W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

   A0310F = 01
   A1600 = 05-18-2011
   A1700 = 2

Assessment Management Requirements and Tips for Entry Tracking Records:

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

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

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

Example (Death in Facility):

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

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

OBRA Discharge Assessments (A0310F)

OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.

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

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

- Must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident returns, the Entry tracking record will be coded A1700=1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the PPS schedule starts with a Medicare-required 5-day scheduled assessment or combination of the Admission and 5-day PPS assessment.

Examples (Discharge-return not anticipated):

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

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

2. Mr. K. was transferred from a Medicare-certified bed to a noncertified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

   A0310F=10
   A2000=12-12-2013
   A2100=2

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

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

- When the resident returns to the nursing home, the IDT must determine if criteria are met for a SCSA (only when the OBRA Admission assessment was completed prior to discharge).
  - If criteria are met, complete a Significant Change in Status assessment.
  - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

Example (Discharge-return anticipated):

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

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

Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge on page 2-10).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.
- May be combined with a PPS Medicare required assessment when requirements for all assessments are met.
- For an OBRA Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (Item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have

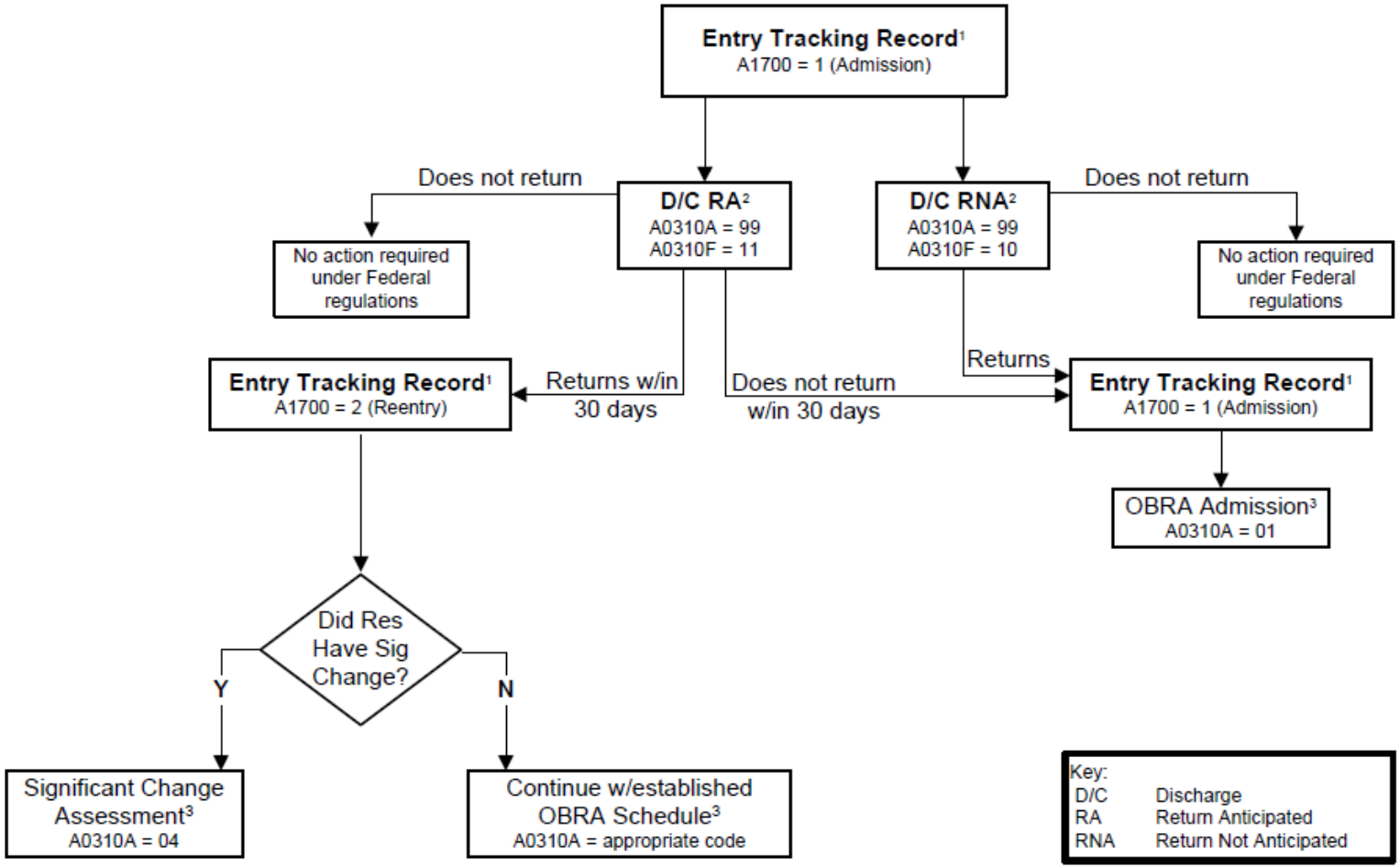
already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met.

- For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
  - An unplanned discharge includes, for example:
    - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
    - Resident unexpectedly leaving the facility against medical advice; or

    Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

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

Entry, OBRA Discharge, and Reentry Algorithms



[1]A0310A = 99 A0310B = 99 A0310C = 0 A0310D = 0 or blank A0310E = 0 A0310F = 01

[2]A0310B – E = appropriate code [3]A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

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

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

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

CAA(s) Completion

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

Care Plan Completion

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

2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

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

Assessment Window

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

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

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

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

Grace Days

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

Scheduled Medicare PPS Assessments

The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments, each with a predetermined time period for setting the ARD for that assessment.

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

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

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

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

Unscheduled Medicare PPS Assessments

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

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

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window—the two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has been completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. See Chapter 6 (Section 6.4) and Section 2.10 below for complete details.

Tracking Records and Discharge Assessments Reporting

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

Part A PPS Discharge Assessment (A0310H)

The Part A PPS Discharge assessment contains data elements used to calculate current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which post-acute care (PAC) providers (which includes SNFs) are required to submit standardized patient assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that patient assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting.

- Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment can also be combined with the OBRA Discharge assessment when 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), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required.

Part A PPS Discharge Assessment (A0310H = 1):

- Must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility).
- For the Part A PPS Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.
- 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). The Part A PPS Discharge assessment may be combined with most PPS and OBRA-required assessments when requirements for all assessments are met (please see Section 2.11 Combining Medicare Assessments and OBRA Assessments).
- Must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day PPS assessment.

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

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

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
5-day A0310B = 01	Days 1-5	6-8	Days 1-8	Sets payment rate for days 1-14	• See Section 2.13 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA.
14-day A0310B = 02	Days 13-14	15-18	Days 13-18	Sets payment rate for days 15-30	• CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. • Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.
30-day A0310B = 03	Days 27-29	30-33	Days 27-33	Sets payment rate for days 31-60	
60-day A0310B = 04	Days 57-59	60-63	Days 57-63	Sets payment rate for days 61-90	
90-day A0310B = 05	Days 87-89	90-93	Days 87-93	Sets payment rate for days 91-100	• If combined with the OBRA Quarterly assessment the completion date requirements for the OBRA Quarterly assessment must also be met.

(continued)

Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities (cont.)

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Start of Therapy Other Medicare-required Assessment (OMRA) A0310C = 1	• 5–7 days after the start of therapy • The day of the first therapy evaluation counts as day 1	N/A	N/A	Modifies payment rate starting on the date of the first therapy evaluation	• Voluntary assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG.
End of Therapy OMRA A0310C = 2	• 1–3 days after all therapy (Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP)) services are discontinued. • The first non-therapy day counts as day 1.	N/A	N/A	Modifies payment rate starting on the day after the latest therapy end date	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Only required for patients who are classified into Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment. • For circumstances when an End of Therapy with Resumption option would be used, See Section 2.9.
Change of Therapy OMRA A0310C = 4	• Day 7 of the COT observation period	N/A	N/A	Modifies payment rate starting on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other scheduled or unscheduled PPS assessment	• Required only if the intensity of therapy during the 7-day look back period would change the RUG category classification of the most recent PPS Assessment • Establishes a new RUG classification

(continued)

Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities (cont.)

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Significant Change in Status Assessment (SCSA) A0310A = 04	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Swing Bed Clinical Change Assessment (CCA) A0310D = 1	Completed by the end of the 14th calendar day after determination that a clinical change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Significant Correction to Prior Comprehensive Assessment (SCPA) A0310A = 05	Completed by the end of the 14th calendar day after identification of a significant, uncorrected error in prior comprehensive assessment.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Entry tracking record A0310F = 01	N/A	N/A	N/A	N/A	• May not be combined with another assessment
OBRA Discharge Assessment A0310F = 10 or 11	Must be set for the day of discharge	N/A	N/A	N/A	• May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment and the resident is physically discharged from the facility.
Part A PPS Discharge Assessment A0310H = 1	Must be set for the last day of the Medicare Part A Stay (A2400C)	N/A	N/A	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).
Death in facility tracking record A0310F = 12	N/A	N/A	N/A	N/A	May not be combined with another assessment.

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

2.9 MDS Medicare Assessments for SNFs

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

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

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

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 13 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 18 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

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

04. Medicare-required 60-Day Scheduled Assessment

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

05. Medicare-required 90-Day Scheduled Assessment

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

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled Assessments Used for PPS

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

Start of Therapy (SOT) OMRA

- **Optional.**

- Completed **only** to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Completed **only** if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group.
- ARD (Item A2300) must be set on days 5–7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) with the exception of the Short Stay Assessment (see Chapter 6, Section 6.4). The date of the earliest therapy evaluation is counted as day 1 when determining the ARD for the Start of Therapy OMRA, regardless if treatment is provided or not on that day.
- May be combined with scheduled PPS assessments.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example if the 5-day assessment is performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued for any reason (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided whether therapy was scheduled or not scheduled for that day. For example:
  - If the resident was discharged from all therapy services on Tuesday, day 1 is Wednesday.
  - If the resident was discharged from all therapy services on Friday, Day 1 would be Saturday.
  - If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday.

- For purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.
- May be combined with any scheduled PPS assessment. In such cases, the item set for the scheduled assessment should be used.
- The ARD for the End of Therapy OMRA may not precede the ARD of the first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example: if the 5-day assessment is completed on day 8 and an EOT is completed in that window, the ARD for the EOT should be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment regardless of day selected for ARD.
- Must be submitted electronically to the QIES ASAP system and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- In cases where a resident is discharged from the SNF ***on or prior to*** the third consecutive day of missed therapy services, then no EOT is required. More precisely, in cases where the date coded for Item A2000 is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If a SNF chooses to complete the EOT OMRA in this situation, they may combine the EOT OMRA with the discharge assessment.
- In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.
- In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.
- If the EOT OMRA is performed because three or more consecutive days of therapy were missed, and it is determined that therapy will resume, there are three options for completion:
  1. Complete only the EOT OMRA and keep the resident in a non-Rehabilitation RUG category until the next scheduled PPS assessment is completed. For example:
     - Mr. K. was discharged from all therapy services on Day 22 of his SNF stay. The EOT OMRA was performed on Day 24 of his SNF stay and classified into HD1. Payment continued at HD1 until the 30- day assessment was completed. At that point, therapy resumed (with a new therapy evaluation) and the resident was classified into RVB.
  2. In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or

therapy services will not resume at the same RUG-IV therapy classification level that had been in effect prior to the EOT OMRA, an SOT OMRA is required to classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well. For example: Mr. G. who had been classified into RVX did not receive therapy on Saturday and Sunday. He also missed therapy on Monday because his family came to visit, on Tuesday he missed therapy due to a doctor's appointment and refused therapy on Wednesday. An EOT OMRA was performed on Monday classifying him into the ES2 non-therapy RUG. He missed 5 consecutive calendar days of therapy. A new therapy evaluation was completed and he resumed therapy services on Thursday. An SOT OMRA was then completed and Mr. G. was placed back into the RVX therapy RUG category.

- Mrs. B., who had been classified into RHC did not receive therapy on Monday, Tuesday, and Wednesday because of an infection, and it was determined that she would be able to start therapy again on Thursday. An EOT OMRA was completed to pay for the three days she did not have therapy with a non-therapy RUG classification of HC2. It was determined that Mrs. B. would not be able to resume therapy at the same RUG-IV therapy classification, and an SOT OMRA was completed to place her into the RMB RUG-IV therapy category. A new therapy evaluation was required.

3. In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level, and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. For Example:

   - Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment, but resumed therapy Tuesday. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. An EOT-R was completed and Mrs. A was placed into ES3 for the three days she did not receive therapy. On Tuesday, Mrs. A. was placed back into RVL, which was the same therapy RUG group she was in prior to the discontinuation of therapy. A new therapy evaluation was not required.

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

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

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

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

Change of Therapy (COT) OMRA

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

  If a facility sets the ARD for its 14-day assessment to day 14, Day 1 for purposes of the COT period would be Day 15 of the SNF stay, and the facility would be required to review the therapy services provided to the patient for the week consisting of Day

15 through 21. The ARD for the COT OMRA would then be set for Day 21, if the facility were to determine that, for example, the total RTM has changed such that the resident's RUG classification would change from that found on the 14-day assessment (assuming no intervening assessments). If the total RTM would not result in a RUG classification change, and all other therapy category qualifiers have remained consistent with the patient's current RUG classification, then the COT OMRA would not be completed.

- If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS assessment, the SNF may choose to complete the scheduled PPS assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is ***on or prior to*** Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS assessment ARD. Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.
- In cases where a resident is discharged from the SNF ***on or prior to*** Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the OBRA 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. If the date listed in A2400C is on Day 7 of the COT observation period, then the SNF must complete both the COT OMRA and the Part A PPS Discharge Assessment. These assessments must be completed separately.

  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 OBRA 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.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 4
  A0310D = 0 (Swing Beds only)

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**, Item A0310C, **PPS Other Medicare Required Assessment - OMRA**, and Item A0310H, **Is this a SNF Part A PPS Discharge Assessment**?, and are required for residents whose stay is covered by Medicare Part A.
- When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA Admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

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

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

The 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 and PPS* Item Sets	Other Required Assessments and Tracking Records/Item Sets
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 • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Start of Therapy OMRA • Change of Therapy OMRA • End of Therapy OMRA
Combined Assessment Types	• OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required PPS • 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 • Medicare required and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Medicare required and any Discharge • Quarterly and OMRA Discharge • Significant Correction to Prior Quarterly and any Discharge	• Start of Therapy OMRA and End of Therapy OMRA • Start of Therapy OMRA and OBRA Discharge • End of Therapy OMRA and OBRA Discharge • Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge • Change of Therapy OMRA and OBRA Discharge

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

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS/Item Set	Other Required Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	• 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) • Swing Bed Clinical Change Assessment	• Entry Record • OBRA Discharge assessment • Death in Facility record • Start of Therapy OMRA • Change of Therapy OMRA • End of Therapy OMRA
Assessment Type Combinations*	• Any Medicare required and any OMRA • Any Medicare required and any Discharge • Swing Bed Clinical Change and any Medicare required • Swing Bed Clinical Change and any Discharge	• Start of Therapy OMRA and End of Therapy OMRA • Start of Therapy OMRA and OBRA Discharge • End of Therapy OMRA and OBRA Discharge • Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge • Change of Therapy OMRA and OBRA Discharge

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

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

2.12 Medicare and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. A provider may choose to combine more than two assessment types when all requirements are met. The coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15).

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).

- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required 14-Day and OBRA Admission Assessment

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

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

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

Medicare-required Scheduled Assessment and Annual Assessment

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

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- Must be completed (Item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.

- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

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

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

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

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

Medicare-required Scheduled Assessment and OBRA Discharge Assessment

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

Medicare-required Scheduled Assessment and Part A PPS Discharge Assessment

- PPS item set.
- ARD (Item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.

- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and OBRA Quarterly Assessment

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

Start of Therapy OMRA and Annual Assessment

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

Start of Therapy OMRA and Significant Change in Status Assessment

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

Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment.

Start of Therapy OMRA and OBRA Discharge Assessment

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

End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1–3 days after the last day therapy was furnished (difference is 3 or less for Item A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.

- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and OBRA Quarterly Assessment

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

End of Therapy OMRA and Annual Assessment

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

End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 1–3 days after the end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.

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

End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and OBRA Discharge Assessment

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

Start and End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (Item A2300) must be 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start and End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for OBRA Annual assessment requirements as described in Section 2.6.

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

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

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

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

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.

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

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

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

Start and End of Therapy OMRA and OBRA Discharge Assessment

- OMRA-Start of Therapy and OBRA Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must fall within 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Change of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier after admission **and** be on the last day of a COT 7-day observation period. Must be completed (Item Z0500B) by day 14 after admission (admission date plus 13 calendar days).
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.

- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and OBRA Quarterly Assessment

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

Change of Therapy OMRA and Annual Assessment

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

Change of Therapy OMRA and Significant Change in Status Assessment

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

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and OBRA Discharge Assessment

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

2.13 Factors Impacting the SNF Medicare Assessment Schedule[8]

Resident Expires Before or On the Eighth Day of SNF Stay

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

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

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

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

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required.

When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments may be combined. (See Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a Discharge assessment.)

Short Stay

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

Resident Is Admitted to an Acute Care Facility and Returns

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted.

For all providers, including Swing bed providers, the first required Medicare assessment is always the Medicare-required 5-Day assessment (Item A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

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

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

Resident Takes a Leave of Absence from the SNF

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-12 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments. For **scheduled PPS assessments**, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves

a SNF at 6:00pm on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00am, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay. Therefore, a facility that would choose Day 27 for the ARD of their 30-day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day.

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

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

There may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days.

If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3).

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

In the situation when a beneficiary's Medicare Part A stay ends but he/she remains in the facility in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission and must also complete a Part A PPS Discharge assessment. There is no reason to change the OBRA schedule

when Part A benefits resume. If the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

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

Resident Discharged from Part A Skilled Services and Is Not Physically Discharged from the Skilled Nursing Facility

In the situation when a resident's Medicare Part A stay ends but the resident is not physically discharged from the facility, the Part A PPS Discharge assessment is required. If the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

Delay in Requiring and Receiving Skilled Services

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

Non-Compliance with the PPS Assessment Schedule

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

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

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

paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

Late PPS Assessment

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

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

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

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment,** had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment.** For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8).

A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the

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

Missed PPS Assessment

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

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

Errors on a PPS Assessment

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

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

2.14 Expected Order of MDS Records

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (Item A1700) indicating admission, and the next record is expected to be an admission assessment, a 5-day PPS assessment, a discharge, or death in facility. The QIES ASAP system will issue a warning when an unexpected record is submitted. Examples include, an assessment record after a discharge (an entry is expected) or any record after a death in facility record.

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

record is expected to follow the prior record; a record order warning will ***not*** be issued for these combinations.

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

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

Expected Order of MDS Records

	Prior Record													
Next Record	**Entry**	**OBRA Admission**	**OBRA Annual**	**OBRA Quarterly**	**PPS 5-day**	**PPS 14-day**	**PPS 30-day**	**PPS 60-day**	**PPS 90-day**	**PPS OMRA/ Clinical Change**	**OBRA Discharge**	**Part A PPS Discharge**	**Death in facility**	**No prior record**
Entry	no	no	no	no	no	no	no	no	no	no		no	no	
OBRA Admission		no	no	no			no	no	no		no		no	no
OBRA Annual		no	no								no		no	no
OBRA Quarterly, sign. change, sign correction											no		no	no
PPS 5-day					no	no	no	no	no		no		no	no
PPS 14-day	no					no	no	no	no		no		no	no
PPS 30-day	no				no		no	no	no		no		no	no
PPS 60-day	no	no			no	no		no	no		no		no	no
PPS 90-day	no	no			no	no	no		no		no		no	no
PPS Unscheduled											no	no	no	no
OBRA Discharge											no		no	no
Part A PPS Discharge											no		no	no
Death in facility											no		no	no

Note: “no” indicates that the record sequence is not expected; record order warnings will be issued for these combinations. Blank cells indicate expected record sequences; no record order warning will be issued for these combinations.

2.15 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, A0310 F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310F, and A0310H. Item A0310D (swing bed clinical change assessment) has been omitted because it will always be skipped on a nursing home record. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of Items A0310A, A0310B, A0310C, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01	01,02,99	0	10,11,99	0,1	NC	Comprehensive
01	01,02,07	1,2,3	10,11,99	0,1	NC	Comprehensive
01	02,07	4	10,11,99	0,1	NC	Comprehensive
03	01 thru 05,99	0	10,11,99	0,1	NC	Comprehensive
03,04,05	01 thru 07	1,2,3	10,11,99	0,1	NC	Comprehensive
03,04,05	02 thru 05,07	4	10,11,99	0,1	NC	Comprehensive
04,05	01 thru 07,99	0	10,11,99	0,1	NC	Comprehensive
02,06	01 thru 05,99	0	10,11,99	0,1	NQ	Quarterly
02,06	01 thru 07	1,2,3	10,11,99	0,1	NQ	Quarterly
02,06	02 thru 05,07	4	10,11,99	0,1	NQ	Quarterly
99	01 thru 05	0,1,2,3	10,11,99	0,1	NP	PPS
99	02 thru 05	4	10,11,99	0,1	NP	PPS
99	07	1	99	0	NS	SOT OMRA
99	07	1	10,11	0,1	NSD	SOT OMRA and Discharge
99	07	2,3,4	99	0	NO	EOT, EOT-R or COT OMRA
99	07	2,3,4	10,11	0,1	NOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	10,11	0,1	ND	OBRA Discharge
99	99	0	01,12	0	NT	Tracking
99	99	0	99	1	NPE	Part A PPS Discharge

Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C = 0, Item A0310F = 99, and A0310H = 0 (a standalone OBRA Admission assessment), then these

values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C = 0, Item A0310F = 12, and A0310H = 0 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C = 0, A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.

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

The next lookup table is for swing bed records. The first 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	Part A Discharge (A0310H)	ISC	Description
99	01 thru 05	0,1,2,3	0	10,11,99	0,1	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	0,1	SP	PPS
99	02 thru 05	4	0	10,11,99	0,1	SP	PPS
99	02 thru 05,07	4	1	10,11,99	0,1	SP	PPS
99	07	1	0	99	0	SS	SOT OMRA
99	07	1	0	10,11	0,1	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	0	SO	EOT, EOT-R or COT OMRA
99	07	2,3,4	0	10,11	0,1	SOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	0,1	SD	Discharge
99	99	0	0	01,12	0	ST	Tracking

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

- 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.

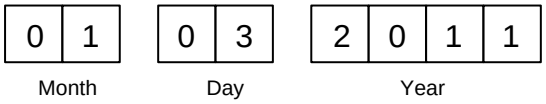
3.3 Coding Conventions

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.**
- When determining the response to items that have a look-back period to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to the QIES ASAP system. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore should not be considered when determining the "prior assessment."
- 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).
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., D0350, **Safety Notification**).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2011 is recorded as:



- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system.
  - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
  - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
  - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
  - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.
- When the term "physician" is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.
- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident's family, significant other, and guardian or legally authorized representative should be consulted.
- Several times throughout the manual the word "significant" is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0 , the term "significant" when discussing clinical, medical, or laboratory findings refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term

"significant" is used in discussing relationships between people, as in "significant other," it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.

- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g., for item K0200B, if the weight was 1010 lbs, you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.

Section	Title	Intent
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

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 ☐☐	**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 ☐☐	**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 ☐	**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 ☐	**D. Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2 0. **No** 1. **Yes**
Enter Code ☐	**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 ☐☐	**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 ☐	**G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned**
Enter Code ☐	**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 ☐	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

A. First name: B. Middle initial:

C. Last name: D. Suffix:

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:

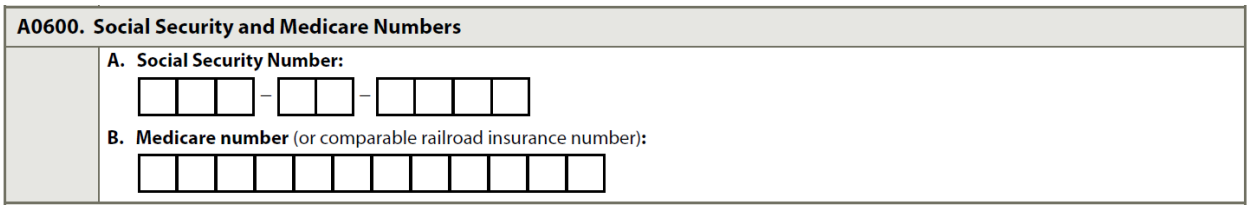
A. First Name

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



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	
	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 ☐	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	
	☐☐ – ☐☐ – ☐☐☐☐ 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	
☐	A. American Indian or Alaska Native
☐	B. Asian
☐	C. Black or African American
☐	D. Hispanic or Latino
☐	E. Native Hawaiian or Other Pacific Islander
☐	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 ☐

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 ☐	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

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

Steps for Assessment

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

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:

  1. Never Married
  2. Married
  3. Widowed
  4. Separated
  5. Divorced

A1300: Optional Resident Items

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

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 ☐	**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?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

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	
☐	A. Serious mental illness
☐	B. Intellectual Disability ("mental retardation" in federal regulation)
☐	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
☐	A. Down syndrome
☐	B. Autism
☐	C. Epilepsy
☐	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
☐	E. ID/DD with no organic condition
	No ID/DD
☐	Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

1. If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (Admission assessment).

2. 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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1700. Type of Entry

Enter Code ☐

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code ☐☐

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	
	Month – Day – Year

Item Rationale

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

Coding Instructions

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

DEFINITION

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

A1700: Type of Entry

A1700. Type of Entry	
Enter Code	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 ☐☐	01. **Community** (private home/apt., board/care, assisted living, group home) 02. **Another nursing home or swing bed** 03. **Acute hospital** 04. **Psychiatric hospital** 05. **Inpatient rehabilitation facility** 06. **ID/DD facility** 07. **Hospice** 09. **Long Term Care Hospital** (LTCH) 99. **Other**

Item Rationale

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

Steps for Assessment

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

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.

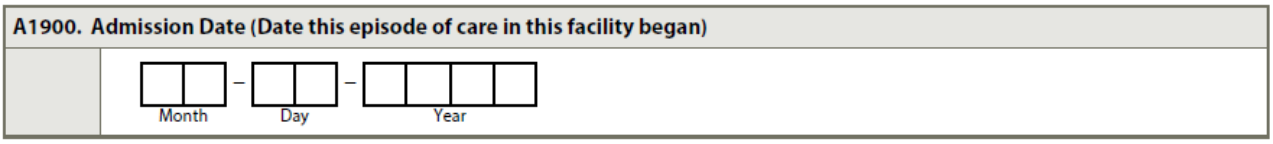
A1800: Entered From (cont.)

- 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)



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.

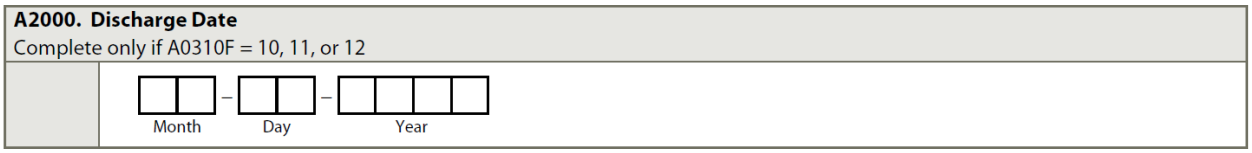
Coding Tips and Special Populations

- 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



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 ☐☐

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	
	☐☐ – ☐☐ – ☐☐☐☐ 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: ☐☐ – ☐☐ – ☐☐☐☐ 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

1. 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 O0600, **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 ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ – ☐☐ – ☐☐☐☐
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.

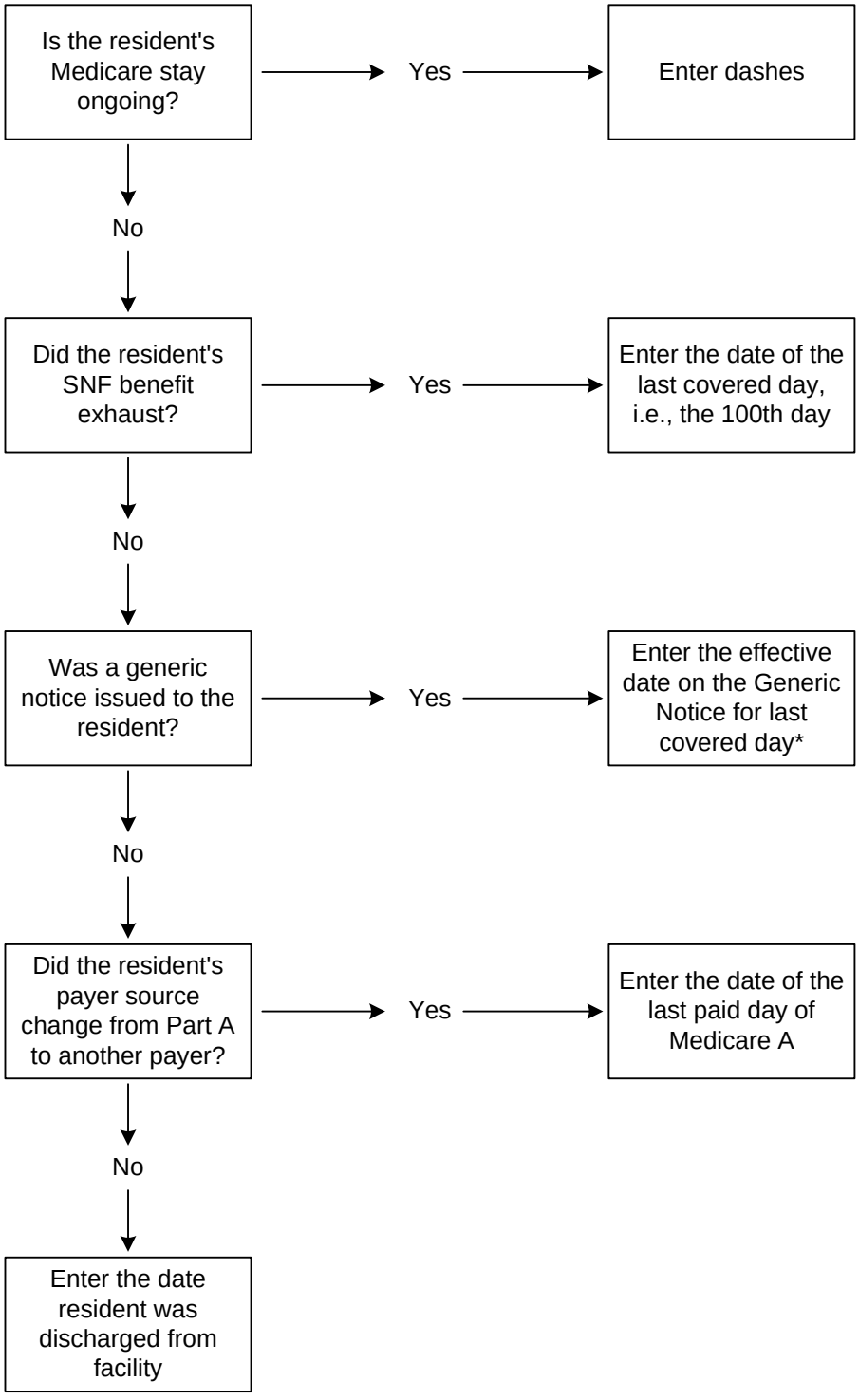
A2400: Medicare Stay (cont.)

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

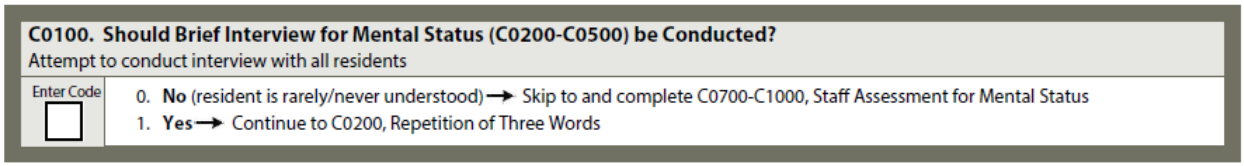


*if resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

SECTION C: COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

C0100: Should Brief Interview for Mental Status Be Conducted?



Item Rationale

Health-related Quality of Life

- This information identifies if the interview will be attempted.
- Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis.
  - Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care.

Planning for Care

- Structured cognitive interviews assist in identifying needed supports.
- The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).

Steps for Assessment

1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 – C1000, Staff Assessment of Mental Status.
2. Review **Language** item (A1100), to determine if the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Record whether the cognitive interview should be attempted with the resident.

- Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
- Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

C0100: Should Brief Interview for Mental Status Be Conducted? (cont.)

Coding Tips

- If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Staff Assessment of Mental Status**, instead of C0200-C0500, **Brief Interview for Mental Status**.
- Includes residents who use American Sign Language (ASL).

C0200-C0500: Brief Interview for Mental Status (BIMS)

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code ☐	Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."* **Number of words repeated after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code ☐	Ask resident: "*Please tell me what year it is right now.*" **A. Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code ☐	Ask resident: "*What month are we in right now?*" **B. Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code ☐	Ask resident: "*What day of the week is today?*" **C. Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**
C0400. Recall	
Enter Code ☐	Ask resident: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?*" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. **A. Able to recall "sock"** 0. **No** - could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
Enter Code ☐	**B. Able to recall "blue"** 0. **No** - could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
Enter Code ☐	**C. Able to recall "bed"** 0. **No** - could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**
C0500. BIMS Summary Score	
Enter Score ☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the resident was unable to complete the interview**

C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact residents may appear to be cognitively impaired because of extreme frailty, hearing impairment or lack of interaction.
- Some residents may appear to be more cognitively intact than they actually are.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.
- A resident's performance on cognitive tests can be compared over time.
  - If performance worsens, then an assessment for delirium and or depression should be considered.
- The BIMS is an opportunity to observe residents for signs and symptoms of delirium (C1310).

Planning for Care

- Assessment of a resident's mental state provides a direct understanding of resident function that may:
  - enhance future communication and assistance and
  - direct nursing interventions to facilitate greater independence such as posting or providing reminders for self-care activities.
- A resident's performance on cognitive tests can be compared over time.
  - An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life threatening illness.
  - A decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning.

Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)

1. Refer to Appendix D for a review of basic approaches to effective interviewing techniques.
2. Interview any resident not screened out by **Should Brief Interview for Mental Status Be Conducted?** (Item C0100).
3. Conduct the interview in a private setting.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.

C0200: Repetition of Three Words (cont.)

Item Rationale

Health-related Quality of Life

- Inability to repeat three words on first attempt may indicate:
  - — a hearing impairment,
  - — a language barrier, or
  - — inattention that may be a sign of delirium.

Planning for Care

- A cue can assist learning.
- Cues may help residents with memory impairment who can store new information in their memory but who have trouble retrieving something that was stored (e.g., not able to remember someone's name but can recall if given part of the first name).
- Staff can use cues when assisting residents with learning and recall in therapy, and in daily and restorative activities.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-3 and C-4. In addition, for repetition of three words:

1. Say to the resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed." Interviewers need to use the words and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.
2. Immediately after presenting the three words, say to the resident: "Now please tell me the three words."
3. After the resident's first attempt to repeat the items:
   - If the resident correctly stated all three words, say, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture" [category cues].
   - Category cues serve as a hint that helps prompt residents' recall ability. Putting words in context stimulates learning and fosters memory of the words that residents will be asked to recall in item C0400, even among residents able to repeat the words immediately.
   - If the resident recalled two or fewer words, say to the resident: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." If the resident still does not recall all three words correctly, you may repeat the words and category cues one more time.

DEFINITION

CATEGORY CUE
Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the resident. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."

C0300: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

- Reorienting those who are disoriented or at risk of disorientation may be useful in treating symptoms of delirium.
- Residents who are not oriented may need further assessment for delirium, especially if this fluctuates or is recent in onset.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-3 and C-4.

1. Ask the resident each of the 3 questions in Item C0300 separately.
2. Allow the resident up to 30 seconds for each answer and do not provide clues.
3. If the resident specifically asks for clues (e.g., "is it bingo day?") respond by saying, "I need to know if you can answer this question without any help from me."

Coding Instructions for C0300A, Able to Report Correct Year

- Code 0, missed by >5 years or no answer: if the resident's answer is incorrect and is greater than 5 years from the current year or the resident chooses not to answer the item.
- Code 1, missed by 2-5 years: if the resident's answer is incorrect and is within 2 to 5 years from the current year.
- Code 2, missed by 1 year: if the resident's answer is incorrect and is within one year from the current year.
- Code 3, correct: if the resident states the correct year.

Examples

1. The date of interview is May 5, 2011. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 2011.

   Coding: C0300A would be coded 3, correct.
   Rationale: 2011 is the current year.

2. The date of interview is June 16, 2011. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 2007.

   Coding: C0300A would be coded 1, missed by 2-5 years.
   Rationale: 2007 is within 2 to 5 years of 2011.

3. The date of interview is January 10, 2011. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 1911.

   Coding: C0300A would be coded 0, missed by more than 5 years.
   Rationale: Even though the '11 part of the year would be correct, 1911 is more than 5 years from 2011.

C0400: Recall

C0400. Recall	
Enter Code ☐	Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. **A. Able to recall "sock"** 0. **No** - could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
Enter Code ☐	**B. Able to recall "blue"** 0. **No** - could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
Enter Code ☐	**C. Able to recall "bed"** 0. **No** - could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**

Item Rationale

Health-related Quality of Life

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize individual function and decrease frustration for those residents who respond.

Planning for Care

- Care plans should maximize use of cueing for resident who respond to recall cues. This will enhance independence.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-3 and C-4.

1. Ask the resident the following: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
2. Allow up to 5 seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after 5 seconds, provide a category cue (refer to "Steps for Assessment," pages C-6–C-7 for the definition of category cue). Category cues should be used only after the resident is unable to recall one or more of the three words.
4. Allow up to 5 seconds after category cueing for each missed word to be recalled.

Coding Instructions

*For **each** of the three words the resident is asked to remember:*

- Code 0, no—could not recall: if the resident cannot recall the word even after being given the category cue or if the resident responds with a nonsensical answer or chooses not to answer the item.
- Code 1, yes, after cueing: if the resident requires the category cue to remember the word.
- Code 2, yes, no cue required: if the resident correctly remembers the word spontaneously without cueing.

C0400: Recall (cont.)

4. The resident is asked to recall the three words. The resident says, "I don't remember." The assessor then says, "One word was something to wear." The resident says, "Hat, shirt, pants, socks, shoe, belt."

   Coding: C0400A, sock, would be coded 0, no—could not recall.

   Rationale: After getting the category cue, the resident named more than one item (i.e., a laundry list of items) in the category. The resident's response is coded as incorrect, even though one of the items was correct, because the resident did not demonstrate recall and likely named the item by chance.

C0500: BIMS Summary Score

C0500. BIMS Summary Score	
Enter Score ☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the resident was unable to complete the interview**

Item Rationale

Health-related Quality of Life

- The total score:
  - — Allows comparison with future and past performance.
  - — Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
  - — Provides staff with a more reliable estimate of resident function and allows staff interactions with residents that are based on more accurate impressions about resident ability.

Planning for Care

- The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance. The final determination of the level of impairment should be made by the resident's physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance:

  The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:

  13-15: cognitively intact

  8-12: moderately impaired

  0-7: severe impairment

C0500: BIMS Summary Score (cont.)

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life threatening illness and a change in cognition may be the only indication of an underlying problem.
- Care plans can be more individualized based upon reliable knowledge of resident function.

Steps for Assessment

After completing C0200-C0400:

1. Add up the values for all questions from C0200 through C0400.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.

Coding Instructions

Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.

- If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed.
- To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-4 for residents who choose not to participate at all.
- Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, ***or*** (c) if any of the BIMS items is coded with a dash.
  - Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

Coding Tips

- Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, **BIMS Summary Score**, and complete the staff assessment of mental status.

C0500: BIMS Summary Score (cont.)

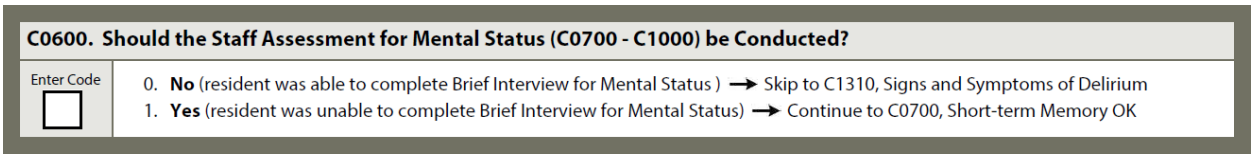
Example

1. The resident's scores on items C0200-C0400 were as follows:

C0200 (repetition)	3
C0300A (year)	2
C0300B (month)	2
C0300C (day)	1
C0400A (recall "sock")	2
C0400B (recall "blue")	2
C0400C (recall "bed")	0

Coding: C0500 would be coded 12.

C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted?



C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function using the BIMS is preferred as it decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium. However, a minority of residents are unable or unwilling to participate in the BIMS.
- Mental status can vary among persons unable to communicate or who do not complete the interview.
  - Therefore, report of observed behavior is needed for persons unable to complete the BIMS interview.
  - When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered.

Planning for Care

- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
  - This remains true for persons who are unable to communicate or to complete the BIMS.
- Specific aspects of cognitive impairment, when identified, can direct nursing interventions to facilitate greater independence and function.

C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted? (cont.)

Steps for Assessment

1. Review whether **BIMS Summary Score** item (C0500), is `coded 99`, unable to complete interview.

Coding Instructions

- `Code 0, no`: if the BIMS was completed and scored between 00 and 15. Skip to C1310.
- `Code 1, yes`: if the resident chooses not to participate in the BIMS or if four or more items were `coded 0` because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be `coded 99`.

Coding Tips

- If a resident is scored 00 on C0500, C0700-C1000, Staff Assessment, should not be completed. **00** is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items.

C0700-C1000: Staff Assessment of Mental Status Item

Staff Assessment for Mental Status	
Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed	
C0700. Short-term Memory OK	
Enter Code ☐	**Seems or appears to recall after 5 minutes** 0. **Memory OK** 1. **Memory problem**
C0800. Long-term Memory OK	
Enter Code ☐	**Seems or appears to recall long past** 0. **Memory OK** 1. **Memory problem**
C0900. Memory/Recall Ability	
↓ **Check all that the resident was normally able to recall**	
☐	**A. Current season**
☐	**B. Location of own room**
☐	**C. Staff names and faces**
☐	**D. That he or she is in a nursing home/hospital swing bed**
☐	**Z. None of the above** were recalled
C1000. Cognitive Skills for Daily Decision Making	
Enter Code ☐	**Made decisions regarding tasks of daily life** 0. **Independent** - decisions consistent/reasonable 1. **Modified independence** - some difficulty in new situations only 2. **Moderately impaired** - decisions poor; cues/supervision required 3. **Severely impaired** - never/rarely made decisions

C0800: Long-term Memory OK (cont.)

3. Observe if the resident responds to memorabilia or family members who visit.
4. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
5. Ask direct care staff across all shifts and family or significant others about the resident's memory status.
6. Review the medical record for clues to the resident's long-term memory during the look-back period.

Coding Instructions

- Code 0, memory OK: if the resident accurately recalled long past information.
- Code 1, memory problem: if the resident did not recall long past information or did not recall it correctly.

Coding Tips

- If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff were unable to make a determination based on observation of the resident, use the standard "no information" code (a dash, "-"), to indicate that the information is not available because it could not be assessed.

C0900: Memory/Recall Ability

C0900. Memory/Recall Ability	
↓ Check all that the resident was normally able to recall	
☐	A. Current season
☐	B. Location of own room
☐	C. Staff names and faces
☐	D. That he or she is in a nursing home/hospital swing bed
☐	Z. None of the above were recalled

Item Rationale

Health-related Quality of Life

- An observed "memory/recall problem" with these items may indicate:
  - cognitive impairment and the need for additional support with reminders to support increased independence; or
  - delirium, if this represents a change from the resident's baseline.

Planning for Care

- An observed "memory/recall problem" with these items may indicate the need for:
  - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or
  - possible evaluation for other problems with thinking;
  - additional signs, directions, pictures, verbal reminders to support the resident's independence;

C0900: Memory/Recall Ability (cont.)

— an evaluation for acute delirium if this represents a change over the past few days to weeks;

— an evaluation for chronic delirium if this represents a change over the past several weeks to months; or

— additional nursing support;

— the need for emotional support, reminders and reassurance to reduce anxiety and agitation.

Steps for Assessment

1. Ask the resident about each item. For example, "What is the current season? Is it fall, winter, spring, or summer?" "What is the name of this place?" If the resident is not in his or her room, ask, "Will you show me to your room?" Observe the resident's ability to find the way.
2. For residents with limited communication skills, in order to determine the most representative level of function, ask direct care staff across all shifts and family or significant other about recall ability.
   - Ask whether the resident gave indications of recalling these subjects or recognizing them during the look-back period.
3. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
4. Review the medical record for indications of the resident's recall of these subjects during the look-back period.

Coding Instructions

For each item that the resident recalls, check the corresponding answer box. If the resident recalls none, check ***none of above.***

- Check C0900A, current season: if resident is able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
- Check C0900B, location of own room: if resident is able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.
- Check C0900C, staff names and faces: if resident is able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.
- Check C0900D, that he or she is in a nursing home/hospital swing bed: if resident is able to determine that he or she is currently living in a nursing home. To check this item, it is not necessary that the resident be able to state the name of the nursing home, but he or she should be able to refer to the nursing home by a term such as a "home for older people," a "hospital for the elderly," "a place where people who need extra help live," etc.
- Check C0900Z, none of above was recalled.

C1310: Signs and Symptoms of Delirium

Delirium		
C1310. Signs and Symptoms of Delirium (from CAM©)		
Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record		
A. Acute Onset Mental Status Change		
☐	**Is there evidence of an acute change in mental status** from the resident's baseline? 0. No 1. Yes	
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**	
	☐	**B. Inattention**- Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?
	☐	**C. 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)?
	☐	**D. Altered level of consciousness**- Did the resident have altered level of consciousness as indicated by any of the following criteria? •**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
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. Used with permission.		

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.

C1310: Signs and Symptoms of Delirium (cont.)

Steps for Assessment

1. Observe resident behavior during the **BIMS** items (C0200-C0400) for the signs and symptoms of delirium. Some experts suggest that increasing the frequency of assessment (as often as daily for new admissions) will improve the level of detection.
2. If the **Staff Assessment for Mental Status** items (C0700-C1000) was completed instead of the BIMS, ask staff members who conducted the interview about their observations of signs and symptoms of delirium.
3. Review medical record documentation during the 7-day look-back period to determine the resident's baseline status, fluctuations in behavior, and behaviors that might have occurred during the 7-day look-back period that were not observed during the BIMS.
4. Interview staff, family members and others in a position to observe the resident's behavior during the 7-day look-back period.

DEFINITION

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

For additional guidance on the signs and symptoms of delirium can be found in Appendix C.

Coding Instructions for C1310A, Acute Mental Status Change

- Code 0, no: if there is no evidence of acute mental status change from the resident's baseline.
- Code 1, yes: if resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline.

Coding Tips

- Interview resident's family or significant others.
- Review medical record prior to 7-day look-back to determine the resident's usual mental status.

Examples

1. Resident was admitted to the nursing home 4 days ago. Her family reports that she was alert and oriented prior to admission. During the BIMS interview, she is lethargic and incoherent.

   Coding: Item C1310A would be coded 1, yes.

   Rationale: There is an acute change of the resident's behavior from alert and oriented (family report) to lethargic and incoherent during interview.

2. Nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place.

   Coding: Item C1310A would be coded 1, yes.

   Rationale: The new behaviors represent an acute change in mental status.

C1310: Signs and Symptoms of Delirium (cont.)

Other Examples of Acute Mental Status Changes

- A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- A resident who is normally quiet and content suddenly becomes restless or noisy.
- A resident who is usually able to find his or her way around the unit begins to get lost.

Steps for Assessment for C1310B, Inattention

1. Assess attention separately from level of consciousness. Evidence of inattention may be found during the resident interview, in the medical record, or from family or staff reports of inattention during the 7-day look-back period.
2. An additional step to identify difficulty with attention is to ask the resident to count backwards from 20.

Coding Instructions for C1310B, Inattention

- Code 0, behavior not present: if the resident remains focused during the interview and all other sources agree that the resident was attentive during other activities.
- Code 1, behavior continuously present, did not fluctuate: if the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary during the look-back period. All sources must agree that inattention was consistently present to select this code.
- Code 2, behavior present, fluctuates: if inattention is noted during the interview or any source reports that the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied during interview or during the look-back period or if information sources disagree in assessing level of attention.

DEFINITIONS

INATTENTION
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look- back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.

C1310: Signs and Symptoms of Delirium (cont.)

Examples

1. The resident tries to answer all questions during the BIMS. Although she answers several items incorrectly and responds "I don't know" to others, she pays attention to the interviewer. Medical record and staff indicate that this is her consistent behavior.

   Coding: Item C1310B would be coded 0, behavior not present.
   Rationale: The resident remained focused throughout the interview and this was constant during the look-back period.

2. Questions during the BIMS must be frequently repeated because resident's attention wanders. This behavior occurs throughout the interview and medical records and staff agree that this behavior is consistently present. The resident has a diagnosis of dementia.

   Coding: Item C1310B would be coded 1, behavior continuously present, does not fluctuate.
   Rationale: The resident's attention consistently wandered throughout the 7-day look-back period. The resident's dementia diagnosis does not affect the coding.

3. During the BIMS interview, the resident was not able to focus on all questions asked and his gaze wandered. However, several notes in the resident's medical record indicate that the resident was attentive when staff communicated with him.

   Coding: Item C1310B would be coded 2, behavior present, fluctuates.
   Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, C1310B cannot be coded as 0, Behavior not present.

4. Resident is dazedly staring at the television for the first several questions. When you ask a question, she looks at you momentarily but does not answer. Midway through questioning, she seems to pay more attention and tries to answer.

   Coding: Item C1310B would be coded 2, behavior present, fluctuates.
   Rationale: Resident's attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be coded 2.

C1310: Signs and Symptoms of Delirium (cont.)

Coding Instructions for C1310C, Disorganized Thinking

DEFINITION

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, or incoherent speech.

- Code 0, behavior not present: if all sources agree that the resident's thinking was organized and coherent, even if answers were inaccurate or wrong.
- Code 1, behavior continuously present, did not fluctuate: if, during the interview and according to other sources, the resident's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the resident unpredictably switched from subject to subject.
- Code 2, behavior present, fluctuates: if, during the interview or according to other data sources, the resident's responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.

Examples

1. The interviewer asks the resident, who is often confused, to give the date, and the response is: "Let's go get the sailor suits!" The resident continues to provide irrelevant or nonsensical responses throughout the interview, and medical record and staff indicate this is constant.

   Coding: C1310C would be coded 1, behavior continuously present, does not fluctuate.
   Rationale: All sources agree that the disorganized thinking is constant.

2. The resident responds that the year is 1837 when asked to give the date. The medical record and staff indicate that the resident is never oriented to time but has coherent conversations. For example, staff reports he often discusses his passion for baseball.

   Coding: C1310C would be coded 0, behavior not present.
   Rationale: The resident's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. The resident was able to tell the interviewer her name, the year and where she was. She was able to talk about the activity she just attended and the residents and staff that also attended. Then the resident suddenly asked the interviewer, "Who are you? What are you doing in my daughter's home?"

   Coding: C1310C would be coded 2, behavior present, fluctuates.
   Rationale: The resident's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be coded 2.

C1310: Signs and Symptoms of Delirium (cont.)

Coding Instructions for C1310D, Altered Level of Consciousness

- Code 0, behavior not present: if all sources agree that the resident was alert and maintained wakefulness during conversation, interview(s), and activities.
- Code 1, behavior continuously present, did not fluctuate: if, during the interview and according to other sources, the resident was consistently lethargic (difficult to keep awake), stuporous (very difficult to arouse and keep aroused), vigilant (startles easily to any sound or touch), or comatose.
- Code 2, behavior present, fluctuates: if, during the interview or according to other sources, the resident varied in levels of consciousness. For example, was at times alert and responsive, while at other times resident was lethargic, stuporous, or vigilant. Also code as fluctuating if information sources disagree.

DEFINITIONS

ALTERED LEVEL OF CONSCIOUSNESS

VIGILANT – startles easily to any sound or touch;

LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch;

STUPOR – very difficult to arouse and keep aroused for the interview;

COMATOSE – cannot be aroused despite shaking and shouting.

Coding Tips

- A diagnosis of coma or stupor does not have to be present for staff to note the behavior in this section.

Examples

1. Resident is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and staff report during the 7-day look-back period consistently noted that the resident was alert.

   Coding: C1310D would be coded 0, behavior not present.

   Rationale: All evidence indicates that the resident is alert during conversation, interview(s) and activities.

2. The resident is lying in bed. He arouses to soft touch but is only able to converse for a short time before his eyes close, and he appears to be sleeping. Again, he arouses to voice or touch but only for short periods during the interview. Information from other sources indicates that this was his condition throughout the look-back period.

   Coding: C1310D would be coded 1, behavior continuously present, does not fluctuate.

   Rationale: The resident's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.

C1310: Signs and Symptoms of Delirium (cont.)

3. Resident is usually alert, oriented to time, place, and person. Today, at the time of the BIMS interview, resident is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.

Coding: C1310D would be coded 2, behavior present, fluctuates.
Rationale: The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be coded 2, fluctuating.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

D0350: Follow-up to D0200I

D0350. **Safety Notification** - Complete only if D0200I1 = 1 indicating possibility of resident self harm	
Enter Code ☐	**Was responsible staff or provider informed that there is a potential for resident self harm?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that he or she had thoughts of being better off dead, or hurting him or herself in some way.
- It is well-known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life threatening behaviors, including poor nutrition and treatment refusal are common.
- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.

Planning for Care

- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).

Steps for Assessment

1. Complete item D0350 **only** if item D0200I1 **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1 indicating the possibility of resident self-harm.

Coding Instructions

- Code 0, no: if responsible staff or provider was not informed that there is a potential for resident self-harm.
- Code 1, yes: if responsible staff or provider was informed that there is a potential for resident self-harm.

D0650: Follow-up to D0500I

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm	
Enter Code ☐	**Was responsible staff or provider informed that there is a potential for resident self harm?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that they had thoughts of being better off dead, or hurting him or herself in some way.
- It is well known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life-threatening behaviors, including poor nutrition and treatment refusal are common.

Planning for Care

- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).

Steps for Assessment

1. Complete item D0650 only if item D0500I, **States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self** = 1 indicating the possibility of resident self-harm.

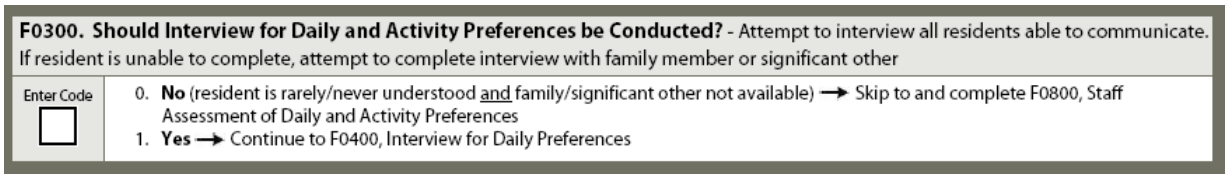
Coding Instructions

- Code 0, no: if responsible staff or provider was not informed that there is a potential for resident self-harm.
- Code 1, yes: if responsible staff or provider was informed that there is a potential for resident self-harm.

SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive.

F0300: Should Interview for Daily and Activity Preferences Be Conducted?



F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

Item Rationale

Health-related Quality of Life

- Most residents capable of communicating can answer questions about what they like.
- Obtaining information about preferences directly from the resident, sometimes called "hearing the resident's voice," is the most reliable and accurate way of identifying preferences.
- If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences.

Planning for Care

- Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident.
- Interviews allow the resident's voice to be reflected in the care plan.
- Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning.

Steps for Assessment

1. Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
2. Conduct the interview during the observation period.
3. Review **Language** item (A1100) to determine whether or not the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.
4. The resident interview should be conducted if the resident can respond:
   - verbally,
   - by pointing to their answers on the cue card, OR

F0300: Should Interview for Daily and Activity Preferences Be Conducted? (cont.)

- by writing out their answers.

Coding Instructions

Record whether the resident preference interview should be attempted.

- Code 0, no: if the interview should not be attempted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences).
- Code 1, yes: if the resident interview should be attempted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences).

Coding Tips and Special Populations

- If the resident needs an interpreter, every effort should be made to have an interpreter present for the MDS clinical interview. If it is not possible for a needed interpreter to be present on the day of the interview, **and** a family member or significant other is not available for interview, **code F0300 = 0** to indicate interview not attempted, and complete the Staff Assessment of Daily and Activity Preferences (F0800) instead of the interview with the resident (F0400 and F0500).

F0400: Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: "***While you are in this facility...***"

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

☐	*A. how important is it to you to* ***choose what clothes to wear?***
☐	*B. how important is it to you to* ***take care of your personal belongings or things?***
☐	*C. how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
☐	*D. how important is it to you to* ***have snacks available between meals?***
☐	*E. how important is it to you to* ***choose your own bedtime?***
☐	*F. how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
☐	*G. how important is it to you to* ***be able to use the phone in private?***
☐	*H. how important is it to you to* ***have a place to lock your things to keep them safe?***

F0400: Interview for Daily Preferences (cont.)

- Code 9, no response or non-responsive:
  - If resident, family, or significant other refuses to answer or says he or she does not know.
  - If resident does not give an answer to the question for several seconds and does not appear to be formulating an answer.
  - If resident provides an incoherent or nonsensical answer that does not correspond to the question.

Coding Tips and Special Populations

- The interview is considered incomplete if the resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500. If the interview is stopped because it is considered incomplete, fill the remaining F0400 and F0500 items with a 9 and proceed to F0600, Daily Activity Preferences Primary Respondent.
- No look-back is provided for resident. He or she is being asked about current preferences while in the nursing home but is not limited to a 7-day look-back period to convey what his/her preferences are.
- The facility is still obligated to complete the interview within the 7-day look-back period.

Interviewing Tips and Techniques

- Sometimes respondents give long or indirect answers to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
- For these questions, it is appropriate to explore residents' answers and try to understand the reason.

Examples for F0400A, How Important Is It to You to Choose What Clothes to Wear (including hospital gowns or other garments provided by the facility)?

1. Resident answers, "It's very important. I've always paid attention to my appearance."

   Coding: F0400A would be coded 1, very important.

2. Resident replies, "I leave that up to the nurse. You have to wear what you can handle if you have a stiff leg."

   Interviewer echoes, "You leave it up to the nurses. Would you say that, while you are here, choosing what clothes to wear is [pointing to cue card] very important, somewhat important, not very important, not important at all, or that it's important, but you can't do it because of your leg?"

   Resident responds, "Well, it would be important to me, but I just can't do it."

   Coding: F0400A would be coded 5, important, but can't do or no choice.

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section assesses the need for assistance with self-care and mobility activities.

GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Code ☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency.
Enter Code ☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
Enter Code ☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Item Rationale

- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

Steps for Assessment

1. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B, Start of most recent Medicare stay.
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. Residents should be coded performing activities based on their "usual performance" (or baseline performance on admission), which is identified as the resident's usual activity/performance for any of the self-care or mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's self-care performance varies during the assessment period, report the resident's usual status, **not** the resident's most independent performance and **not** the resident's most dependent episode.
6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

Admission or Discharge Performance Coding Instructions

- Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- Code 04, Supervision or touching assistance: if the helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

Admission or Discharge Performance Coding Tips

- The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted under SNF Part A.
  - For the Admission assessment, code the resident's functional status based on an assessment of the resident's performance that occurs soon after the resident's admission. This assessment must be completed within 3 calendar days (days 1 through 3 of the Medicare Part A stay), starting with the date in A2400B, Start of most recent Medicare stay and the following two days, ending at 11:59 PM on day 3. The assessment should occur prior to the start of therapeutic intervention in order to capture the resident's true admission baseline status.
- The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (or when the resident is discharged from the facility on the day of, or one day after the Medicare Part A Stay ends. When this occurs, the OBRA Discharge assessment may be combined with the Part A PPS Discharge assessment.).

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

  - For the Discharge assessment, code the resident's functional status, based on an assessment of the resident's performance that occurs as close to the time of the resident's discharge as possible. The discharge function scores are to reflect the resident's discharge status and are to be based on an assessment. The assessment must be completed within the last 3 calendar days of the resident's stay, which includes the day of discharge and the two days prior to the day of discharge.

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.
- When coding the resident's usual performance, use the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.
- At admission, when coding for the resident's discharge goal(s), use the same 6-point scale. Instructions about coding discharge goals are provided below under Discharge Goal(s): Coding Tips.
- On discharge, use the same 6-point scale or "activity was not attempted" codes that are used for the admission assessment to identify the resident's usual performance on the Discharge assessment.
- Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's *usual performance* during the assessment period.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash ("-").
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

Examples for Coding Admission Performance or Discharge Performance

Note: The following are coding examples for each self-care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for GG0130A, Eating

1. **Eating:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-fourths of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

   Coding: GG0130A. Eating would be coded 03, Partial/moderate assistance.

   Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

2. **Eating:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M's hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

   Coding: GG0130A. Eating would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Eating:** Mr. A. eats all meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

   Coding: GG0130A. Eating would be coded 06, Independent.
   Rationale: The resident can independently complete the activity without any assistance from a helper for this activity. The presence of a G-tube does not affect the eating score.

4. **Eating:** The dietary aide opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A. Eating would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.
   Rationale: Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

6. **Eating:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, the certified nursing assistant has to remind her to scan her entire meal tray to ensure she has seen all the food.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, the certified nursing assistant provides verbal and tactile cueing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

   Coding: GG0130A. Eating would be coded 04, Supervision or touching assistance.
   Rationale: The resident requires supervision and touching assistance in order to eat safely.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

8. **Eating:** Mr. R is unable to eat by mouth due to his medical condition. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   Coding: GG0130A. Eating would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not eat by mouth at this time. Assistance with G-tube feedings is not considered when coding the item Eating.

9. **Eating:** Mr. F is fed all meals by the certified nursing assistant, because Mr. F has severe arm weakness and he is unable to assist.

   Coding: GG0130A. Eating would be coded 01, Dependent.
   Rationale: The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.

10. **Eating:** Mr. J had a stroke that affects his left side. He is left-handed and feeds himself more than half of his meals, but tires easily. Mr. J requests assistance from the certified nursing assistant with the remainder of his meals.

    Coding: GG0130A. Eating would be coded 03, Partial/moderate assistance.
    Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating.

11. **Eating:** Mrs. M has osteoporosis, which contributed to the fracture of her right wrist and hip during a recent fall. She is right-handed. Mrs. M. starts eating on her own, but she does not have the coordination in her left hand to manage the eating utensils to feed herself without great effort. Mrs. M tires easily and cannot complete eating the meal. The certified nursing assistant feeds her more than half of the meal.

    Coding: GG0130A. Eating would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provides more than half the effort for the resident to complete the activity of eating.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. Each time, the certified nursing assistant gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

   Coding: GG0130B. Oral hygiene would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup and clean-up assistance. The resident brushes her teeth without any help.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns and provides steadying assistance as the resident walks back to his bed.

   Coding: GG0130B. Oral hygiene would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Mr. S brushes his teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

3. **Oral hygiene:** At night, the certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

   Coding: GG0130B. Oral hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

4. **Oral hygiene:** Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. In the morning and evening, Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

   Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The resident begins the activity. The helper completes the activity by performing more than half the effort.

5. **Oral hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts tooth brushing and the certified nursing assistant usually completes the activity by performing more than half of this activity.

   Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of oral hygiene.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

6. **Oral hygiene:** Ms. T has Lewy body dementia and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

   Coding: GG0130B. Oral hygiene would be coded 01, Dependent.
   Rationale: The helper provides all the effort for the activity to be completed.

7. **Oral hygiene:** Mr. D has experienced a stroke. He can brush his teeth while sitting on the side of the bed, but when the certified nursing assistant hands him the toothbrush and toothpaste, he looks up at her puzzled what to do next. The certified nursing assistant cues Mr. D to put the toothpaste on the toothbrush and instructs him to brush his teeth. Mr. D then completes the task of brushing his teeth.

   Coding: GG0130B. Oral hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing his teeth.

8. **Oral hygiene:** Ms. K suffered a stroke a few months ago that resulted in cognitive limitations. She brushes her teeth at the sink, but is unable to initiate the task on her own. The occupational therapist cues Ms. K to put the toothpaste onto the toothbrush, brush all areas of her teeth, and rinse her mouth after brushing. The occupational therapist remains with Ms. K providing verbal cues until she has completed the task of brushing her teeth.

   Coding: GG0130B. Oral hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing her teeth.

9. **Oral hygiene:** Mrs. N has early stage amyotrophic lateral sclerosis. She starts brushing her teeth and completes cleaning her upper teeth and part of her lower teeth when she becomes fatigued and asks the certified nursing assistant to help her finish the rest of the brushing.

   Coding: GG0130B. Oral hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her pants and underwear before sitting down on the toilet. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her pants and underwear.

   Coding: GG0130C. Toileting hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

2. **Toileting hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

   Coding: GG0130C. Toileting hygiene would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as the resident performs the toilet hygiene activity. The resident is unsteady and the staff provide supervision for safety reasons.

3. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls her underwear back up.

   Coding: GG0130C. Toileting hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

4. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

   Coding: GG0130C. Toileting hygiene would be coded 01, Dependent.
   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Toileting hygiene:** Mr. C has Parkinson's disease and significant tremors that cause intermittent difficulty for him to perform perineal hygiene after having a bowel movement in the toilet. He walks to the bathroom with close supervision and lowers his pants, but asks the certified nursing assistant to help him with perineal hygiene after moving his bowels. He then pulls up his pants without assistance.

   Coding: GG0130C. Toileting hygiene would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by himself. Walking to the bathroom is not considered when scoring toileting hygiene.

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident's eating abilities:

   Nurse: "Please describe to me how Mr. S eats his meals. Once the food is presented to him, does he use utensils to bring food to his mouth and swallow?"

   Certified nursing assistant: "No, I have to feed him."

   Nurse: "Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?"

   Certified nursing assistant: "No, he can't do anything by himself. I scoop up each portion of the food and bring the fork or spoon to his mouth. I try to encourage him to feed himself or to help guide the spoon to his mouth but he can't hold the fork. I even tried encouraging him to eat food he could pick up with his fingers, but he will not eat unless he is completely assisted."

   In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

   Coding: GG0130A. Eating would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat his meals.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident's oral hygiene routine:

   Nurse: "Does Mrs. K help with brushing her teeth?"

   Certified nursing assistant: "She can help clean her teeth."

   Nurse: "How much help does she need to brush her teeth?"

   Certified nursing assistant: "She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth."

   In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

   Coding: GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.
   Rationale: The certified nursing assistant provides more than half the effort to complete Mrs. K's oral hygiene.

Discharge Goal(s): Coding Tips

- Use the 6-point scale to code the resident's discharge goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code discharge goal(s). Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-care or mobility. **Using the dash in this allowed instance does not affect APU determination**.
- Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan.
- For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a resident.
- Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family, and the clinician's consideration of expected treatments, and resident motivation to improve.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a discharge goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

Discharge Goal: Coding Examples

Example 1: Discharge Goal Code Is *Higher* than 5-Day PPS Assessment Admission Performance Code

If the clinician determines that the resident is expected to make gains in function by discharge, the code reported for discharge goal will be higher than the admission performance code.

Example 2: Discharge Goal Code Is the *Same* as 5-Day PPS Assessment Admission Performance Code

The clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the clinician determines that the resident would be able to maintain her admission functional performance level. The clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the discharge goal is coded at the same level as the resident's admission performance code.

Oral Hygiene 5-Day PPS Assessment Admission Performance and Discharge Goal: In this example, the clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the discharge goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The clinician observes Mrs. E's 5-Day PPS admission performance and discusses her usual performance with clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E's limb). The clinician codes Mrs. E's 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding her limb.

Oral Hygiene 5-Day PPS Assessment Admission Performance and Discharge Goal: The clinician anticipates Mrs. E's discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the clinician and resident feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a discharge goal.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Example 3: Discharge Goal Code Is *Lower* than 5-Day PPS Assessment Admission Performance Code

The clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the discharge goal code is lower than the resident's 5-Day PPS assessment admission performance code.

Toileting Hygiene: Mrs. T's participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The resident's discharge *goal* code will be lower than the 5-Day PPS *admission performance* code.

Toileting Hygiene 5-Day PPS Assessment Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. T's toileting hygiene.

Toileting Hygiene Discharge Goal: By discharge, it is expected that Mrs. T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The clinician codes her discharge goal as 02, Substantial/maximal assistance.

GG0170: Mobility (3-day assessment period) Admission (Start of Medicare Part A Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
		☐ **H1. Does the resident walk?** 0. **No**, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. **No**, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
		☐ **Q1. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

GG0170: Mobility (3-day assessment period)
Discharge (End of Medicare Part A Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance Enter Codes in Boxes	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
	☐ **H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	☐ **Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Item Rationale

- Residents in Medicare Part A SNF stays may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

Steps for Assessment

1. Assess the resident's mobility abilities based on direct observation, the resident's self-report, and reports from the clinician, care staff, or family as documented in the medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B, Start of most recent Medicare stay.
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
3. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. Residents should be coded performing activities based on their "usual performance" (baseline performance on admission), which is identified as the resident's usual activity/performance for any of the self-care or mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's mobility performance varies during the assessment period, report the resident's usual status, **not** the resident's most independent performance and **not** the resident's most dependent episode.
6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

Admission or Discharge Performance Coding Instructions

- Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper.
- Code 05, Setup or clean-up assistance: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- Code 04, Supervision or touching assistance: if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.
- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

Admission or Discharge Performance Coding Tips

- The 5-Day PPS assessment is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - For the Admission assessment, code the resident's functional status based on an assessment of the resident's performance that occurs soon after the resident's admission. This assessment must be completed within 3 calendar days (days 1 through 3 of the Medicare Part A stay), starting with the date in A2400B, Start of most recent Medicare stay and the following two days, ending at 11:59 PM on day 3. The assessment should occur prior to the start of therapeutic intervention in order to capture the resident's true admission baseline status.
- The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

  - For the Discharge assessment, code the resident's functional status, based on an assessment of the resident's performance that occurs as close to the time of the resident's discharge as possible. The discharge function scores are to reflect the resident's discharge status and are to be based on assessment. The assessment must be completed within the last 3 calendar days of the resident's stay, which includes the day of discharge and the two days prior to the day of discharge.

- When reviewing the health records, interviewing staff, and observing the resident, be familiar with the definition of each activity. For example, when assessing Walk 50 feet with 2 turns (item GG0170J), determine the level of assistance required to walk 50 feet while making 2 turns.
- On the 5-Day PPS assessment, code the resident's "usual performance," or baseline performance, using the 6-point scale or code the reason an activity was not attempted, as well as the resident's discharge goal(s) using the 6-point scale. **Instructions above related to coding Discharge Goals for the mobility items (GG0170) are the same as those for coding Discharge Goals for the self-care items (GG0130)**.
- The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane or wheelchair).
- On the Part A PPS Discharge assessment, code the resident's usual performance using the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.
- Record the resident's usual ability to perform each activity (e.g., sit to lying). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's *usual performance* during the assessment period.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in annual payment update. If the reason that the activity was not attempted is that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash ("-").
- For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one discharge goal is required, the facility may choose to code more than one discharge goal for a resident.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.

Examples and Coding Tips for Admission or Discharge Performance

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days. Some examples do not have coding tips.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0170B, Sit to lying

1. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body. Overall, Mrs. H performs more than half of the effort.

   Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; Mrs. H does more than half of the effort.

2. **Sit to lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

   Coding: GG0170B. Sit to lying would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

3. **Sit to lying:** Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B. Sit to lying would be coded 01, Dependent.
   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Sit to lying:** Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   Coding: GG0170B. Sit to lying would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Sit to lying:** Mrs. G suffered a traumatic brain injury three months prior to admission. She requires the certified nursing assistant to steady her movements from sitting on the side of the bed to lying flat on the bed. Mrs. G requires steadying (touching) assistance throughout the completion of this activity.

   Coding: GG0170B. Sit to lying would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides steadying assistance in order for the resident to complete the activity of sit to lying flat on her bed.

6. **Sit to lying:** Mrs. E suffered a pelvic fracture during a motor vehicle accident. Mrs. E requires the certified nursing assistant to lift and position her left leg when she transfers from sitting at the edge of the bed to lying flat on the bed due to severe pain in her left pelvic area. Mrs. E uses her arms to position and lower her upper body to lying flat on the bed. Overall, Mrs. E performs more than half of the effort.

   Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. E's left leg and helps her position it as Mrs. E transitions from a seated to a lying position; Mrs. E does more than half of the effort.

7. **Sit to lying:** Mr. A suffered multiple vertebral fractures due to a fall off a ladder. He requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back. The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed. Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

   Coding: GG0170B. Sit to lying would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Mr. B pushes up from the bed to get himself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Mr. B scoots himself to the edge of the bed and lowers his feet onto the floor.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident moves from a lying to sitting position.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the occupational therapist performs more than half of the effort.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 02, Substantial/ maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 01, Dependent.
   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the resident.

4. **Lying to sitting on side of bed:** Ms. H is recovering from a spinal fusion. She rolls to her right side and pushes herself up from the bed to get from a lying to a seated position. The therapist provides verbal cues as Ms. H safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed. Ms. H then maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues as the resident moves from a lying to sitting position and does not lift the resident during the activity.

5. **Lying to sitting on side of bed:** Mrs. P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Mrs. P's trunk as she gets to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Mrs. P then scoots toward the edge of the bed and places both feet flat on the floor. Mrs. P completes most of the effort to get from lying to sitting on the side of the bed.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on side of bed.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Coding Tips for GG0170C, Lying to sitting on side of bed

- Item GG0170C, Lying to sitting on side of bed, indicates that the resident transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support. The clinician is to assess the resident's ability to perform each of the tasks within this activity and determine how much support the resident requires to complete the activity.
- For item GG0170C, Lying to sitting on the side of bed, clinical judgment should be used to determine what is considered a "lying" position for that resident.
- If the resident's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool.
- Back support refers to an object or person providing support of the resident's back.

Examples for GG0170D, Sit to stand

1. **Sit to stand:** Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Mr. M's trunk.

   Coding: GG0170D. Sit to stand would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance only.

2. **Sit to stand:** Mrs. L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist her to stand up from sitting in a chair.

   Coding: GG0170D. Sit to stand would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

   Coding: GG0170D. Sit to stand would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the resident's diagnosis of complete tetraplegia.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

4. **Sit to stand:** Ms. Z has amyotrophic lateral sclerosis with moderate weakness in her lower and upper extremities. Ms. Z has prominent foot drop in her left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Ms. Z's AFO and places the platform walker in front of her; Ms. Z uses the walker to steady herself once standing. The certified nursing assistant provides lifting assistance to get Ms. Z to a standing position and must also provide assistance to steady Ms. Z's balance to complete the activity.

   Coding: GG0170D. Sit to stand would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.

   Coding: GG0170D. Sit to stand would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

Examples for GG0170E, Chair/bed-to-chair transfer

1. **Chair/bed-to-chair transfer:** Mr. L had a stroke and currently is not able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 05, Setup or clean-up assistance.
   Rationale: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

2. **Chair/bed-to-chair transfer:** Mr. C is sitting on the side of the bed. He stands and pivots into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Mr. C only required verbal cues for safety, but usually Mr. C requires touching assistance.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance during the transfers.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Chair/bed-to-chair transfer:** Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 01, Dependent.

   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer:** Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides trunk support with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance. Overall, the therapist provides less than half of the effort.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 03, Partial/moderate assistance.

   Rationale: The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

5. **Chair/bed-to-chair transfer:** Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength. The physical therapist assists him in side scooting by lifting his trunk in a rocking motion as Mr. U scoots across the transfer board and into the wheelchair. Overall, the therapist provides more than half of the effort.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Coding Tip for GG0170E, Chair/bed-to-chair transfer

- Item GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B. Sit to lying and GG0170C. Lying to sitting on the side of the bed are two separate activities that are not assessed as part of GG0170E.

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips the footrests back down herself.

   Coding: GG0170F. Toilet transfer would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (moving the footrest out of the way) before Mrs. T can transfer safely onto the toilet.

2. **Toilet transfer:** Mrs. Q transfers onto and off the elevated toilet seat with the certified nursing assistant supervising due to her unsteadiness.

   Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as the resident transfers onto and off the toilet. The resident may use an assistive device.

3. **Toilet transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

   Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z transfers onto the toilet and lowers her underwear. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

   Coding: GG0170F. Toilet transfer would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C. Toileting hygiene and is not considered when rating the Toilet transfer item.

5. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

   Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

6. **Toilet transfer:** Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The certified nursing assistant slowly lowers Ms. W onto the bedside commode. Ms. W contributes less than half of the effort to transfer onto the toilet.

   Coding: GG0170F. Toilet transfer would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

7. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

   Coding: GG0170F. Toilet transfer would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

8. **Toilet transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

   Coding: GG0170F. Toilet transfer would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

Examples for GG0170H1, Does the resident walk?

1. **Does the resident walk?** Mr. Z currently does not walk, but a walking goal is clinically indicated.

   Coding: GG0170H1. Does the resident walk? would be coded 1, No, and walking goal is clinically indicated. Discharge goal(s) for items J. Walk 50 feet with two turns and K. Walk 150 feet may be coded.
   Rationale: Resident does not currently walk, so no admission performance code is entered for the walking items. However, a walking goal is clinically indicated and walking goals may be coded.

2. **Does the resident walk?** Ms. Y currently walks with great difficulty due to her progressive neurological disease. It is not expected that Ms. Y will continue to walk. Ms. Y also uses a wheelchair so both GG0170H1. Does the resident walk? and GG0170Q1. Does the resident use a wheelchair/scooter? will be coded Yes.

   Coding: GG0170H1. Does the resident walk? would be coded 2, Yes, and each walking admission performance activity for items J. Walk 50 feet with two turns and K. Walk 150 feet would then be coded.
   Rationale: The resident currently walks and admission performance codes are entered for each walking item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Mrs. W gets up from a sitting position to a standing position. After the therapist places Mrs. W's walker within reach, Mrs. W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while she walks.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 05, Setup or clean-up assistance.
   Rationale: Mrs. W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D. Sit to stand (04, Supervision or touching assistance).

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Walk 50 feet with two turns:** Mrs. P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Mrs. P turns.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.

3. **Walk 50 feet with two turns:** Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the certified nursing assistant supports her trunk and provides less than half the effort.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Mr. T walks 50 feet with the therapist providing trunk support and the therapy assistant providing supervision. Mr. T walks the 50 feet with two turns.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete the activity.

5. **Walk 50 feet with two turns:** Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides more than half of the effort.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 02, Substantial/ maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D, who intermittently loses her balance while she uses the walker.

   Coding: GG0170K. Walk 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance intermittently throughout the activity.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

   Coding: GG0170K. Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.

   Rationale: The activity was not attempted.

3. **Walk 150 feet:** Mrs. T has an unsteady gait due to balance impairment. Mrs. T walks the length of the hallway using her quad cane in her right hand. The physical therapist supports her trunk, helping her to maintain her balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   Coding: GG0170K. Walk 150 feet would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Mr. W, who has Parkinson's disease, walks the length of the hallway using his rolling walker. The physical therapist provides trunk support and advances Mr. W's right leg in longer strides with each step. The therapist occasionally prevents Mr. W from falling as he loses his balance during the activity. The therapist provides more than half the effort for the activity.

   Coding: GG0170K. Walk 150 feet would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair/scooter used

1. **Wheel 50 feet with two turns:** Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Mrs. M from the bed into the wheelchair. Once in her wheelchair, Mrs. M propels herself about 60 feet down the hall using her left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R. Wheel 50 feet with two turns would be coded 06, Independent.

   Rationale: The resident wheels herself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Indicate the type of wheelchair/scooter used:** In the above example Mrs. M used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mrs. M used a manual wheelchair during the 3-day assessment period.

3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The therapy assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. R's wheelchair for him so that he may continue mobilizing/wheeling himself. Overall, Mr. R provides more than half of the effort.

   Coding: GG0170R. Wheel 50 feet with two turns would be coded 03, Partial/moderate assistance.

   Rationale: The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns. The resident provided more than half the effort.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. R used a motorized wheelchair during the 3-day assessment period.

   Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. R used a motorized wheelchair during the 3-day assessment period.

5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The therapy assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.

   Coding: GG0170R. Wheel 50 feet with two turns would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example Mr. V used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mr. V used a manual wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet, then asks the certified nursing assistant to push the wheelchair an additional 40 feet into her room and her bathroom.

   Coding: GG0170R. Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort.

8. **Indicate the type of wheelchair/scooter used:** In the above example Ms. R used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR. Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Ms. R used a manual wheelchair during the 3-day assessment period.

Coding Tip for GG0170R, Wheel 50 feet with two turns

- Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair by discharge, even if the resident is anticipated to ambulate during the stay or by discharge.

Examples for GG0170S, Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

1. **Wheel 150 feet:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

   Coding: GG0170S. Wheel 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

2. **Indicate the type of wheelchair/scooter used:** In the example above, Mr. G uses a motorized scooter.

   Coding: GG0170SS. Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. G used a motorized scooter during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Wheel 150 feet:** Mr. N uses a below-the-knee prosthetic limb. Mr. N has peripheral neuropathy and limited vision due to complications of diabetes. Mr. N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing himself within the community. Mr. N is assessed for the activity of 150 feet wheelchair mobility. Mr. N's usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

   Coding: GG0170S. Wheel 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: Mr. N requires the helper to provide verbal cues for his safety when using a wheelchair for 150 feet.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. N used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170SS. Indicate the type of wheelchair/scooter used would be coded 1, Manual.
   Rationale: Mr. N used a manual wheelchair during the 3-day assessment period.

5. **Wheel 150 feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S. Wheel 150 feet would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

6. **Indicate the type of wheelchair/scooter used:** In the above example Mr. L used a motorized wheelchair during the 3-day assessment period.

   Coding: GG0170SS. Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident's score for sit to lying and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?"

   Certified nursing assistant: "She can lie down with some help."

   Nurse: "Please describe how much help she needs and exactly how you help her."

   Certified nursing assistant: "I have to lift and position her right leg, but once I do that, she can use her arms to position her upper body."

   In this example, the nurse inquired specifically about how Mrs. H moves from a sitting position to a lying position. The nurse asked about physical assistance.

   Coding: GG0170B. Sit to lying would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant lifts Mrs. H's right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

   Certified nursing assistant: "She can sit up by herself."

   Nurse: "She sits up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself."

   In this example, the nurse inquired specifically about how Mrs. L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C. Lying to sitting on side of bed would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident's sit to stand ability:

   Nurse: "Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?"

   Certified nursing assistant: "She needs help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help she needs for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair."

   In this example, the nurse inquired specifically about how Mrs. L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D. Sit to stand would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident's chair/bed-to-chair transfer ability:

   Nurse: "Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?"

   Certified nursing assistant: "He needs me to help him move from the bed to the chair."

   Nurse: "Does he help with these transfers when you give him any instructions, setup, or physical help?"

   Certified nursing assistant: "Yes, he will follow some of my instructions to get ready to transfer, such as moving his feet from being spread out to placing them under his knees. I have to place the chair close to the bed and then I lift him because he is very weak. I then tell him to reach for the armrest of the chair. Mr. C follows these directions and that helps a little in transferring him from the bed to the chair. He does help with the transfer."

   In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

   Coding: GG0170E. Chair/bed-to-chair transfer would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident's toilet transfer assessment:

   Nurse: "I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for her, but she does it with my help."

   Nurse: "Can you describe the amount of help in more detail?"

   Certified nursing assistant: "I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself."

   In this example, the nurse inquired specifically about how Mrs. M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

   Coding: GG0170F. Toilet transfer would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "How much help does Mr. T need to walk 50 feet and make two turns once he is standing?"

   Certified nursing assistant: "He needs help to do that."

   Nurse: "How much help does he need?"

   Certified nursing assistant: "He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down."

   In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

   Coding: GG0170J. Walk 50 feet with two turns would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete this activity.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "Please describe how Mrs. D walks 150 feet in the corridor once she is standing."

   Certified nursing assistant: "She uses a walker and some help."

   Nurse: "She uses a walker and how much instructions or physical help does she need?"

   Certified nursing assistant: "I have to support her by holding onto the gait belt that is around her waist so that she doesn't fall. She does push the walker forward most of the time."

   Nurse: "Do you help with more than or less than half the effort?"

   Certified nursing assistant: "I have to hold onto her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort."

   In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

   Coding: GG0170K. Walk 150 feet would be coded 02, Substantial/maximal assistance**.**
   Rationale: The certified nursing assistant provides trunk support that is more than half the effort as Mrs. D walks 150 feet.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair."

   Certified nursing assistant: "She wheels herself."

   Nurse: "She wheels herself without any instructions or physical help?"

   Certified nursing assistant: "Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself."

   In this example, the nurse inquired specifically about how Ms. R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

   Coding: GG0170R. Wheel 50 feet with two turns would be coded 03, Partial/Moderate assistance.
   Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?"

   Certified nursing assistant: "He drives the scooter himself … he's very slow."

   Nurse: "He uses the scooter himself without any instructions or physical help?"

   Certified nursing assistant: "That is correct."

   In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

   Coding: GG0170S. Wheel 150 feet would be coded 06, Independent.
   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.

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/doc?oid=107574.

Cancer

- I0100, cancer (with or without metastasis)

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/hai/

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.

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment

1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Coding Instructions

- Code 0, no: if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100).
- Code 1, yes: if the resident has fallen since the last assessment. Continue to **Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)** item (J1900), whichever is more recent.

Example

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

   Coding: J1800 would be coded 1, yes.

   Rationale: An intercepted fall is considered a fall.

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		
	↓ Enter Codes in Boxes	
Coding: 0. **None** 1. **One** 2. **Two or more**	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

DEFINITION

INJURY RELATED TO A FALL
Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.
- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.

DEFINITIONS

INJURY (EXCEPT MAJOR)
Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY
Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Steps for Assessment

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.
4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.
5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record.
6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

Coding Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. **If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.**

Coding Instructions for J1900A, No Injury

- Code 0, none: if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 2, two or more: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- Code 0, none: if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

- Code 2, two or more: if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- Code 2, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Tip

- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

Examples

1. A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, an assessment was completed that indicated no injury.

   Coding: J1900A would be coded 1, one

   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Nurse's notes describe a situation in which Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she fell in the bathroom. No injury was noted when she returned from dinner.

   Coding: J1900A would be coded 1, one

   Rationale: Falls during the nursing home stay, even if on outings, are captured here.

3. A nurse's note describes a resident who, while being treated for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. He was sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   Coding: J1900B would be coded 1, one

   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

4. A resident fell, lacerated his head, and head CT scan indicated a subdural hematoma.

   Coding: J1900C would be coded 1, one.

   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

5. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.

   Original Coding: J1900B, Injury (except major) was coded 1, one.
   Rationale: Mr. R. had a fall-related injury that caused him to complain of pain.
   Modification of Quarterly assessment: J1900B, Injury (except major) is coded 0, none and J1900C, Major Injury, is coded 1, one.
   Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

Step 3: Determine "Present on Admission"

*For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.*

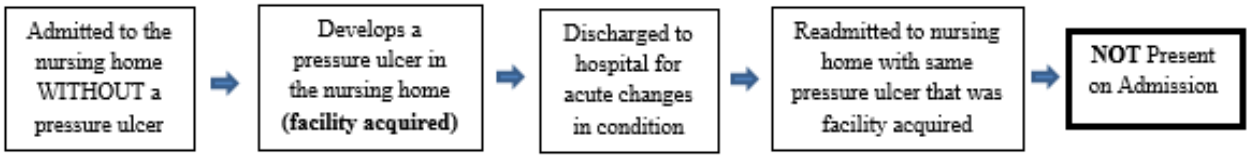
DEFINITION

ON ADMISSION
As close to the actual time of admission as possible.

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry.
3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."**
4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."**
5. If a resident who has a pressure ulcer that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as "present on admission**" because it was present and acquired at the facility prior to the hospitalization.
6. If a resident who has a pressure ulcer that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is **still coded as "present on admission"** because it was **originally acquired outside the facility** and has not changed in stage.
7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it **should be coded as "present on admission"** at that higher stage upon reentry.

Examples

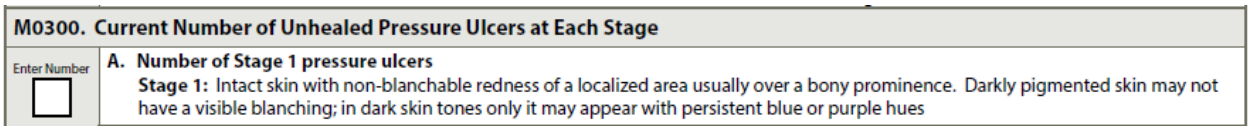
1. Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when she returns from the hospital.



M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed.

M0300A: Number of Stage 1 Pressure Ulcers



Item Rationale

Health-related Quality of Care

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure ulcer should be one of multiple factors that initiate pressure ulcer prevention interventions.

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).

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.

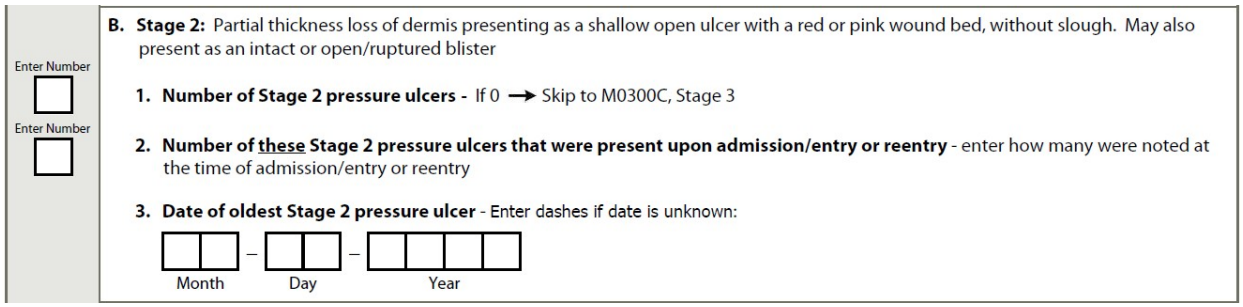
M0300A: Number of Stage 1 Pressure Ulcers (cont.)

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.

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.

M0300B: Stage 2 Pressure Ulcers



Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers may worsen without proper interventions.
- These residents are at risk for further complications or skin injury.

Planning for Care

- **Most Stage 2** pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.

DEFINITION

STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.

May also present as an intact or open/ ruptured blister.

M0300B: Stage 2 Pressure Ulcers (cont.)

- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

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. **Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.**
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.
5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-6).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

Coding Instructions for M0300B

M0300B1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0** if no Stage 2 pressure ulcers are present and skip to M0300C, Stage 3.

M0300B2

- **Enter the number** of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.

M0300B3

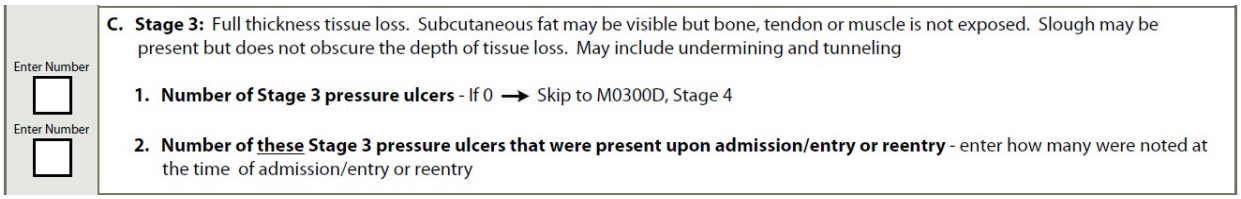
- **Enter the date of the oldest Stage 2 pressure ulcer.** The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. 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, 2012, should be entered as 01-02-2012.

M0300B: Stage 2 Pressure Ulcers (cont.)

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.
- Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers



Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

DEFINITION

STAGE 3 PRESSURE ULCER
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

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).

M0300C: Stage 3 Pressure Ulcers (cont.)

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. Identify all Stage 3 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

Coding Instructions for M0300C

M0300C1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- **Enter 0** if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4.

M0300C2

- **Enter the number** of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Examples

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.

   Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry.
   Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location and not have increased in numerical stage. This pressure ulcer worsened after admission.

M0300C: Stage 3 Pressure Ulcers (cont.)

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

   Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry.
   Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.

3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer.

   Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.
   Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; the one that increased in numerical stage to a Stage 3 cannot be coded in M0300C2 as present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry.

4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.

   Coding: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.
   Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.

M0300D: Stage 4 Pressure Ulcers

Enter Number ☐ Enter Number ☐	**D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling **1. Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing **2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

DEFINITION

STAGE 4 PRESSURE ULCER
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

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. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

DEFINITIONS

TUNNELING
A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

UNDERMINING
The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

Coding Instructions for M0300D

M0300D1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers are present and skip to M0300E, Unstageable – Non-removable dressing.

M0300D: Stage 4 Pressure Ulcers (cont.)

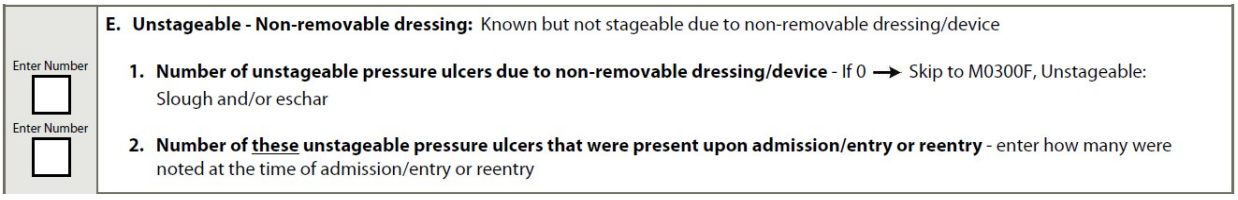
M0300D2

- **Enter the number** of these Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device



Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity and may be painful.

DEFINITION

NON-REMOVABLE DRESSING/ DEVICE
Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Planning for Care

- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing.
2. Determine the number of pressure ulcers unstageable related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

Coding Instructions for M0300E

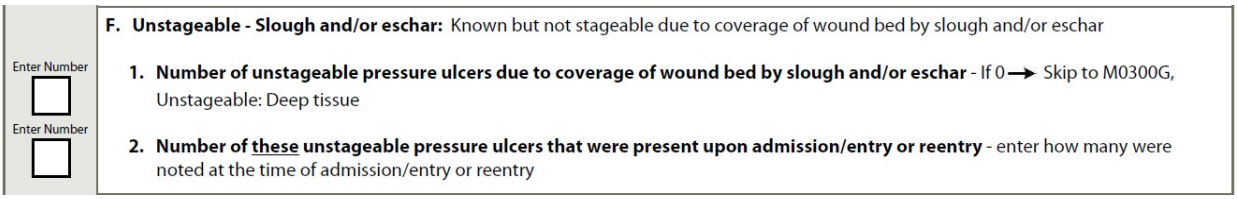
M0300E1

- **Enter the number** of pressure ulcers that are unstageable related to non-removable dressing/device.
- **Enter 0** if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar.

M0300E2

- **Enter the number** of these unstageable pressure ulcers related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar



Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

DEFINITIONS

SLOUGH TISSUE
Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE
Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar.
2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

Coding Instructions for M0300F

M0300F1

- **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to M0300G, Unstageable – Deep tissue injury.

M0300F2

- **Enter the number** of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

- Enter 0 if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry.

Coding Tips

DEFINITION

FLUCTUANCE
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

Examples

1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.

   Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.
   Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission.

2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.

   Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.
   Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar.

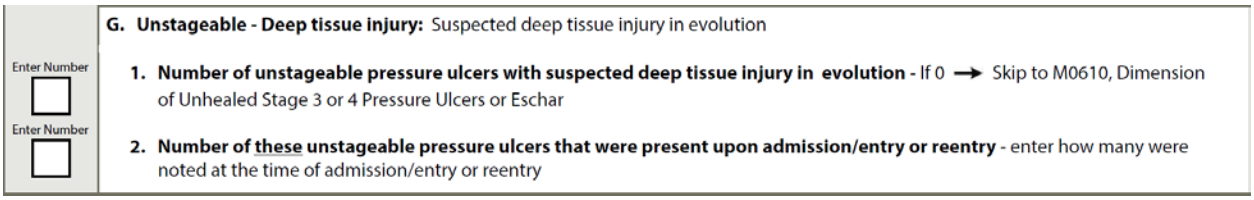
M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.

   Coding: Code at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry.

   Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury



Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of suspected deep tissue injury (sDTI) is imperative.

DEFINITION

SUSPECTED DEEP TISSUE INJURY
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Planning for Care

- Suspected deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

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 a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not** code as a suspected deep tissue injury.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure ulcers that are unstageable related to suspected deep tissue injury.
6. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for instructions).
7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

Coding Instructions for M0300G

M0300G1

- **Enter the number** of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- **Enter 0** if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).

M0300G2

- **Enter the number** of these unstageable pressure ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital)..
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or reentry.

Coding Tips

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
☐☐.☐ cm	**A. Pressure ulcer length:** Longest length from head to toe
☐☐.☐ cm	**B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
☐☐.☐ cm	**C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

Item Rationale

Health-related Quality of Life

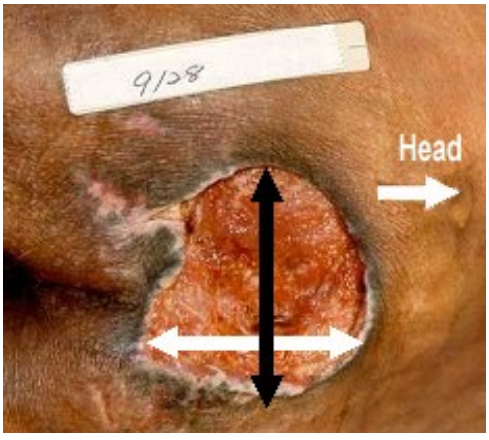
- Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.

Planning for Care

- Evaluating the dimensions of the pressure ulcer is one aspect of the process of monitoring response to treatment.
- Pressure ulcer measurement findings are used to plan interventions that will best prepare the wound bed for healing.

Steps for Assessment

*If the resident has **one or more** unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, **identify the pressure ulcer with the largest surface area** (length × width) and record in centimeters. **Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1.** The Figure (right) illustrates the measurement process.*



1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar after the dressing and any exudate are removed.
2. Use a disposable measuring device or a cotton-tipped applicator.
3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar.
4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

5. Using a similar approach, measure the longest width (perpendicular to the length forming a "+," side to side).
6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest. Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.
7. Considering **only** the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Stage and measure each pressure ulcer separately.

Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar

- Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.
- Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

Coding Tips

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.

M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Example

1. A resident has three toes on her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

   Coding: Code M1030 as 3.

   Rationale: Ischemic changes point to the ulcer being vascular.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

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

- M1040D, Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- M1040E, Surgical wound(s)
- M1040F, Burn(s)(second or third degree)
- M1040G, Skin tear(s)
- M1040H, Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
- M1040Z, None of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.
- Do **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M1040D Open Lesion Other than Ulcers, Rashes, Cuts

- Do **not** code rashes or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

M1040E Surgical Wounds

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

M1200: Skin and Ulcer Treatments (cont.)

4. Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

   Coding: Do **not** check item M1200C.

   Rationale: Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident's response to turning and repositioning. There are not any skin or ulcer treatments being provided.

Scenarios for Pressure Ulcer Coding

Example M0300, M0610, M0700 and M0800

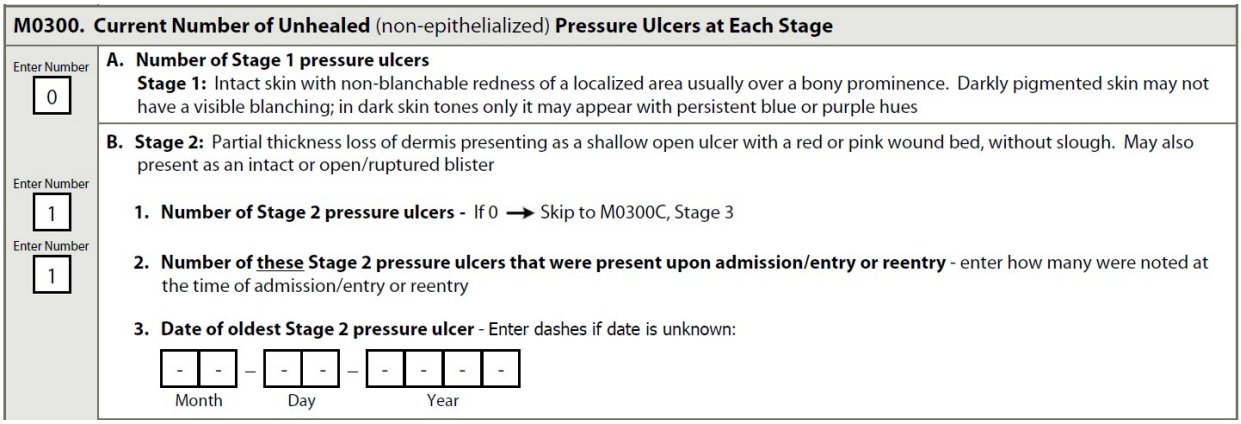
1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.

   Admission Assessment:

   Coding:

   - M0300A (Number of Stage 1 pressure ulcers), Code 0.
   - M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
   - M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.
   - M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

   Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.



M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number 0

A. Number of Stage 1 pressure ulcers
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number 1

Enter Number 1

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. **Number of Stage 2 pressure ulcers -** If 0 → Skip to M0300C, Stage 3

2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

- - / - - / - - - - (Month / Day / Year)

N0410: Medications Received

N0410. Medications Received	
Indicate the number of DAYS the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days	
Enter Days ☐	**A. Antipsychotic**
Enter Days ☐	**B. Antianxiety**
Enter Days ☐	**C. Antidepressant**
Enter Days ☐	**D. Hypnotic**
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**

Item Rationale

Health-related Quality of Life

- Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.
- As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

DEFINITIONS

ADVERSE CONSEQUENCE
An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (e.g., medication-medication, medication-food, and medication-disease).

NON-PHARMACOLOGICAL INTERVENTION
Approaches that do not involve the use of medication to address a medical condition.

N0410: Medications Received (cont.)

Planning for Care

- The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication.
- Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.
- Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects.
- Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

Steps for Assessment

1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).

DEFINITIONS

DOSE
The total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

MONITORING
The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or the treatments and support decisions about adding, modifying, continuing, or discontinuing any interventions.

Coding Instructions

- N0410A–G: Code medications according to the pharmacological classification, not how they are being used.
- N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

N0410: Medications Received (cont.)

- N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- N0410D, Hypnotic: Record the number of days a hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.
- N0410F, Antibiotic: Record the number of days an antibiotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- N0410G, Diuretic: Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

Coding Tips and Special Populations

- Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- Code a medication even if it was given only once during the look-back period.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are given during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then both antipsychotic and antidepressant categories should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.

N0410: Medications Received (cont.)

- When residents are having difficulty sleeping, nursing home staff should explore non-pharmacological interventions (e.g., sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and prior customary routine) to try to improve sleep prior to initiating pharmacologic interventions. If residents are currently on sleep-enhancing medications, nursing home staff can try non-pharmacologic interventions to help reduce the need for these medications or eliminate them.

DEFINITION

SLEEP HYGIENE
Practices, habits and environmental factors that promote and/or improve sleep patterns.

- Many psychoactive medications increase confusion, sedation, and falls. For those residents who are already at risk for these conditions, nursing home staff should develop plans of care that address these risks.
- Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.
- Doses of psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.

DEFINITIONS

GRADUAL DOSE REDUCTION (GDR)
Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.

MEDICATION INTERACTION
The impact of medication or other substance (such as nutritional supplements including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

N0410: Medications Received (cont.)

- During the first year in which a resident on a psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications 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 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html).
- Prior to discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).
- 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 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html]), 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.

N0410: Medications Received (cont.)

- 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.

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 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html)].

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- GlobalRPh Drug Reference, http://globalrph.com/drug-A.htm
- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"
- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html
- The DrugLib.com Index of Drugs by Category, http://www.druglib.com/drugindex/category/

This list is not all-inclusive. CMS is not responsible for the content or accessibility of the pages found at these sites. URL addresses were current as of the date of this publication.

O0250: Influenza Vaccine (cont.)

- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC: http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html
- Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases) national goal of increasing to 90 percent, the percentage of adults aged 18 years or older in long-term care nursing homes who are vaccinated annually against seasonal influenza.

Steps for Assessment

1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.

Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?

- Code 0, no: if the resident did NOT receive the influenza vaccine *in this facility* during this year's influenza vaccination season. Proceed to **If influenza vaccine not received, state reason** (O0250C).
- Code 1, yes: if the resident did receive the influenza vaccine *in this facility* during this year's influenza season. Continue to **Date influenza vaccine received** (O0250B).

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
  - If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
  - If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
  - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

O0600: Physician Examinations (cont.)

Steps for Assessment

1. **Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.**

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
  - Chapter 15 of the ***Medicare Benefit Policy Manual*** (Pub. 100-2) and Chapter 12 of the ***Medicare Claims Processing Manual*** (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.
- Does not include visits made by Medicine Men.

Q0400: Discharge Plan (cont.)

- Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge.
- For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at https://www.medicare.gov/Pubs/pdf/11376.pdf

Steps for Assessment

1. A review should be conducted of the care plan, the medical record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy to consider the resident's discharge planning needs.
2. If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual.
3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and the capability to address a resident's needs and arrange for that resident to discharge back to the community, a referral to the LCA may not be necessary. Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them.
4. Record the resident's expectations as expressed/communicated, whether you assess that they are realistic or not realistic.
5. If the resident's discharge needs cannot be met by the nursing facility, an evaluation of the community living situation to evaluate whether it can meet the resident's needs should be conducted by the LCA, along with other community providers who will be providing the transition and other community based services to determine the need for assistive/adaptive devices, medical supplies, and equipment and other services.
6. The resident, his or her interdisciplinary team, and LCA (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).
7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.).
8. A determination of family involvement, capability and support after discharge should also be made.

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is Active Discharge planning already occurring for the Resident to Return to the Community?

- Code 0, No: if there is not active discharge planning already occurring for the resident to return to the community.
- Code 1, Yes: if there is active discharge planning already occurring for the resident to return to the community; skip to **Referral** item (Q0600).

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

For Quarterly, Correction to Quarterly, and Not-OBRA Assessments. (A0310A=02, 06, 99)

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B
Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Item Rationale

This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, **Referral**.

Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.

Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

- Code 0, No: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again.

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (cont.)

- Code 1, Yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, **Referral**. If this is a comprehensive assessment, proceed to the next item Q0500B.

Coding Tips

- Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded No to item Q0550.

If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

Examples

1. Ms. G is a 45-year old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.

   Coding: Q0490 would be coded 1, Yes, skip to Q0600; because this is a quarterly assessment.

   If this is a comprehensive assessment, then proceed to the next item Q0500B.

   Rationale: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

   Coding: Q0490 would be coded 1, Yes, skip to Q0600;

   Unless this is a comprehensive assessment, then proceed to the next item Q0500B.

   Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code ☐	**A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 9. **None of the above**

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.
- Code 8, Information not available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again (cont.)

Coding Instructions for Q0550B, Indicate information source for Q0550A

- Code 1, Resident: if resident responded to Q0550A.
- Code 2, If not resident, then family or significant other.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative.
- Code 9, None of the above.

Example

1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her and she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.

   Coding: Q0550A would be coded 1, Yes.
   Q0550B would be coded 1, Resident.

   Rationale: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

Q0600: Referral

Q0600. Referral	
Enter Code ☐	**Has a referral been made to the Local Contact Agency?** (Document reasons in resident's clinical record) 0. **No** - referral not needed 1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. **Yes** - referral made

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.

V0100: Items From the Most Recent Prior OBRA or PPS Assessment

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment
Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 05

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)
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
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)
Month – Day – Year

Enter Score

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score

E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

Item Rationale

The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status. The values of these items are derived from a prior OBRA or scheduled PPS assessment that was performed since the most recent admission of any kind (i.e., since the most recent entry or reentry), if one is available. Items V0100A, B, C, D, E and F are skipped on the first assessment (OBRA or PPS) following the most recent admission of any kind (i.e., when A0310E = 1, Yes). Complete these items only if a prior assessment has been completed since the most recent admission of any kind to the facility (i.e., when A0310E = 0, No) and if the prior assessment is an OBRA or a scheduled PPS assessment. If such an assessment is available, the values of V0100A, B, C, D, E, and F should be copied from the corresponding items on that prior assessment.

Coding Instructions for V0100A, Prior Assessment Federal OBRA Reason for Assessment (A0310A Value from Prior Assessment)

- Record in V0100A the value for A0310A (Federal OBRA Reason for Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 06 or 99) must be selected.

V0100: Items From the Most Recent Prior OBRA or PPS Assessment (cont.)

Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)

- Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 05 or 07 or 99) must be selected.

  Note: The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 through 05 or 07, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Coding Instructions for V0100C, Prior Assessment Reference Date (A2300 Value from Prior Assessment)

- Record in V0100C the value of A2300 (Assessment Reference Date) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details).

Coding Instructions for V0100D, Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 Value from Prior Assessment)

- Record in V0100D, the value for C0500 Mental Status (BIMS) Summary Score from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details).This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

Coding Instructions for V0100E, Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 Value from Prior Assessment)

- Record in V0100E the value of D0300 (Resident Mood Interview [PHQ-9©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600 Value from Prior Assessment)

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood [PHQ-9-OV©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

X0500: Social Security Number (A0600A on existing record to be modified/inactivated)

X0500. **Social Security Number** (A0600A on existing record to be modified/inactivated)
☐☐☐ - ☐☐ - ☐☐☐☐

Coding Instructions for X0500, Social Security Number

- Fill in the boxes with the Social Security number exactly as submitted for item A0600 "Social Security and Medicare numbers" on the prior erroneous record to be modified/inactivated. If the Social Security number was unknown or unavailable and left blank on the prior record, leave X0500 blank.
- Note that the Social Security number in X0500 does not have to match the current value of A0600 on a modification request. The entries may be different if the modification is correcting the Social Security number.

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

These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated.

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

Enter Code ☐☐

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 ☐☐

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 ☐

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

X0600 continued on next page

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

X0600. Type of Assessment - Continued	
Enter Code ☐	**D. Is this a Swing Bed clinical change assessment?** Complete only if X0150 = 2 0. **No** 1. **Yes**
Enter Code ☐☐	**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 ☐	**H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

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 QIES 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 QIES 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 QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

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

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.
- 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 QIES 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 QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600H, Is this a Part A PPS Discharge Assessment?

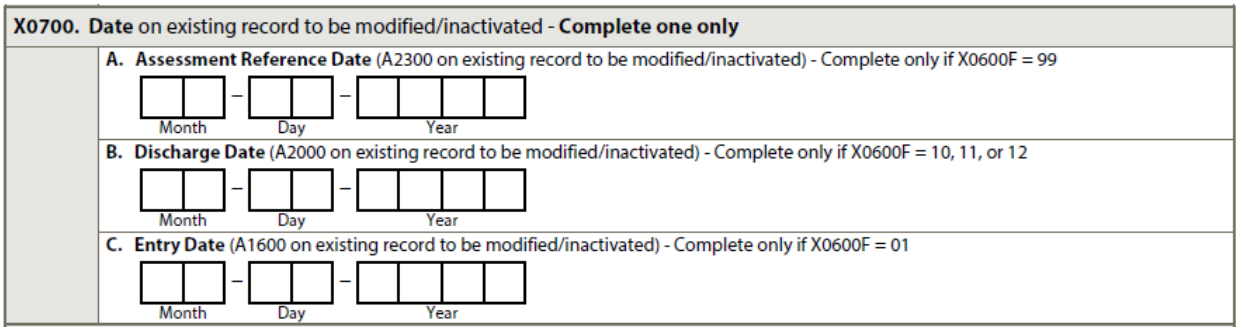
- Enter the code exactly as submitted for item A0310H, "Is this a Part A PPS Discharge Assessment?" on the prior erroneous record to be modified/inactivated.
- Code 0, no: if this is not a Part A PPS Discharge assessment.
- Code 1, yes: if this is a Part A PPS Discharge assessment.
- Note that the code in X0600H must match the current value of A0310H on a modification request.

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

- If item A0310H was incorrect on an assessment that was previously submitted and accepted by the QIES 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.



Coding Instructions for X0700A, Assessment Reference Date—(A2300 on existing record to be modified/inactivated) – Complete Only if X0600F = 99

- If the prior erroneous record to be modified/inactivated is an OBRA assessment or a PPS assessment, where X0600F = 99, enter the assessment reference date here exactly as submitted in item A2300 "Assessment Reference Date" on the prior record.
- Note that the assessment reference date in X0700A must match the current value of A2300 on a modification request.

Coding Instructions for X0700B, Discharge Date—(A2000 on existing record to be modified/inactivated) – Complete Only If X0600F = 10, 11, or 12

- If the prior erroneous record to be modified/inactivated is a discharge record (indicated by X0600F = 10, 11, or 12), enter the discharge date here exactly as submitted for item A2000 "Discharge Date" on the prior record. If the prior erroneous record was a discharge combined with an OBRA or PPS assessment, then that prior record will contain both a completed assessment reference date (A2300) and discharge date (A2000) and these two dates will be identical. If such a record is being modified or inactivated, enter

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

the prior discharge date in X0700B and leave the prior assessment reference date in X0700A blank.

- Note that the discharge date in X0700B must match the current value of A2000 on a modification request.

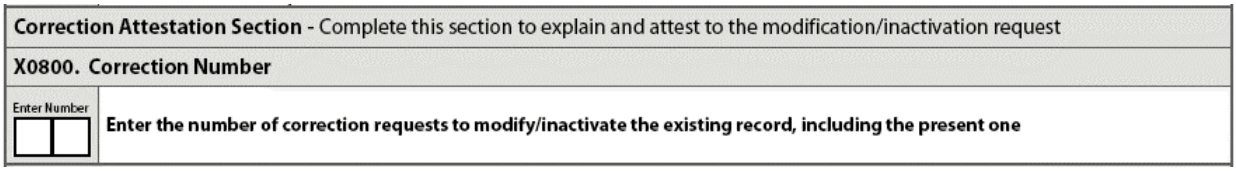
Coding Instructions for X0700C, Entry Date—(A1600 on existing record to be modified/inactivated) – Complete Only If X0600F = 01

- If the prior erroneous record to be modified/inactivated is an entry record (indicated by X0600F = 01), enter the entry date here exactly as submitted for item A1600 "Entry Date [date of admission/reentry into the facility]" on the prior record.
- Note that the entry date in X0700C must match the current value of A1600 on a modification request.

X0800: Correction Attestation Section

The items in this section indicate the number of times the QIES ASAP database record has been corrected, the reason for the current modification/inactivation request, the person attesting to the modification/inactivation request, and the date of the attestation.

This item may be populated automatically by the nursing home's data entry software; however, if it is not, the nursing home should enter this information.



Coding Instructions for X0800, Correction Number

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

X0900: Reasons for Modification

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

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

Coding Instructions for X0900A, Transcription Error

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

Coding Instructions for X0900B, Data Entry Error

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

Coding Instructions for X0900C, Software Product Error

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

Coding Instructions for X0900D, Item Coding Error

- Check the box if any errors in the prior QIES ASAP record were caused by item coding errors.

X0900: Reasons for Modification (cont.)

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

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

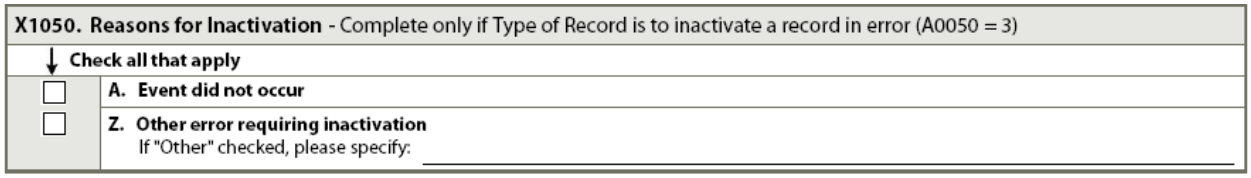
- Check the box if the End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not indicating a resumption of therapy date in item O0450B).
- Do not check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

Coding Instructions for X0900Z, Other Error Requiring Modification

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

X1050: Reasons for Inactivation

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



X1050: Reasons for Inactivation (cont.)

Coding Instructions for X1050A, Event Did Not Occur

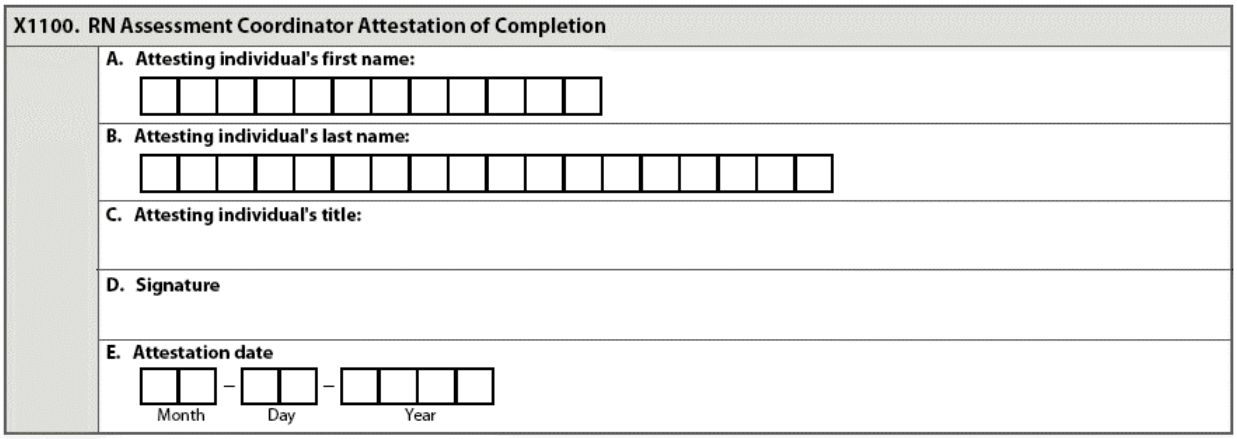
- Check the box if the prior QIES ASAP record does not represent an event that actually occurred.
- An example would be a discharge record submitted for a resident, but there was no actual discharge. There was **no event**.

Coding Instructions for X1050Z, Other Reason Requiring Inactivation

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

X1100: RN Assessment Coordinator Attestation of Completion

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



Coding Instructions for X1100A, Attesting Individual's First Name

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

Coding Instructions for X1100B, Attesting Individual's Last Name

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

Coding Instructions for X1100C, Attesting Individual's Title

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

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

Coding Instructions for X1100D, Signature

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

Coding Instructions for X1100E, Attestation Date

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

0	1		0	2		2	0	1	1

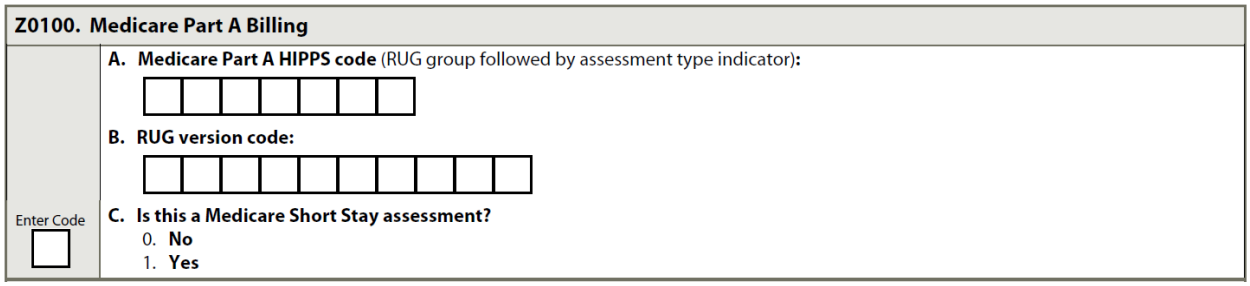
Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion

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

SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

Z0100: Medicare Part A Billing



Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):

B. RUG version code:

Enter Code

C. Is this a Medicare Short Stay assessment?

0. **No**
1. **Yes**

Item Rationale

- Used to capture the Resource Utilization Group (RUG) followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

DEFINITION

MEDICARE-COVERED STAY

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

Coding Instructions for Z0100A, Medicare Part A HIPPS Code

- Typically the software data entry product will calculate this value.
- The HIPPS code is a Skilled Nursing Facility (SNF) Part A billing code and is composed of a five-position code representing the RUG group code, plus a two-position assessment type indicator. For information on HIPPS, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
- If the value for Z0100A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the RUG code and a table that defines the assessment type indicator).
- Note that the RUG included in this HIPPS code takes into account all MDS items used in the RUG logic and is the "normal" group since the classification considers the rehabilitation therapy received. This classification uses all reported speech/language pathology and auditory services, occupational therapy, and physical therapy values in Item O0400 (Therapies).
- This HIPPS code is usually used for Medicare SNF Part A billing by the provider.
- Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.

DEFINITION

HIPPS CODE

Health Insurance Prospective Payment System code is comprised of the RUG category calculated by the assessment followed by an indicator of the type of assessment that was completed.

Z0150: Medicare Part A Non-Therapy Billing (cont.)

Coding Instructions for Z0150A, Medicare Part A Non-therapy HIPPS Code

- Typically the software data entry product will calculate this value.
- The HIPPS code is a SNF Part A billing code and is comprised of a five-position code representing the RUG code, plus a two-position assessment type indicator. For information on HIPPS, access https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
- If the value for Z0150A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the RUG-IV group and a table that defines assessment type indicator). Note that the RUG included in this HIPPS code is the "non-therapy" group and classification ignores the rehabilitation therapy received. This classification ignores all reported speech/language pathology and auditory services, occupational therapy, and physical therapy values in Item O0400 (Therapies).
- In some instances, this non-therapy HIPPS code may be required for Medicare SNF Part A billing by the provider.
- Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.

Coding Instructions for Z0150B, RUG Version Code

- Typically the software data entry product will calculate this value.
- If the value for Z0150B is not automatically calculated by the software data entry product, enter the RUG version code in the spaces provided. This is the version code appropriate to the RUG included in the Medicare Part A non-therapy HIPPS code in Item Z0150A.
- With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is "1.0066."

Z0200: State Medicaid Billing (if required by the state)

Z0200. State Medicaid Billing (if required by the state)	
	A. RUG Case Mix group: ☐☐☐☐☐☐☐☐☐☐ B. RUG version code: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Used to capture the payment code in states that employ the MDS for Medicaid case-mix reimbursement.

RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents. By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes. Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.

- The MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- The MDS is not a diagnostic tool or treatment selection guide
- The MDS does not identify causation or history of problems

Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision making processes to analyze and address MDS findings and CAAs. Table 2 provides a framework for a more complete approach to clinical problem solving and decision making essential to the appropriate care of individuals with multiple and/or complex illnesses and impairments.

4.7 The RAI and Care Planning

As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(k)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.

Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see.42 CFR 483.20(k), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.

4.10 The Twenty Care Areas

NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not checked. Example: "I4800=0" means that a check mark has not been placed in the check box item I4800.

1. Delirium

Delirium is acute brain failure caused by medical conditions, which presents with psychiatric symptoms, acute confusion, and fluctuations in levels of consciousness. It is a serious condition that can be caused by medical issues/conditions such as medication-related adverse consequences, infections, or dehydration. It can easily be mistaken for the onset or progression of dementia, particularly in individuals with more advanced pre-existing dementia.

Unlike dementia, delirium typically has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness periodically during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusions), seeing or feeling things that are not there (hallucinations), or a fixed false belief (delusions).

Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) as indicated by:

(a)

C1310A = 1

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

(b)

C1310B, C1310C or C1310D = 2

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. Staff who are closely involved with residents should report promptly any new onset or worsening of cognitive impairment and the other aforementioned symptoms in that resident.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting an acute change in mental status and/or the presence of inattention, disorganized thinking or altered mental status.

The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s) and/or condition(s), as well as to identify related underlying causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process (e.g., treating infections, addressing dehydration, identifying and treating hypo- or hyperthyroidism, relieving pain and depression, managing medications, and promoting adaptation and a comfortable environment for the resident to function. Other simple preventive measures that can be applied in all settings include addressing hearing and visual impairments to the extent possible (e.g., with the use of glasses and hearing aids) and minimizing the use of indwelling urinary catheters.

2. Cognitive Loss/Dementia

Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has evidence of cognitive loss.

Cognitive Loss/Dementia CAT Logic Table

Triggering Conditions (any of the following):

1. BIMS summary score is less than 13 as indicated by:

   C0500 >= 00 AND C0500 < 13

2. BIMS summary score has a missing value and there is a problem with short-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0700 = 1)

3. BIMS summary score has a missing value and there is a problem with long-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0800 = 1)

4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C1000 >= 1 AND C1000 <= 3)

5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking or altered level of consciousness as indicated by:

   (C1310B = 1 OR C1310B = 2) OR

   (C1310C = 1 OR C1310C = 2) OR

   (C1310D = 1 OR C1310D = 2)

6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:

   (E0200A >= 1 AND E0200A <= 3) OR

   (E0200B >= 1 AND E0200B <= 3) OR

   (E0200C >= 1 AND E0200C <= 3)

7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:

   E0800 >= 1 AND E0800 <= 3

8. Wandering occurred at least 1 day in the past 7 days as indicated by:

   E0900 >= 1 AND E0900 <= 3

The information gleaned from the assessment should be used to evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. It is important to define the nature

of the impairment, e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue and/or condition is apparently not related to reversible causes, assessment should focus on the details of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss, to facilitate care planning specific to the resident's needs, issues and/or conditions, and strengths. The focus of the care plan should be to optimize remaining function by addressing underlying issues identified through this assessment process, such as relieving pain, optimizing medication use, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

The aging process leads to a decline in visual acuity, for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has a diagnosis of glaucoma, macular degeneration or cataracts or B1000 is coded 1-4.

Visual Function CAT Logic Table

Triggering Conditions (any of the following):

1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:

   I6500 = 1

2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:

   B1000 >= 1 AND B1000 <= 4

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through

the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves related activities, including expressive communication (making oneself understood to others, both verbally and via non-verbal exchange) and receptive communication (comprehending or understanding the verbal, written, or visual communication of others). Typical expressive issues and/or conditions include disruptions in language, speech, and voice production. Typical receptive communication issues and/or conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

   B0200 >= 1 AND B0200 <= 3

2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

   B0700 >= 1 AND B0700 <= 3

3. Impaired ability to understand others through verbal content as indicated by:

   B0800 >= 1 AND B0800 <= 3

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet use, bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving or maintaining function when possible, and preventing additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:

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

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:

   (G0110B1 >= 1 AND G0110B1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:

   (G0110C1 >= 1 AND G0110C1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:

(G0110D1 >= 1 AND G0110D1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

5. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion on unit (including with wheel chair, if applicable) was needed as indicated by:

(G0110E1 >= 1 AND G0110E1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

6. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion off unit (including with wheel chair, if applicable) was needed as indicated by:

(G0110F1 >= 1 AND G0110F1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

7. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for dressing was needed as indicated by:

(G0110G1 >= 1 AND G0110G1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

8. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for eating was needed as indicated by:

(G0110H1 >= 1 AND G0110H1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

9. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for toilet use was needed as indicated by:

(G0110I1 >= 1 AND G0110I1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

10. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for grooming/personal hygiene was needed as indicated by:

(G0110J1 >= 1 AND G0110J1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

11. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for self-performance bathing (excluding washing of back and hair) has a value of 1 through 4 as indicated by:

(G0120A>= 1 AND G0120A<= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

12. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while balance during transition has a value of 1 or 2 for any item as indicated by:

((G0300A = 1 OR G0300A = 2) OR

(G0300B = 1 OR G0300B = 2) OR

(G0300C = 1 OR G0300C = 2) OR

(G0300D = 1 OR G0300D = 2) OR

(G0300E = 1 OR G0300E = 2)) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

13. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while resident believes he/she is capable of increased independence as indicated by:

G0900A = 1 AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

14. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while direct care staff believe resident is capable of increased independence as indicated by:

G0900B = 1 AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is the involuntary loss or leakage of urine or the inability to urinate in a socially acceptable manner. There are several types of urinary incontinence (e.g., functional, overflow, stress, and urge) and the individual resident may experience more than one type at a time (mixed incontinence).

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence can be a risk factor for various complications, including skin rashes, falls, and social isolation. Often, it is at least partially correctable. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters, which can increase the risk of life threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Urinary Incontinence and Indwelling Catheter CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for toileting was needed as indicated by:

   (G0110I1 >= 2 AND G0110I1 <= 4)

2. Resident requires a indwelling catheter as indicated by:

   H0100A = 1

3. Resident requires an external catheter as indicated by:

   H0100B = 1

4. Resident requires intermittent catheterization as indicated by:

   H0100D = 1

5. Urinary incontinence has a value of 1 through 3 as indicated by:

   H0300 >= 1 AND H0300 <= 3

6. Resident has moisture associated skin damage as indicated by:

   M1040H = 1

Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or the reason for the indwelling catheter. Some of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies can prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be used for appropriate indications and when no other viable options exist. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter, the potential for removal of the

catheter, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, it can cloud other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Similarly, declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood. Psychosocial well-being may also be negatively impacted when a person has significant life changes such as the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident exhibits minimal interest in social involvement.

Psychosocial Well-Being CAT Logic Table

Triggering Conditions (any of the following):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 or 4 as indicated by:

   F0500F = 3 OR F0500F = 4

4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities:

   F0800Q = 0

5. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

   (E0200A >= 1 AND E0200A <= 3) AND

   (I4800 = 0 OR I4800 = -) AND

   (I4200 = 0 OR I4200 = -)

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

   (E0200B >=1 AND E0200B <= 3) AND

(I4800 = 0 OR I4800 = -) AND

(I4200 = 0 OR I4200 = -)

7. Any six items for interview for activity preferences has the value of 4 and resident is primary respondent for daily and activity preferences as indicated by:

(Any 6 of F0500A through F0500H = 4) AND

(F0600 = 1)

The information gleaned from the assessment should be used to identify whether their minimal involvement is typical or customary for that person or a possible indication of a problem. If it is problematic, then address the underlying cause(s) of the resident's minimal social involvement and factors associated with reduced social relationships and engagement, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes in order to stimulate and facilitate social engagement.

8. Mood State

Sadness and anxiety are normal human emotions, and fluctuations in mood are also normal. But mood states (which reflect more enduring patterns of emotions) may become as extreme or overwhelming as to impair personal and psychosocial function. Mood disorders such as depression reflect a problematic extreme and should not be confused with normal sadness or mood fluctuation.

The mood section of the MDS screens for—but is not intended to definitively diagnose—any mood disorder, including depression. Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness. They may also result in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains. However, because none of these symptoms is specific for a mood disorder, diagnosis of mood disorders requires additional assessment and confirmation of findings. In addition, other problems (e.g., lethargy, fatigue, weakness, or apathy) with different causes, which require a very different approach, can be easily confused with depression.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue and/or condition may be present.

Mood State CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has had thoughts he/she would be better off dead, or thoughts of hurting him/herself as indicated by:

D0200I1 = 1

2. Staff assessment of resident mood suggests resident states life isn't worth living, wishes for death, or attempts to harm self as indicated by:

   D0500I1 = 1

3. The resident mood interview total severity score has a non-missing value (0 to 27) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the resident interview summary score on the current non-admission comprehensive assessment (D0300) is greater than the prior assessment (V0100E) as indicated by:

   ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND

   ((D0300 >= 00) AND (D0300 <= 27)) AND

   ((V0100E >= 00) AND (V0100E <= 27)) AND

   (D0300 > V0100E)

4. The resident mood interview is not successfully completed (missing value on D0300), the staff assessment of resident mood has a non-missing value (0 to 30) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the staff assessment current total severity score on the current non-admission comprehensive assessment (D0600) is greater than the prior assessment (V0100F) as indicated by:

   ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND

   ((D0300 < 00) OR (D0300 > 27)) AND

   ((D0600 >= 00) AND (D0600 <= 30)) AND

   ((V0100F >= 00) AND (V0100F <= 30)) AND

   (D0600 > V0100F)

5. The resident mood interview is successfully completed and the current total severity score has a value of 10 through 27 as indicated by:

   D0300 >= 10 AND D0300 <= 27

6. The staff assessment of resident mood is recorded and the current total severity score has a value of 10 through 30 as indicated by:

   D0600 >= 10 AND D0600 <= 30

The information gleaned from the assessment should be used as a starting point to assess further in order to confirm a mood disorder and get enough detail of the situation to consider whether treatment is warranted. If a mood disorder is confirmed, the individualized care plan should, in part, focus on identifying and addressing underlying causes, to the extent possible.

9. Behavioral Symptoms

In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a

symptom and not a disease. The MDS only identifies certain behaviors, but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention.

Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms.

Behavioral Symptoms CAT Logic Table

Triggering Conditions (any of the following):

1. Rejection of care has a value of 1 through 3 indicating resident has rejected evaluation or care necessary to achieve his/her goals for health and well-being as indicated by:

   E0800 >= 1 AND E0800 <= 3

2. Wandering has a value of 1 through 3 as indicated by:

   E0900 >= 1 AND E0900 <= 3

3. Change in behavior indicates behavior, care rejection or wandering has gotten worse since prior assessment as indicated by:

   E1100 = 2

4. Presence of at least one behavioral symptom as indicated by:

   E0300 = 1

The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm.

10. Activities

The capabilities of residents vary, especially as abilities and expectations change, illness intervenes, opportunities become less frequent, and/or extended social relationships become less common. The purpose of the activities CAA is to identify strategies to help residents become more involved in relevant activities, including those that have interested and stimulated them in the past and/or new or modified ones that are consistent with their current functional and cognitive capabilities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident may have evidence of decreased involvement in social activities.

Activities CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Any 6 items for interview for activity preferences has the value of 4 (not important at all) or 5 (important, but cannot do or no choice) as indicated by:

   Any 6 of F0500A through F0500H = 4 or 5

4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by:

   Any 6 of F0800L through F0800T = 0

The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The care plan should focus on addressing the underlying cause(s) of activity limitations and the development or inclusion of activity programs tailored to the resident's interests and to his or her cognitive, physical/functional, and social abilities and improve quality of life.

11. Falls

A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other

serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has had recent history of falls and balance problems.

Falls CAT Logic Table

Triggering Conditions (any of the following):

1. Wandering occurs as indicated by a value of 1 through 3 as follows:

   E0900 >= 1 AND E0900 <= 3

2. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:

   (G0300A = 1 OR G0300A = 2) OR

   (G0300B = 1 OR G0300B = 2) OR

   (G0300C = 1 OR G0300C = 2) OR

   (G0300D = 1 OR G0300D = 2) OR

   (G0300E = 1 OR G0300E = 2)

3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:

   If A0310A = 01 AND J1700A = 1

4. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:

   If A0310A = 01 AND J1700B = 1

5. Resident has fallen at least one time since admission or the prior assessment as indicated by:

   J1800 = 1

6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C> = 1 AND N0410C<=7

8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

   P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

J1550C = 1

2. Body mass index (BMI) is too low or too high as indicated by:

BMI < 18.5000 OR BMI > 24.9000

3. Any weight loss as indicated by a value of 1 or 2 as follows:

K0300 = 1 OR K0300 = 2

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

K0310 = 1 OR K0310 = 2

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510A1 = 1 OR K0510A2 = 1

6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510C1 = 1 OR K0510C2 = 1

7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510D1 = 1 OR K0510D2 = 1

8. 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))

13. Feeding Tubes

This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510B1 = 1 OR K0510B2 = 1

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s), including any reversible issues and conditions that led to using a feeding tube.

SNF must bill the default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

Under all situations other than exceptions 1-5, the following apply when the SNF failed to set the ARD prior to the end of the last day of the ARD window, including grace days, or later and the resident was already discharged from Medicare Part A when this was discovered:

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

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

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a scheduled PPS assessment, unless that scheduled PPS assessment is combined with an OBRA Discharge Assessment (see Section 2.12). For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.

A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections 2.4 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency

room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

Term	Abbreviation	Definition
Physical Therapy	**PT**	Services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Includes services provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist. Physical therapist and physical therapist assistant are defined in regulation 42 CFR 484.4. Physical therapists (PTs) are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status for people of all ages. PTs alleviate impairments and activity limitations and participation restrictions, promote and maintain optimal fitness, physical function, and quality of life, and reduce risk as it relates to movement and health. Following an evaluation of an individual with impairments, activity limitations, and participation restrictions or other health-related conditions, the physical therapist designs an individualized plan of physical therapy care and services for each patient. Physical therapists use a variety of interventions to treat patients. Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, physical agents, and electrotherapeutic modalities.
Physician Prescribed Weight-loss Regimen		A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight-loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.
Program Transmittal		Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added, or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following Web site: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Prompted Voiding		Prompted voiding is a behavioral intervention to maintain or regain urinary continence and may include timed verbal reminders and positive feedback for successful toileting.

(continued)

Term	Abbreviation	Definition
Suprapubic Catheter		An indwelling catheter that is placed into the bladder through the abdominal wall above the pubic symphysis.
Swing Bed		A rural hospital with fewer 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.
System of Records	**SOR**	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Temporal Orientation		In general, the ability to place oneself in correct time. For BIMS, it is the ability to indicate correct date in current surroundings.
Therapeutic Diet		A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium) (ADA, 2011)
Tooth Fragment		A remnant of a tooth.
Total Severity Score		A summary of the Patient Health Questionnaire frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication between clinicians and mental health specialists.
Urostomy		A stoma for the urinary system, intended to bypass the bladder or urethra.
Utilization Guidelines		Instructions concerning 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.
Vomiting		The forceful expulsion of stomach contents through the mouth or nose.

(continued)

Term	Abbreviation	Definition
Worsening in Pressure Ulcer Status		Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.
Z Codes		ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00–Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

1. DELIRIUM

Review of Indicators of Delirium

✓	Changes in vital signs compared to baseline	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	Temperatures 2.4^{0}F higher than baseline or a temperature of 100.4^{0}F (38^{0}C) on admission prior to establishment of baseline. (J1550A)	
☐	Pulse rate less than 60 or greater than 100 beats per minute	
☐	Respiratory rate over 25 breaths per minute or less than 16 per minute (J1100)	
☐	Hypotension or a significant decrease in blood pressure: (I0800)	
☐	• Systolic blood pressure of less than 90 mm Hg, OR	
☐	• Decline of 20 mm Hg or greater in systolic blood pressure from person's usual baseline, OR	
☐	• Decline of 10 mm Hg or greater in diastolic blood pressure from person's usual baseline, OR	
☐	Hypertension - a systolic blood pressure above 160 mm Hg, OR a diastolic blood pressure above 95 mm Hg (I0700)	
✓	**Abnormal laboratory values** (from clinical record)	**Supporting Documentation**
☐	• Electrolytes, such as sodium	
☐	• Kidney function	
☐	• Liver function	
☐	• Blood sugar	
☐	• Thyroid function	
☐	• Arterial blood gases	
☐	• Other	
✓	**Pain**	**Supporting Documentation**
☐	• Pain CAA triggered (J0100, J0200) [review findings for relationship to delirium (C1310)]	
☐	• Pain frequency, intensity, and characteristics (time of onset, duration, quality) (J0400, J0600, J0800, J0850 and clinical record) indicate possible relationship to delirium (C1310)	
☐	• Adverse effect of pain on function (J0500A, J0500B) may be related to delirium (C1310)	

✓	Indicators of Dehydration	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Dehydration CAA triggered, indicating signs or symptoms of dehydration are present (J1550C)	
☐	• Recent decrease in urine volume or more concentrated urine than usual (I and O) (clinical record)	
☐	• Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss (K0300)	
☐	• Nausea, vomiting (J1550B), diarrhea, or blood loss	
☐	• Receiving intravenous drugs (O0100H)	
☐	• Receiving diuretics or drugs that may cause electrolyte imbalance (medication administration record)(N0410G)	
✓	**Functional Status**	**Supporting Documentation**
☐	• Recent decline in ADL status (Section G0110) (may be related to delirium) (C1310)	
☐	• Increased risk for falls (J1700) (may be related to delirium) (See Falls CAA)	
✓	**Medications** (that may contribute to delirium)	**Supporting Documentation**
☐	• New medication(s) or dosage increase(s)	
☐	• Drugs with anticholinergic properties (for example, some antipsychotics (N0410A), antidepressants (N0410C), antiparkinsonian drugs, antihistamines)	
☐	• Opioids (narcotic pain drug)	
☐	• Benzodiazepines, especially long-acting agents (N0410B)	
☐	• Analgesics, cardiac and GI medications, anti-inflammatory drugs	
☐	• Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0410B)	
☐	• Drug interactions (pharmacist review may be required)	
☐	• Resident taking more than one drug from a particular class of drugs	
☐	• Possible drug toxicity, especially if the person is dehydrated (J1550C) or has renal insufficiency (I1500). Check serum drug levels	

2. COGNITIVE LOSS/DEMENTIA

Review of Indicators of Cognitive Loss/Dementia

✓	Reversible causes of cognitive loss	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Delirium (C1310) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.)	
✓	**Neurological factors**	**Supporting Documentation**
☐	• Intellectual disability/Developmental Disability (A1550)	
☐	• Alzheimer's Disease or other dementias (I4200, I4800)	
☐	• Parkinson's Disease (I5300)	
☐	• Traumatic brain injury (I5500)	
☐	• Brain tumor (clinical record)	
☐	• Normal pressure hydrocephalus	
☐	• Other (clinical record, I8000)	
✓	**Observable characteristics and extent** of this resident's cognitive loss	**Supporting Documentation**
☐	• Analyze component of Brief Interview for Mental Status (BIMS) (C0200-C0500) (V0100D)	
☐	• If unable to complete BIMS, analyze components of Staff Assessment for Mental Status (C0700, C0800, C0900,C1000)	
☐	• Identify components of Delirium assessment (C1310) that are present and not new onset or worsening	
☐	• Confusion, disorientation, forgetfulness (observation, clinical record) (C0200, C0300, C0400, C0500,C0700, C0800, C0900, C1310)	
☐	• Decreased ability to make self understood (B0700) or to understand others (B0800)	
☐	• Impulsivity (observation, clinical record)	
☐	• Other (observation, clinical record)	

✓	**Functional status and its relationship to cognitive loss**	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Activities of Daily Living (ADL) status (Section G) — ADL Care Area triggered (G0110). Analysis of Findings provides important information about relationship of ADL decline to cognitive loss (C0500, C0700, C0800, C0900, C1000, V0100D) — Resident has potential for more independence with cueing, restorative nursing program, and/or task segmentation or other programs (G0600, O0100 – O0500)	
☐	• Decline in continence (H0300, H0400, clinical record)	
☐	• Impaired daily decision-making (C1000, clinical record)	
☐	• Participates better in small group programs (F0800P, observation, clinical record)	
☐	• Staff and/or resident believe resident is capable of doing more (G0900)	
✓	**Other Considerations**	**Supporting Documentation**
☐	• Cognitive decline occurred slowly over time (V0100D)	
☐	• Unexplainable behavior may be attempt at communication about pain, toileting needs, uncomfortable position, etc.	
☐	• Use of physical restraints (P0100)	
☐	• Hearing or vision impairment (B0200, B0300, B1000, B1200) - may have an impact on ability to process information (directions, reminders, environmental cues)	
☐	• Lack of frequent reorientation, reassurance, reminders to help make sense of things (C0900, C1310)	
☐	• Interference with the resident's ability to get enough sleep (noise, light, etc.) (D0200C, D0500C)	
☐	• Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes)	

4. COMMUNICATION

Review of Indicators of Communication

✓	**Diseases and conditions** that may be related to communication problems	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Alzheimer's Disease or other dementias (I4200, I4800, I8000)	
☐	• Aphasia (I4300) following a cerebrovascular accident (I4500)	
☐	• Parkinson's disease (I5300)	
☐	• Mental health problems (I5700 – I6100)	
☐	• Conditions that can cause voice production deficits, such as	
☐	— Asthma (I6200)	
☐	— Emphysema/COPD (I6200)	
☐	— Cancer (I0100) — Poor-fitting dentures (L0200)	
☐	• Transitory conditions, such as	
☐	— Delirium (C1310, I8000, clinical record)	
☐	— Infection (I1700 – I2500) — Acute illness (I8000, clinical record)	
☐	• Other (I8000, clinical record)	
✓	**Medications** (consultant pharmacist review of medication regimen can be very helpful)	**Supporting Documentation**
☐	• Narcotic analgesics (medication administration record)	
☐	• Antipsychotics (N0410A)	
☐	• Antianxiety (N0410B)	
☐	• Antidepressants (N0410C)	
☐	• Parkinson's medications (medication administration record)	
☐	• Hypnotics (N0410D)	
☐	• Gentamycin (N0410F) (medication administration record)	
☐	• Tobramycin(N0410F) (medication administration record)	
☐	• Aspirin (medication administration record)	
☐	• Other (clinical record)	

✓	**Characteristics of the communication impairment** (from clinical record)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Expressive communication (B0700)	
☐	— Speaks different language (A1100)	
☐	— Disruption in ability to speak (B0600, clinical record)	
☐	— Problem with voice production, low volume (B0600, clinical record)	
☐	— Word-finding problems (clinical record)	
☐	— Difficulty putting sentence together (B0700, C1310C, clinical record)	
☐	— Problem describing objects and events (B0700, clinical record)	
☐	— Pronouncing words incorrectly (B0600, clinical record)	
☐	— Stuttering (B0700, clinical record)	
☐	— Hoarse or distorted voice (clinical record)	
☐	• Receptive communication (B0800)	
☐	— Does not understand English (A1100)	
☐	— Hearing impairment (B0200, B0300 = 1, B0800)	
☐	— Speech discrimination problems (clinical record)	
☐	— Decreased vocabulary comprehension (clinical record) (A1100A-B)	
☐	— Difficulty reading and interpreting facial expressions (clinical record, direct observation)	
☐	• Communication is more successful with some individuals than with others. Identify and build on the successful approaches (clinical record, interviews, observation)	
☐	• Limited opportunities for communication due to social isolation or need for communication devices (clinical record, interviews)	
☐	• Communication problem may be mistaken as cognitive impairment	

5. ACTIVITIES OF DAILY LIVING (ADLs) – FUNCTIONAL STATUS/REHABILITATION POTENTIAL

Review of Indicators of ADLs - Functional Status/Rehabilitation Potential

✓	**Possible underlying problems** that may affect function. Some may be reversible.	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310) (clinical record and Delirium CAA)	
☐	• Acute episode or flare-up of chronic condition (I8000, clinical record)	
☐	• Changing cognitive status (C0100) (see Cognitive Loss CAA)	
☐	• Mood decline (D0100)(clinical record and Mood State CAA)	
☐	• Daily behavioral symptoms/decline in behavior(E0200) (see Behavioral Symptoms CAA)	
☐	• Use of physical restraints(P0100) (See Physical Restraints CAA)	
☐	• Pneumonia (I2000)	
☐	• Fall(J1700) (from record and Falls CAA)	
☐	• Hip fracture (I3900)	
☐	• Recent hospitalization (clinical record) (A1700, A1800= 3, 4)	
☐	• Fluctuating ADLs (G0110A-J, G0120, G0300A-E, G0900) (observation, clinical record)	
☐	• Nutritional problems (K0510A1, K0510A2) (clinical record and Nutrition CAA)	
☐	• Pain(J0700) (See Pain CAA)	
☐	• Dizziness	
☐	• Communication problems (B0200, B0700, B0800) (clinical record and Communication CAA)	
☐	• Vision problems(B1000) (observation, interview, clinical record, and Vision CAA)	
✓	**Abnormal laboratory values** (from clinical record)	**Supporting Documentation**
☐	• Electrolytes	
☐	• Complete blood count	
☐	• Blood sugar	
☐	• Thyroid function	
☐	• Arterial blood gases	
☐	• Other	

6. URINARY INCONTINENCE AND INDWELLING CATHETER

Review of Indicators of Urinary Incontinence and Indwelling Catheter

✓	**Modifiable factors** contributing to transitory urinary incontinence	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310) (See Delirium CAA)	
☐	• Urinary Tract Infection (I2300)	
☐	• Atrophic vaginitis in postmenopausal women (I8000)	
☐	• Medications (see below)	
☐	• Psychological or psychiatric problems (I5700-I6100)	
☐	• Constipation/impaction (H0600, clinical record)	
☐	• Caffeine use	
☐	• Excessive fluid intake	
☐	• Pain (J0300)	
☐	• Environmental factors	
☐	— Restricted mobility (G0110.1.A-F. = 2, 3,4)(G0110.2.A-F.=2, 3) (See ADL CAA)	
☐	— Lack of access to a toilet	
☐	— Other environmental barriers (such as pads or briefs)	
☐	— Restraints (P0100)	
✓	**Other factors** that contribute to incontinence or catheter use	**Supporting Documentation**
☐	• Excessive or inadequate urine output	
☐	• Urinary urgency AND need for assistance in toileting (G0110.1.I = 2, 3, 4)	
☐	• Bladder cancer (I0100) or stones (I8000)	
☐	• Spinal cord or brain lesions (I8000)	
☐	• Tabes dorsalis (I8000)	
☐	• Neurogenic bladder (I1550)	
✓	**Laboratory tests**	**Supporting Documentation**
☐	• High serum calcium	
☐	• High blood glucose	
☐	• Low B12	
☐	• High BUN or creatinine	

✓	**Diseases and conditions** that may impede ability to interact with others	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310, C1310A = 1, Delirium CAA)	
☐	• Intellectual disability /developmental disability (A1550)	
☐	• Alzheimer's disease (I4200)	
☐	• Aphasia (I4300)	
☐	• Other dementia (I4800)	
☐	• Depression (I5800)	
✓	**Health status factors** that may inhibit social involvement	**Supporting Documentation**
☐	• Decline in activities of daily living (G0110)	
☐	• Health problem, such as falls (J1700, J1800), pain (J0300, J0800), fatigue, etc.	
☐	• Mood (D0200A1, D0300, D0500A1, D0600) or behavior (E0200) problem that impacts interpersonal relationships or that arises because of social isolation (See Mood State and Behavioral Symptoms CAAs)	
☐	• Change in communication (B0700, B0800), vision (B1000), hearing (B0200), cognition (C0100, C0600)	
☐	• Medications with side effects that interfere with social interactions, such as incontinence, diarrhea, delirium, or sleepiness	
✓	**Environmental factors** that may inhibit social involvement	**Supporting Documentation**
☐	• Use of physical restraints (P0100)	
☐	• Change in residence leading to loss of autonomy and reduced self-esteem (A1700)	
☐	• Change in room assignment or dining location or table mates	
☐	• Living situation limits informal social interaction, such as isolation precautions (O0100M)	

8. MOOD STATE

Review of Indicators of Mood

✓	**Psychosocial changes**	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Personal loss	
☐	• Recent move into or within the nursing home (A1700)	
☐	• Recent change in relationships, such as illness or loss of a relative or friend	
☐	• Recent change in health perception, such as perception of being seriously ill or too ill to return home (Q0300 - Q0600)	
☐	• Clinical or functional change that may affect the resident's dignity, such as new or worsening incontinence, communication, or decline	
✓	**Clinical issues** that can cause or contribute to a mood problem	**Supporting Documentation**
☐	• Relapse of an underlying mental health problem (I5700 – I6100)	
☐	• Psychiatric disorder (anxiety, depression, manic depression, schizophrenia, post-traumatic stress disorder) (I5700 – I6100)	
☐	• Alzheimer's disease (I4200)	
☐	• Delirium (C1310)	
☐	• Delusions (E0100B)	
☐	• Hallucinations (E0100A)	
☐	• Communication problems (B0700, B0800)	
☐	• Decline in Activities of Daily Living (ADLs) (G0110, clinical record)	
☐	• Infection (I1700 – I2500, clinical record)	
☐	• Pain (J0300 or J0800)	
☐	• Cardiac disease (I0200 – I0900)	
☐	• Thyroid abnormality (I3400)	
☐	• Dehydration (J1550C, clinical record)	
☐	• Metabolic disorder (I2900 – I3400)	
☐	• Neurological disease (I4200 – I5500)	
☐	• Recent cerebrovascular accident (I4500)	
☐	• Dementia, cognitive decline (I4800, clinical record)	
☐	• Cancer (I0100)	
☐	• Other (I8000)	

✓	**Factors that can cause or exacerbate the behavior** (from observation, interview, record)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Frustration due to problem communicating discomfort or unmet need	
☐	• Frustration, agitation due to need to urinate or have bowel movement	
☐	• Fear due to not recognizing caregiver	
☐	• Fear due to not recognizing the environment or misinterpreting the environment or actions of others	
☐	• Major unresolved sources of interpersonal conflict between the resident and family members, other residents, or staff (see Psychosocial Well-Being CAA)	
☐	• Recent change, such as new admission (A1700) or a new unit, assignment of new care staff, or withdrawal from a treatment program	
☐	• Departure from normal routines	
☐	• Sleep disturbance (D0500C = 1)	
☐	• Noisy, crowded area	
☐	• Dimly lit area	
☐	• Sensory impairment, such as hearing or vision problem (B0200, B1000)	
☐	• Restraints (P0100)	
☐	• Fatigue (D0500D = 1)	
☐	• Need for repositioning (M1200)	
✓	**Cognitive status problems** (also see Cognitive Loss CAT/CAA)	**Supporting Documentation**
☐	• Delirium (C1310), clinical record (Delirium CAT)	
☐	• Dementia (I4800)	
☐	• Recent cognitive loss (clinical record, interviews with family, etc.)	
☐	• Alzheimer's disease (I4200)	
☐	• Effects of cerebrovascular accident (I4500)	

✓	**Internal risk factors** (from diagnosis list and clinical indicators) (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Neuromuscular/functional — Cerebral palsy (I4400) — Loss of arm or leg movement (G0400) — Decline in functional status (G0110) — Incontinence (H0300, H0400) — Hemiplegia/Hemiparesis (I4900) — Parkinson's disease (I5300) — Seizure disorder (I5400) — Paraplegia (I5000) — Multiple sclerosis (I5200) — Traumatic brain injury (I5500) — Syncope — Chronic or acute condition resulting in instability — Peripheral neuropathy — Muscle weakness	
☐	• Orthopedic — Joint pain — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Missing limb(s) (G0600D)	
☐	• Perceptual — Visual impairment (B1000) — Hearing impairment (B0200) — Dizziness/vertigo	
☐	• Psychiatric or cognitive — Impulsivity or poor safety awareness — Delirium (C1310) — Wandering (E0900) — Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. — Cognitive impairment (C0500, C0700-C1000) — Alzheimer's disease (I4200) — Other dementia (I4800) — Anxiety disorder (I5700) — Depression (I5800) — Manic depression (I5900) — Schizophrenia (I6000)	

(continued)

✓	Communication problems	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Review Communication CAA	
☐	• Comatose (B0100)	
☐	• Difficulty making self understood (B0700)	
☐	• Difficulty understanding others (B0800)	
☐	• Aphasia (I4300)	
✓	**Dental/oral problems** (from Section L and physical assessment)	**Supporting Documentation**
☐	• See Dental Care CAA	
☐	• Broken or fractured teeth (L0200D)	
☐	• Toothache (L0200F)	
☐	• Bleeding gums (L0200E)	
☐	• Loose dentures, dentures causing sores (L0200A)	
☐	• Lip or mouth lesions (for example, cold sores, fever blisters, oral abscess) (L0200C)	
☐	• Mouth pain (L0200F)	
☐	• Dry mouth	
✓	**Other diseases and conditions** that can affect appetite or nutritional needs	**Supporting Documentation**
☐	• Anemia (I0200)	
☐	• Arthritis (I3700)	
☐	• Burns (M1040F)	
☐	• Cancer (I0100)	
☐	• Cardiovascular disease (I0300-I0900)	
☐	• Cerebrovascular accident (I4500)	
☐	• Constipation (H0600)	
☐	• Delirium (C1310)	
☐	• Depression (I5800)	
☐	• Diabetes (I2900)	
☐	• Diarrhea	
☐	• Gastrointestinal problem (I1100-I1300)	
☐	• Hospice care (O0100K)	
☐	• Liver disease (I8000)	
☐	• Pain (J0300)	
☐	• Parkinson's disease (I5300)	
☐	• Pressure ulcers (M0300)	

(continued)

13. FEEDING TUBE(S)

Review of Indicators of Feeding Tubes

✓	Reason for tube feeding	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Unable to swallow or to eat food and unlikely to eat within a few days due to — Physical problems in chewing or swallowing (for example, stroke or Parkinson's disease) (L0200F, K0100D) — Mental problems (I5700 – I6100) (for example, Alzheimer's (I4200), depression (I5800))	
☐	• Normal caloric intake is substantially impaired due to endotracheal tube or a tracheostomy (O0100E)	
☐	• Prevention of meal-induced hypoxemia (insufficient oxygen to blood), in resident with COPD (I6200) or other pulmonary problems that interfere with eating (I6200)	
✓	**Complications of tube feeding**	**Supporting Documentation**
☐	• Diagnostic conditions — Delirium (C1310) — Repetitive physical movements — Anxiety (I5700, clinical record) — Depression (I5800) — Lung aspiration, pneumonia (I2000, clinical record) — Infection at insertion site — Shortness of breath (J1100)	
☐	• Bleeding around insertion site	
☐	• Constipation (H0600)	
☐	• Abdominal distension or abdominal pain	
☐	• Diarrhea or cramping	
☐	• Nausea, vomiting (J1550B)	
☐	• Tube dislodgement, blockage, leakage	
☐	• Bowel perforation	
☐	• Dehydration (J1550C) or fluid overload	
☐	• Self-extubation	
☐	• Use of physical restraints (P0100)	

14. DEHYDRATION/FLUID MAINTENANCE

Review of Indicators of Dehydration/Fluid Maintenance

✓	**Symptoms of dehydration**	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Dizziness on sitting or standing	
☐	• Confusion or change in mental status (delirium) (C1310, V0100D)	
☐	• Lethargy (C1310D)	
☐	• Recent decrease in urine volume or more concentrated urine than usual	
☐	• Decreased skin turgor, dry mucous membranes (J1550)	
☐	• Newly present constipation (H0600), fecal impaction	
☐	• Fever (J1550A)	
☐	• Functional decline (G0110)	
☐	• Increased risk for falls (J1700)	
☐	• Fluid and electrolyte disturbance	
✓	**Abnormal laboratory values** (from clinical record)	**Supporting Documentation**
☐	• Hemoglobin	
☐	• Hematocrit	
☐	• Potassium chloride	
☐	• Sodium	
☐	• Albumin	
☐	• Blood urea nitrogen	
☐	• Urine specific gravity	

✓	**Cognitive, communication, and mental status** issues that can interfere with intake	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Depression (I5800, D0300, D0600) or anxiety (I5700)	
☐	• Behavioral disturbance that interferes with intake (E0200, clinical record)	
☐	• Recent change in mental status (C1310)	
☐	• Alzheimer's or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating/drinking, etc. (I4200, I4800)	
☐	• Difficulty making self understood (B0700)	
☐	• Difficulty understanding others (B0800)	
✓	**Diseases and conditions** that predispose to limitations in maintaining normal fluid balance	**Supporting Documentation**
☐	• Infection (I1700 – I2500)	
☐	• Fever (J1550A)	
☐	• Diabetes (I2900)	
☐	• Congestive heart failure (I0600)	
☐	• Swallow problem (K0100)	
☐	• Renal disease (I1500)	
☐	• Weight loss (K0300)	
☐	• Weight gain (K0310)	
☐	• New cerebrovascular accident (clinical record, I4500)	
☐	• Unstable acute or chronic condition (clinical record, I8000)	
☐	• Nausea or vomiting (J1550B)	
☐	• Diarrhea (clinical record)	
☐	• Excessive sweating (clinical record)	
☐	• Recent surgery (clinical record, I8000)	
☐	• Recent decline in activities of daily living (G0110), including body control or hand control problems, inability to sit up (G0300), etc. (observation, interview, clinical record)	
☐	• Parkinson's or other neurological disease that requires unusually long time to eat (I4200 – I5500)	
☐	• Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, (J1550B)	

(continued)

✓	Intrinsic risk factors	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Immobility (G0110)	
☐	• Altered mental status — Delirium limits mobility (see Delirium CAA) — Cognitive loss (C0500, C0700-C1000) limits mobility (see Cognitive Loss CAA)	
☐	• Incontinence (H0300, H0400, M1040H) (see Incontinence CAA)	
☐	• Poor nutrition (see Nutrition CAA)	
✓	**Medications** that increase risk for pressure ulcer development	**Supporting Documentation**
☐	• Antipsychotics (N0410A)	
☐	• Antianxiety agents (N0410B)	
☐	• Antidepressants (N0410C)	
☐	• Hypnotics (N0410D)	
☐	• Steroids	
☐	• Narcotics	
✓	**Diagnoses and conditions** that present complications or increase risk for pressure ulcers	**Supporting Documentation**
☐	• Delirium (C1310)	
☐	• Comatose (B0100)	
☐	• Cancer (I0100)	
☐	• Peripheral Vascular Disease (I0900)	
☐	• Diabetes (I2900)	
☐	• Alzheimer's disease (I4200)	
☐	• Cerebrovascular Accident (I4500)	
☐	• Other dementia (I4800)	
☐	• Hemiplegia/hemiparesis (I4900)	
☐	• Paraplegia (I5000), Quadriplegia (I5100)	
☐	• Multiple sclerosis (I5200)	
☐	• Depression (D0300, D0600, I5800)	
☐	• Edema	
☐	• Severe pulmonary disease (I6200)	
☐	• Sepsis (I2100)	
☐	• Terminal illness (O0100K)	

✓	**Adverse consequences of ANTIDEPRESSANTS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Worsening of depression and/or suicidal behavior or thinking (D0350, D0650, V0100E, V0100F, clinical record)	
☐	• Delirium unrelated to medical illness or severe depression (C1310, clinical record)	
☐	• Hallucinations (E0100A)	
☐	• Dizziness (clinical record)	
☐	• Nausea (clinical record)	
☐	• Diarrhea (clinical record)	
☐	• Anxiety (I5700, clinical record)	
☐	• Nervousness, fidgety or restless (clinical record)	
☐	• Insomnia (clinical record)	
☐	• Somnolence (clinical record)	
☐	• Weight gain (K0310, clinical record)	
☐	• Anorexia or increased appetite (clinical record)	
☐	• Increased risk for falls (clinical record), falls (J1700-J1900)	
☐	• Seizures (I5400)	
☐	• Hypertensive crisis if combined with certain foods, cheese, wine (MAO inhibitors)	
☐	• Anticholinergic (tricyclics), such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)	
☐	• Postural hypotension (tricyclics) (I0800, clinical record)	
✓	**Adverse consequences of ANTIPSYCHOTICS** exhibited by this resident	**Supporting Documentation**
☐	• Anticholinergic effects, such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)	
☐	• Increase in total cholesterol and triglycerides (clinical record)	
☐	• Akathisia (inability to sit still) (clinical record)	
☐	• Parkinsonism (any combination of tremors, postural unsteadiness, muscle rigidity, pill-rolling of hands, shuffling gait, etc.) (clinical record)	

(continued)

✓	**Adverse consequences of ANTIPSYCHOTICS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Neuroleptic malignant syndrome (high fever with severe muscular rigidity) (clinical record)	
☐	• Blood sugar elevation (clinical record)	
☐	• Cardiac arrhythmias (I0300)	
☐	• Orthostatic hypotension (I0800, clinical record)	
☐	• Cerebrovascular accident or transient ischemic attack (I4500)	
☐	• Falls (J1700-J1900)	
☐	• Tardive dyskinesia (persistent involuntary movements such as tongue thrusting, lip movements, chewing or puckering movements, abnormal limb movements, rocking or writhing trunk movements) (clinical record)	
☐	• Lethargy (D0200D, clinical record)	
☐	• Excessive sedation (clinical record)	
☐	• Depression (D0300, D0600, I5800)	
☐	• Hallucinations (E0100A)	
☐	• Delirium unrelated to medical illness or severe depression (C1310, clinical record)	
✓	**Adverse consequences of ANXIOLYTICS** exhibited by this resident	**Supporting Documentation**
☐	• Sedation manifested by short-term memory loss (C0500, C0700), decline in cognitive abilities, slurred speech (B0600), drowsiness, little/no activity involvement (clinical record)	
☐	• Delirium unrelated to medical illness or severe depression (C1310, clinical record)	
☐	• Hallucinations (E0100A)	
☐	• Depression (D0300, D0600, I5800)	
☐	• Disturbances of balance, gait, positioning ability (G0300, G0110C, G0110D, G0110A, clinical record)	

✓	**Adverse consequences of SEDATIVES/HYPNOTICS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• May increase the metabolism of many medications (for example, anticonvulsants, antipsychotics), which may lead to decreased effectiveness and subsequent worsening of symptoms or decreased control of underlying illness (clinical record)	
☐	• Hypotension (I0800, clinical record)	
☐	• Dizziness, lightheadedness (clinical record)	
☐	• "Hangover" effect (interview, clinical record)	
☐	• Drowsiness (observation, clinical record)	
☐	• Confusion, delirium unrelated to acute illness or severe depression (C1310, clinical record)	
☐	• Mental depression (I5800, I5900)	
☐	• Unusual excitement (clinical record)	
☐	• Nervousness (clinical record)	
☐	• Headache (interview, clinical record)	
☐	• Insomnia (clinical record)	
☐	• Nightmares (interview, clinical record)	
☐	• Hallucinations (E0100A)	
☐	• Falls (J1700-J1900)	
✓	**Drug-related discomfort** requiring treatment and/or prevention	**Supporting Documentation**
☐	• Dehydration (J1550C, I8000)	
☐	• Reduced dietary bulk (from observation of food intake)	
☐	• Lack of exercise (observation, clinical record)	
☐	• Constipation/fecal impaction (H0600, clinical record)	
☐	• Urinary retention (clinical record)	
☐	• Dry mouth (interview, clinical record)	
✓	**Overall status change** for relationship to psychotropic drug use (from clinical record)	**Supporting Documentation**
☐	• Major differences in a.m./p.m. performance	
☐	• Decline in cognition/communication (V0100D)	
☐	• Decline in mood (V0100E, V0100F)	
☐	• Decline in behavior	
☐	• Decline in Activities of Daily Living (ADLs) (G0110)	

✓	**Cognitive impairment/behavioral symptoms that may lead to restraint use** (also see Cognitive Loss and Behavior CAAs)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Inattention, easily distracted (C1310B)	
☐	• Disorganized thinking (C1310C)	
☐	• Fidgety, restless	
☐	• Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
☐	• Confusion (C0100, C0600)	
☐	• Psychosis (E0100A, E0100B)	
☐	• Physical symptoms directed toward others (E0200A)	
☐	• Verbal behavioral symptoms directed toward others (E0200B)	
☐	• Rejection of care (E0800)	
☐	• Wandering (E0900)	
☐	• Delirium (C1310), including side effects of medications (clinical record)	
☐	• Alzheimer's disease (I4200) or other dementia (I4800)	
☐	• Traumatic brain injury (I5500)	
☐	• Psychiatric disorder (I5700-I6100)	
✓	**Risk for falls that may lead to restraint use** (also see Falls CAA)	**Supporting Documentation**
☐	• Poor safety awareness, impulsivity (clinical record)	
☐	• Urinary urgency (clinical record)	
☐	• Incontinence of bowel and/or bladder (H0300, H0400)	
☐	• Side effect of medication, such as dizziness, postural/orthostatic hypotension (I0800), sedation, etc. (clinical record)	
☐	• Insomnia, fatigue (D0200D, D0500D)	
☐	• Need for assistance with mobility (G0110)	
☐	• Balance problem (G0300)	
☐	• Postural/orthostatic hypotension (I0800, clinical record)	
☐	• Hip or other fracture (I3900, I4000)	
☐	• Hemiplegia/hemiparesis (I4900), paraplegia (I5000), quadriplegia (I5100)	
☐	• Other neurological disorder (for example, Cerebral Palsy (I4400), Multiple Sclerosis (I5200), Parkinson's Disease (I5300))	
☐	• Respiratory problems (J1100, I6200, I6300, clinical record)	
	• History of falls (J1700 – J1900)	

✓	**Associated signs and symptoms**	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Agitation or new or increased behavior problems (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
☐	• Delirium (C1310)	
☐	• Withdrawal	
✓	**Other Considerations**	**Supporting Documentation**
☐	• Improper positioning (M1200C)	
☐	• Contractures (G0400)	
☐	• Immobility (G0110)	
☐	• Use of restraints (P0100)	
☐	• Recent change in pain (characteristics, frequency, intensity, etc.) (J0400, J0600)	
☐	• Insufficient pain relief (from resident/staff interview, clinical record, direct observation) (J0100 – J0850)	
☐	• Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain (J0100 – J0850)	

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/professionals/clinicians-providers/index.html;
- 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.eatrightpro.org/resource/practice/position-and-practice-papers/position-papers/individualized-nutrition-approaches-for-older-adults;
- 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.paltc.org/product-store;
- 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): https://www.cms.gov/Regulations-and-Guidance/Guidance/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: https://consultgeri.org/tools;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: https://consultgeri.org/;
- 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://geriatrictoolkit.missouri.edu/; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: http://www.guideline.gov/.

Centers for Medicare & Medicaid Services: Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1). Available from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html?DLPage=1&DLSort=0&DLSortDir=ascending

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Centers for Medicare & Medicaid Services: Minimum Data Set (MDS) 3.0 Provider User's Guide. Available from https://www.qtso.com/mds30.html

Centers for Medicare & Medicaid Services: State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Section 483.20(b) Utilization Guidelines for Completion of the RAI. Available from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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National Pressure Ulcer Advisory Panel: Unstageable [image of cross-sectioned unstageable pressure ulcer]. Retrieved November 18, 2009, from http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg

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Saliba, D., and Buchanan, J.: Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0 Final Report to CMS. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA. Rand Corporation, April 2008. Available from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/mds30finalreport.pdf.

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U.S. Department of Health and Human Services, Health Care Financing Administration: Medicare program; Prospective payment system and consolidated billing for skilled nursing facilities—Update; final rule and notice. Fed. Regist. 64(146):41644-41683, Jul. 30, 1999.

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Track Changes
from Title Page v1.13
to Title Page v1.14

Chapter	Section	Page	Change
—	—	—	Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.1~~3~~4 October 201~~5~~6

Track Changes
from TOC v1.13
to TOC v1.14

Chapter	Section	Page	Change
—	—	i	Section GG Functional Abilities and Goals……...GG-1
—	—	i–ii	Updated page numbers.
—	—	i–iii	Page length changed due to addition of Section GG.

Track Changes
from Chapter 1 v1.13
to Chapter 1 v1.14

Chapter	Section	Page	Change
1	—	1-1	**Experts in Long Term Care** • Tracy Burger Montag, RN, BSN, RAC-CT • ~~Teresa M. Mota, BSN, RN, CALA, WCC, CPEHR~~ • John Morris, PhD, MSW
1	—	1-1–1-4	Page length changed due to revised content.
1	—	1-3–1-4	**CMS** • Brandy Barnette, MBA, RN, CCM • Ellen M. Berry, PT • CMS Regional Office RAI Coordinators • Lori Grocholski, MSW, LCSW • Christine Grose, MS, RN • Renee Henry, MSN, RN • Sheila Lambowitz, Director (Retired)—Division of Institutional Post-Acute Care • Sharon Lash, MPH, MA, RN • Alan Levitt, MD, Medical Officer—Division of Chronic and Post-Acute Care • Shari Ling, MD • Stella Mandl, BSW, BSN, PHN, RN, Deputy Director—Division of Chronic and Post-Acute Care • Tara McMullen, PhD, MPH • Teresa M. Mota, BSN, RN, CALA, WCC • Mary Pratt, MSN, RN, Director—Division of Chronic and Post-Acute Care • Michael Stoltz • Jennifer Sutcliffe, RN, BSN, RAC-CT • Christine Teague, RN-BC, BS, RAC-CT

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Chapter	Section	Page	Change
1	1.2	1-6	• **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data items for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, OBRA Discharge, Entry Tracking, PPS item sets) can be found in Appendix H.
1	1.3	1-7	• **Medicare and Medicaid Payment Systems.** The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at ~~http://www.cms.gov/Manuals/IOM/list.asp~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.
1	1.7	1-14	G — Functional Status — Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. GG — Functional Abilities and Goals — Assess the need for assistance with self-care and mobility activities.

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Chapter	Section	Page	Change
2	2.1	2-1	MDS assessments are also required for Medicare payment (Prospective Payment System [PPS]) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF QRP required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).
2	2.3	2-3	• **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
2	2.3	2-3	• **Swing bed facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level of care in order to be reimbursed under the SNF PPS. CMS collects MDS data for quality monitoring purposes of swing bed facilities effective October 1, 2010. Therefore, swing bed providers must also complete the Entry record, PPS assessments, Discharge assessments, and Death in Facility record.

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Chapter	Section	Page	Change
2	2.3	2-3–2-4	**Skilled Nursing Facility Quality Reporting Program:** The IMPACT Act of 2014 established the Skilled Nursing Facility Quality Reporting Program (SNF QRP). Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that skilled nursing facilities are to collect and report on standardized patient assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year. • Section GG: Functional Abilities and Goals assesses the need for assistance with self-care and mobility activities; it is collected at the start of a Medicare Part A stay on the 5-Day PPS assessment and is also collected at the end of the Medicare Part A stay on the Part A PPS Discharge assessment. Section GG was added to the MDS 3.0 in order to be able to collect the data required to calculate the functional status process-based quality measure, Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). An adapted version of this LTCH measure was finalized for skilled nursing facilities in the Fiscal Year (FY) 2016 SNF PPS final rule for FY 2018 payment determination. Data collected for the SNF QRP is submitted through the QIES ASAP system as it currently is for other MDS assessments. It is important to note that data collection for Section GG **does not substitute** for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for both Section GG and Section G. Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html.
2	2.3–2.15	2-3–2-88	Page length changed due to revised content.

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Chapter	Section	Page	Change
2	2.3	2-4–2-5	o 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, OBRA Discharge, etc., the facility may receive a sequencing warning message, but should still submit the required assessment.
2	2.3	2-5	o The previous owner would complete an OBRA 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.
2	2.5	2-8–2-9	**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 OBRA Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.
2	2.5	2-10	**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~~ No Discharge assessment is ~~not~~ required.

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Chapter	Section	Page	Change
2	2.5	2-10–2-11	**Discharge** refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in 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~~ three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with ~~both~~ all three types of discharges. Section 2.6 provides detailed instructions regarding ~~both discharge~~ return anticipated and return not anticipated types~~.~~, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:
2	2.5	2-11	• Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed. • Resident's Medicare Part A stay ends, but the resident remains in the facility.
2	2.5	2-11	**Discharge Assessment** refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. This assessment includes clinical items for quality monitoring as well as discharge tracking information.
2	2.5	2-11	**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 a nursing home, ~~or~~ leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.
2	2.5	2-11	**Item Set** refers to the MDS items that are active on a particular assessment type or tracking form. There are ~~10~~ 11 different item subsets for nursing homes and 8 for swing bed providers as follows:

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Chapter	Section	Page	Change
2	2.5	2-12	— **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility. — **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
2	2.5	2-13	— **Discharge (SD) Item Set.** This is the set of items active on a standalone swing bed Discharge assessment (either return anticipated or not anticipated).
2	2.5	2-13	The item set for a particular MDS record is completely determined by the Type of Provider, Item A0200 (indicating nursing home or swing bed), and the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, ~~and~~ A0310F, and A0310H). 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.
2	2.5	2-13	**~~MDS Assessment~~ Item Set Codes** are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, ~~and~~ A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

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Chapter	Section	Page	Change
2	2.5	2-14	**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), and A0310H (Is this a Part A PPS Discharge Assessment?). 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 • Part A PPS Discharge Assessment
2	2.5	2-15	**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 an OBRA Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.
2	2.6	2-16	Revised heading of table's first column. Assessment Type/Item Set
2	2.6	2-16	In table, revised Assessment Combination for Admission (Comprehensive). May be combined with ~~another~~ any OBRA assessment; 5- and 14-day PPS; or Part A PPS Discharge assessment

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Chapter	Section	Page	Change
2	2.6	2-16	In table, revised Assessment Combination for Annual (Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-16	In table, revised Assessment Combination for Significant Change in Status (SCSA) (Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-17	In table, revised Assessment Combination for Significant Correction to Prior Comprehensive (SCPA) (Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-17	In table, revised Assessment Combination for Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-17	In table, revised Assessment Combination for Discharge Assessment – return not anticipated (Non-Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-17	In table, revised Assessment Combination for Discharge Assessment – return anticipated (Non-Comprehensive). May be combined with ~~another~~ any OBRA or PPS assessment
2	2.6	2-20	• May be combined with a Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details) or any Discharge assessment type.
2	2.6	2-21	• For a resident who goes in and out of the facility on a relatively frequent basis and return 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 an OBRA Discharge assessment **each time** the resident is discharged. • The nursing home may combine the Admission assessment with ~~the~~ a Discharge assessment when applicable.

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Chapter	Section	Page	Change
2	2.6	2-23	— 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 an OBRA 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).
2	2.6	2-31	The Quarterly and Significant Correction to Prior Quarterly assessments are not required for Swing Bed residents. However, Swing Bed providers are required to complete the OBRA Discharge assessments.
2	2.6	2-34	If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit OBRA Discharge assessments and Entry records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.
2	2.6	2-36	## OBRA Discharge Assessments (A0310F) OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. ~~These are OBRA required assessments.~~
2	2.6	2-37	1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:

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Chapter	Section	Page	Change
2	2.6	2-37	**10. OBRA Discharge Assessment–Return Anticipated (A0310F=11)** • Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days. • For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
2	2.6	2-38	• When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310~~E~~F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.
2	2.6	2-38	1. Ms. C. was admitted to the nursing home on May 22, 2011. She tripped while at a restaurant with her daughter. She was discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows:
2	2.6	2-38	**Assessment Management Requirements and Tips for OBRA Discharge Assessments:**
2	2.6	2-38	• For an OBRA Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (Item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).

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Chapter	Section	Page	Change
2	2.6	2-38–2-39	• The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met. • For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
2	2.6	2-39	The following chart details the sequencing and coding of Tracking records and OBRA Discharge assessments.
2	2.6	2-40	Revised chart title. **Entry, OBRA Discharge, and Reentry Algorithms**

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Chapter	Section	Page	Change
2	2.8	2-44–2-45	**Part A PPS Discharge Assessment (A0310H)** The Part A PPS Discharge assessment contains data elements used to calculate current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which post-acute care (PAC) providers (which includes SNFs) are required to submit standardized patient assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that patient assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting. • Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment can also be combined with the OBRA Discharge assessment when 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), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required.

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Chapter	Section	Page	Change
2	2.8	2-45	**Part A PPS Discharge Assessment (A0310H = 1):** • Must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility). • For the Part A PPS Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days). • If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required. • 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). The Part A PPS Discharge assessment may be combined with most PPS and OBRA-required assessments when requirements for all assessments are met (please see Section 2.11 Combining Medicare Assessments and OBRA Assessments). • Must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days). • Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). • Consists of demographic, administrative, and clinical items. • If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day PPS assessment.

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Chapter	Section	Page	Change
2	2.8	2-46	Revised table title. **Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities**
2	2.8	2-46	Revised heading of table's first column. ~~**Codes for**~~ **Assessments** **Type/Item Set** **Required for Medicare**
2	2.8	2-47	Revised row title. Start of Therapy Other Medicare-required Assessment (OMRA) ~~A0310B = 01-07 and~~ A0310C = 1~~ or 3~~
2	2.8	2-47	Revised row title. End of Therapy OMRA ~~A0310B = 01-07 and~~ A0310C = 2 ~~or 3~~
2	2.8	2-47	Revised row title. Change of Therapy OMRA ~~A0310B = 01-07 And~~ A0310C = 4
2	2.8	2-48	Revised row title. Swing Bed Clinical Change Assessment (CCA) ~~A0310B = 01-07 and~~ A0310D = 1
2	2.8	2-48	Revised row title. OBRA Discharge Assessment A0310F = 10 or 11
2	2.8	2-48	Revised Special Comment for OBRA Discharge Assessment A0310F = 10 or 11. • May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment and the resident is physically discharged from the facility.
2	2.8	2-48	Added row to Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities table. Part A PPS Discharge Assessment A0310H = 1 | Must be set for the last day of the Medicare Part A Stay (A2400C) | N/A | N/A | N/A | • Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

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Chapter	Section	Page	Change
2	2.9	2-50–2-51	Changed font style on key words to bold for emphasis. ***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.
2	2.9	2-55	• If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS assessment, the SNF may choose to complete the scheduled PPS assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is ***on or prior to*** Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS assessment ARD. Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.

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Chapter	Section	Page	Change
2	2.9	2-55	• 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 OBRA 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. If the date listed in A2400C is on Day 7 of the COT observation period, then the SNF must complete both the COT OMRA and the Part A PPS Discharge Assessment. These assessments must be completed separately. 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 OBRA Discharge assessment under the rules outlined for such combination in this chapter.
2	2.10	2-62	• Code the Item A0310 of the MDS 3.0 as follows: A0310A = 99 A0310B = 01, 02, 03, 04, or 05 as appropriate A0310C = 4 A0310D = 0 (Swing Beds only)
2	2.11	2-64	• The Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, ~~and~~ Item A0310C, **PPS Other Medicare Required Assessment - OMRA**, and Item A0310H, **Is this a SNF Part A PPS Discharge Assessment**?, and are required for residents whose stay is covered by Medicare Part A.

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Chapter	Section	Page	Change
2	2.11	2-65	Updated Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities table.

OLD

	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

NEW

	Comprehensive Item Set	Quarterly and PPS* Item Sets	Other Required Assessments and Tracking Records/Item Sets
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 • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Start of Therapy OMRA • Change of Therapy OMRA • End of Therapy OMRA
Combined Assessment Types	• OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required PPS • 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 • Medicare required and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Medicare required and any Discharge • Quarterly and OMRA Discharge • Significant Correction to Prior Quarterly and any Discharge	• Start of Therapy OMRA and End of Therapy OMRA • Start of Therapy OMRA and OBRA Discharge • End of Therapy OMRA and OBRA Discharge • Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge • Change of Therapy OMRA and OBRA Discharge

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>2</td><td>2.11</td><td>2-66</td><td>Updated Minimum Required Item Set By Assessment Type for Swing Bed Providers table.

OLD

<table>
<tr><th></th><th>Swing Bed PPS</th><th>Other Required Assessments/Tracking Item Sets for Swing Bed Providers</th></tr>
<tr><td>Assessment Type</td><td>• PPS 5-Day (5-Day)
• PPS 14-Day (14-Day)
• PPS 30-Day (30-Day)
• PPS 60-Day (60-Day)
• PPS 90-Day (90-Day)
• Clinical Change Assessment</td><td>• Entry Record
• Discharge assessments
• Death in Facility record
• Start of Therapy OMRA
• Start of Therapy OMRA and Discharge
• Change of Therapy OMRA
• OMRA
• OMRA and Discharge</td></tr>
<tr><td>Assessment Type Combinations</td><td>• Clinical Change and any Medicare-required
• Any Medicare-required and any Discharge</td><td>N/A</td></tr>
</table>

NEW

<table>
<tr><th></th><th>Swing Bed PPS/Item Set</th><th>Other Required Assessments/Tracking Item Sets for Swing Bed Providers</th></tr>
<tr><td>Assessment Type</td><td>• 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)
• Swing Bed Clinical Change Assessment</td><td>• Entry Record
• OBRA Discharge assessment
• Death in Facility record
• Start of Therapy OMRA
• Change of Therapy OMRA
• End of Therapy OMRA</td></tr>
<tr><td>Assessment Type Combinations*</td><td>• Any Medicare required and any OMRA
• Any Medicare required and any Discharge
• Swing Bed Clinical Change and any Medicare required
• Swing Bed Clinical Change and any Discharge</td><td>• Start of Therapy OMRA and End of Therapy OMRA
• Start of Therapy OMRA and OBRA Discharge
• End of Therapy OMRA and OBRA Discharge
• Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge
• Change of Therapy OMRA and OBRA Discharge</td></tr>
</table>
</td></tr>
<tr><td>2</td><td>2.11</td><td>2-66</td><td>The OMRA item sets are all unique item sets and are never completed when combining with other assessments, which require completion of additional items. For example, a Start of Therapy OMRA item set is completed only when an assessment is conducted to capture the start of therapy and assign a RUG-IV therapy group. In addition, a Start of Therapy OMRA and OBRA Discharge item set is only completed when the facility staff choose to complete an assessment to reflect both the start of therapy and discharge from facility. If ~~those~~ assessments are completed in combination with another assessment type, an item set that contains all items required for both assessments must be selected.</td></tr>
</table>

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

Chapter	Section	Page	Change
2	2.12	2-68	***Medicare-required Scheduled Assessment and OBRA Discharge Assessment***
2	2.12	2-68	***Medicare-required Scheduled Assessment and Part A PPS Discharge Assessment*** • PPS item set. • ARD (Item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9. • Must be completed (Item Z0500B) within 14 days after the ARD.
2	2.12	2-70	***Start of Therapy OMRA and OBRA Discharge Assessment***
2	2.12	2-72	***End of Therapy OMRA and OBRA Discharge Assessment*** • OMRA and OBRA Discharge item set.
2	2.12	2-75	***Start and End of Therapy OMRA and OBRA Discharge Assessment*** • OMRA-Start of Therapy and OBRA Discharge item set.
2	2.12	2-78	***Change of Therapy OMRA and OBRA Discharge Assessment*** • COT OMRA and OBRA Discharge item set.

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

Chapter	Section	Page	Change
2	2.13	2-78–2-79	***Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay*** If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (e.g., transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required. When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments may be combined. (~~s~~See Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a Discharge assessment.)~~.~~
2	2.13	2-80–2-81	***Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services*** In the situation when a ~~beneficiary is discharged from~~ beneficiary's Medicare Part A ~~services~~ stay ends but he/she remains in the facility in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule ~~will be continued~~ from the beneficiary's original date of admission and must also complete a Part A PPS Discharge assessment. ~~Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission.~~ There is no reason to change the OBRA schedule when Part A benefits resume. If ~~and when~~ the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

Track Changes
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<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>2</td><td>2.13</td><td>2-81</td><td>

Resident Discharged from Part A Skilled Services and Is Not Physically Discharged from the Skilled Nursing Facility

In the situation when a resident's Medicare Part A stay ends but the resident is not physically discharged from the facility, the Part A PPS Discharge assessment is required. If the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

</td></tr>
<tr><td>2</td><td>2.14</td><td>2-85</td><td>

Updated Expected Order of MDS Records table.

OLD

<table>
<tr><th></th><th colspan="13">Prior Record</th></tr>
<tr><th>Next Record</th><th>Entry</th><th>OBRA Admission</th><th>OBRA annual</th><th>OBRA quarterly</th><th>PPS 5-day</th><th>PPS 14-day</th><th>PPS 30-day</th><th>PPS 60-day</th><th>PPS 90-day</th><th>PPS unscheduled</th><th>Discharge</th><th>Death in facility</th><th>No prior record</th></tr>
<tr><td>Entry</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td></tr>
<tr><td>OBRA Admission</td><td></td><td>no</td><td>no</td><td>no</td><td></td><td></td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>OBRA Annual</td><td></td><td>no</td><td>no</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>OBRA Quarterly, sign. change, sign correction</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>PPS 5-day</td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>PPS 14-day</td><td>no</td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td>no</td><td>no</td></tr>
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<tr><td>PPS 90-day</td><td>no</td><td>no</td><td></td><td></td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>PPS unscheduled</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>Discharge</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>Death in facility</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td></tr>
</table>

NEW

<table>
<tr><th></th><th colspan="14">Prior Record</th></tr>
<tr><th>Next Record</th><th>Entry</th><th>OBRA Admission</th><th>OBRA Annual</th><th>OBRA Quarterly</th><th>PPS 5-day</th><th>PPS 14-day</th><th>PPS 30-day</th><th>PPS 60-day</th><th>PPS 90-day</th><th>PPS OMRA/ Clinical Change</th><th>OBRA Discharge</th><th>Part A PPS Discharge</th><th>Death in facility</th><th>No prior record</th></tr>
<tr><td>Entry</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td>no</td><td></td></tr>
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<tr><td>OBRA Quarterly, sign. change, sign correction</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS 5-day</td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS 14-day</td><td>no</td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS 30-day</td><td>no</td><td></td><td></td><td></td><td>no</td><td></td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS 60-day</td><td>no</td><td>no</td><td></td><td></td><td>no</td><td>no</td><td></td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS 90-day</td><td>no</td><td>no</td><td></td><td></td><td>no</td><td>no</td><td>no</td><td></td><td>no</td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>PPS Unscheduled</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td>no</td><td>no</td><td>no</td></tr>
<tr><td>OBRA Discharge</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>Part A PPS Discharge</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
<tr><td>Death in facility</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>no</td><td></td><td>no</td><td>no</td></tr>
</table>

</td></tr>
</table>

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

Chapter	Section	Page	Change
2	2.15	2-86	**2.15 Determining the Item Set for an MDS Record** The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, ~~and~~ A0310 F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable. The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, ~~and~~ A0310F, and A0310H. Item A0310D (swing bed clinical change assessment) has been omitted because it will always be skipped on a nursing home record. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, ~~and~~ A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of Items A0310A, A0310B, A0310C, ~~and~~ A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

Chapter	Section	Page	Change
2	2.15	2-86	Updated Nursing Home Item Set Code (ISC) Reference Table.

OLD

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

NEW

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01	01,02,99	0	10,11,99	0,1	NC	Comprehensive
01	01,02,07	1,2,3	10,11,99	0,1	NC	Comprehensive
01	02,07	4	10,11,99	0,1	NC	Comprehensive
03	01 thru 05,99	0	10,11,99	0,1	NC	Comprehensive
03,04,05	01 thru 07	1,2,3	10,11,99	0,1	NC	Comprehensive
03,04,05	02 thru 05,07	4	10,11,99	0,1	NC	Comprehensive
04,05	01 thru 07,99	0	10,11,99	0,1	NC	Comprehensive
02,06	01 thru 05,99	0	10,11,99	0,1	NQ	Quarterly
02,06	01 thru 07	1,2,3	10,11,99	0,1	NQ	Quarterly
02,06	02 thru 05,07	4	10,11,99	0,1	NQ	Quarterly
99	01 thru 05	0,1,2,3	10,11,99	0,1	NP	PPS
99	02 thru 05	4	10,11,99	0,1	NP	PPS
99	07	1	99	0	NS	SOT OMRA
99	07	1	10,11	0,1	NSD	SOT OMRA and Discharge
99	07	2,3,4	99	0	NO	EOT, EOT-R or COT OMRA
99	07	2,3,4	10,11	0,1	NOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	10,11	0,1	ND	OBRA Discharge
99	99	0	01,12	0	NT	Tracking
99	99	0	99	1	NPE	Part A PPS Discharge

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

Chapter	Section	Page	Change
2	2.15	2-86–2-87	Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C = 0, ~~and~~ Item A0310F = 99, and A0310H = 0 (a standalone OBRA A~~a~~dmission assessment), then these values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C = 0, ~~and~~ Item A0310F = 12, and A0310H = 0 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C = 0, ~~and~~ A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.
2	2.15	2-87	The next lookup table is for swing bed records. The first 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, ~~and~~ A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, ~~and~~ A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310C, A0310D, ~~and~~ A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Track Changes
from Chapter 2 v1.13
to Chapter 2 v1.14

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>2</td><td>2.15</td><td>2-87</td><td>Updated Swing Bed Item Set Code (ISC) Reference Table.

OLD

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

<table>
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<tr><td>99</td><td>01 thru 05</td><td>0,1,2,3</td><td>0</td><td>10,11,99</td><td>0,1</td><td>SP</td><td>PPS</td></tr>
<tr><td>99</td><td>01 thru 07</td><td>0,1,2,3</td><td>1</td><td>10,11,99</td><td>0,1</td><td>SP</td><td>PPS</td></tr>
<tr><td>99</td><td>02 thru 05</td><td>4</td><td>0</td><td>10,11,99</td><td>0,1</td><td>SP</td><td>PPS</td></tr>
<tr><td>99</td><td>02 thru 05,07</td><td>4</td><td>1</td><td>10,11,99</td><td>0,1</td><td>SP</td><td>PPS</td></tr>
<tr><td>99</td><td>07</td><td>1</td><td>0</td><td>99</td><td>0</td><td>SS</td><td>SOT OMRA</td></tr>
<tr><td>99</td><td>07</td><td>1</td><td>0</td><td>10,11</td><td>0,1</td><td>SSD</td><td>SOT OMRA and Discharge</td></tr>
<tr><td>99</td><td>07</td><td>2,3,4</td><td>0</td><td>99</td><td>0</td><td>SO</td><td>EOT, EOT-R or COT OMRA</td></tr>
<tr><td>99</td><td>07</td><td>2,3,4</td><td>0</td><td>10,11</td><td>0,1</td><td>SOD</td><td>EOT, EOT-R or COT OMRA and Discharge</td></tr>
<tr><td>99</td><td>99</td><td>0</td><td>0</td><td>10,11</td><td>0,1</td><td>SD</td><td>Discharge</td></tr>
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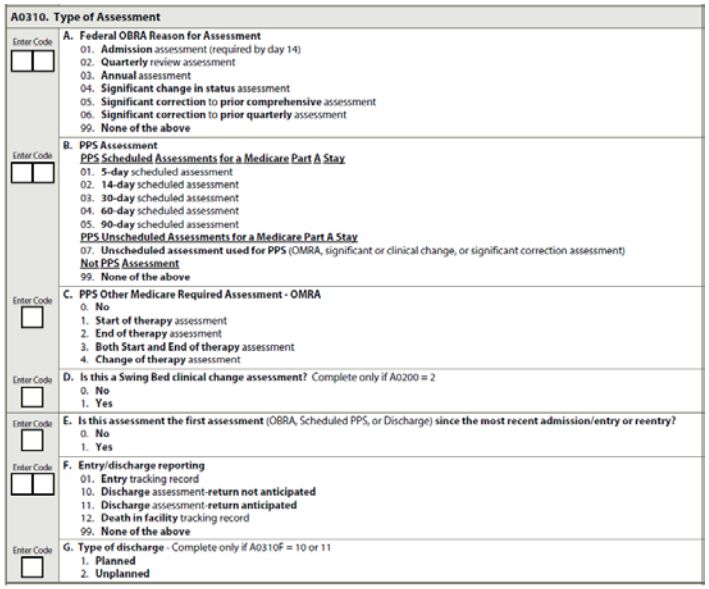
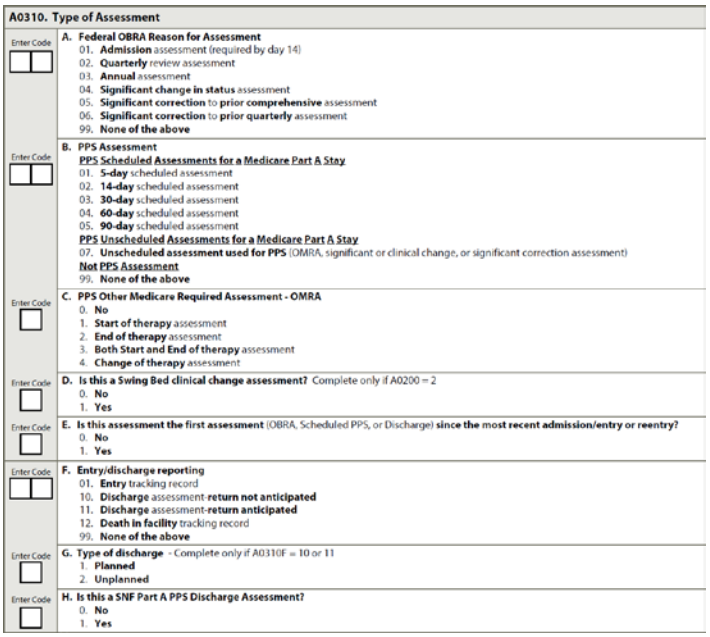
Track Changes
from Chapter 3 Intro v1.13
to Chapter 3 Intro v1.14

Chapter	Section	Page	Change
3	3.3	3-3	• **With the exception of certain items (e.g., some items in Sections K and O), the look-back period generally <u>does not</u> include hospital stay.** • When determining the response to items that have a look-back period to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to the QIES ASAP system. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore should not be considered when determining the "prior assessment."
3	3.3	3-3–3-6	Page length changed due to revised content on page 3-3.
3	3.3	3-4	— The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD~~-9~~ diagnosis codes (Item I8000).
3	3.3	3-5	G Functional Status — Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. GG Functional Abilities and Goals — Assess the need for assistance with self-care and mobility activities.

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A0310	A-4	A0310: Type of Assessment *For Comprehensive, Quarterly, and PPS Assessments, Entry and OBRA Discharge Records, and Part A PPS Discharge Assessment.*
3	A0310	A-4	Replaced screenshot. OLD  NEW 

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A0310–A0500	A-4–A-37	Page length changed due to revised content.
3	A0310	A-6–A-7	**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. • 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: o ~~any tracking record (~~Entry or Death in Facility~~)~~ ~~because~~ tracking records (A0310F = 01 or 12); ~~are not considered assessments.~~ o A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or o 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.
3	A0310	A-7	**Coding Instructions for A0310G, Type of Discharge *(complete only if A0310F = 10 or 11)***

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A0310	A-7–A-8	**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. • 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).
3	A0310	A-7	Definition text box added. 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).
3	A1900	A-26	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.

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2000	A-28	A2000: OBRA Discharge Date
3	A2000	A-28	**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 ~~d~~Discharge assessments, the ~~d~~Discharge ~~d~~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 ~~was~~ receiving services under SNF Part A PPS~~, the discharge date may be later than the end of Medicare stay date (A2400C)~~ 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).
3	A2100	A-29	A2100: OBRA Discharge Status

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-33	• The ~~e~~End ~~d~~Date of the Most Recent Medicare ~~s~~Stay (A2400C) may be **earlier** than the actual ~~d~~Discharge ~~d~~Date (A2000) from the facility ~~(Item A2000)~~. 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).

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-34	**Examples** 1. Mrs. G. began receiving services under Medicare Part A on October 14, 201~~0~~6. 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. ~~issued an~~ An Advanced Beneficiary Notice (ABN) and an NOMNC with the last day of coverage as November 23, 201~~0~~6 were issued. Mrs. G. was discharged home from the facility on November 24, 201~~0~~6. Code the following on her combined OBRA and Part A PPS Discharge assessment: • A0310F = 10 • A0310G = 1 • A0310H = 1 • A2000 = 11-24-201~~0~~6 • A2100 = 01 • A2300 = 11-24-2016 • A2400A = 1 • A2400B = 10-14-201~~0~~6 • A2400C = 11-23-201~~0~~6 **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.

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-34	2. Mr. N began receiving services under Medicare Part A on December 11, 201~~0~~6. He was unexpectedly sent to the ER on December 19, 201~~0~~6 at 8:30pm and was not admitted to the hospital. He returned to the facility on December 20, 201~~0~~6, at 11:00 am. The facility completed his 14-day PPS assessment with an ARD of December 23, 201~~0~~6. Code the following on his 14-day PPS assessment: • A2400A = 1 • A2400B = 12-11-201~~0~~6 • 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.

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-35	3. Mr. R. began receiving services under Medicare Part A on October 15, 201~~0~~6. Due to complications from his recent surgery, ~~He~~ he was unexpectedly discharged to the hospital for emergency surgery ~~return anticipated~~ on October 20, 201~~0~~6, but is expected to return within 30 days ~~to the hospital~~. Code the following on his OBRA Discharge assessment: • A0310F = 11 • A0310G = 2 • A0310H = 0 • A2000 = 10-20-201~~0~~6 • A2100 = 03 • A2300 = 10-20-2016 • A2400A = 1 • A2400B = 10-15-201~~0~~6 • A2400C = 10-20-201~~0~~6 **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.

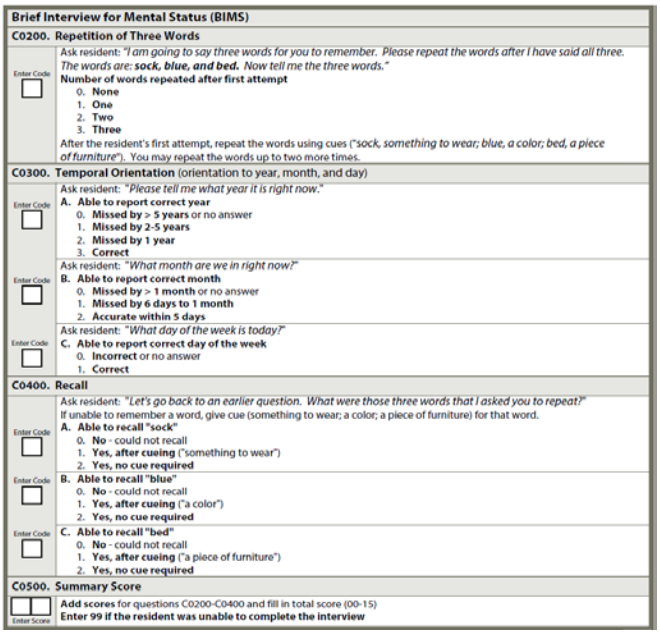
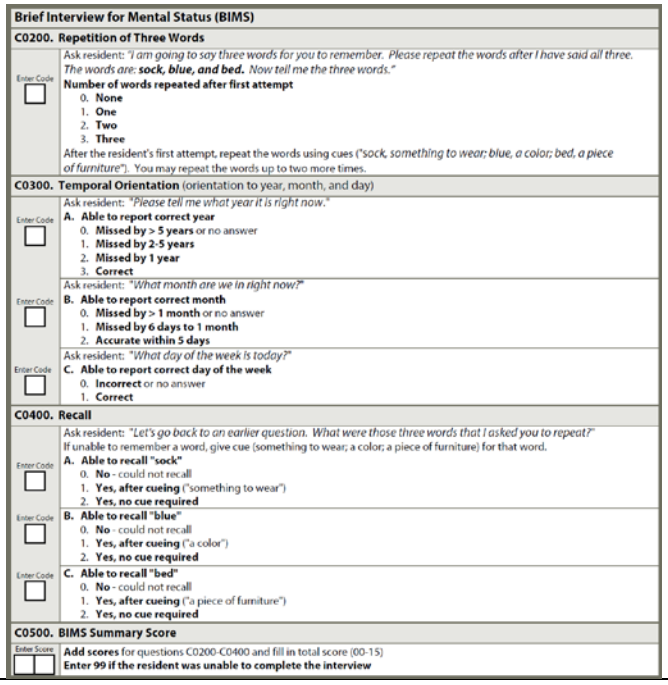
Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-35	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.

Track Changes
from Chapter 3 Section A v1.13
to Chapter 3 Section A v1.14

Chapter	Section	Page	Change
3	A2400	A-36	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.
3	A2400	A-37	The Medicare Stay End Date Algorithm was moved to the last page of this section.

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C0100	C-1	• The structured cognitive interview is helpful for identifying possible delirium behaviors (C~~1300~~1310).
3	C0200–C0500	C-2	Replaced screenshot. OLD  NEW 

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*
B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*
C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.
A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

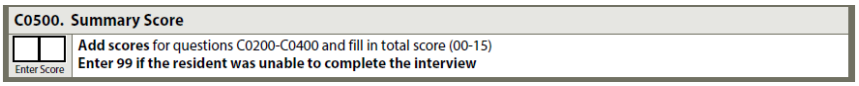
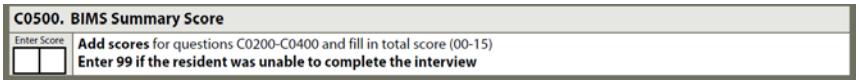
B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

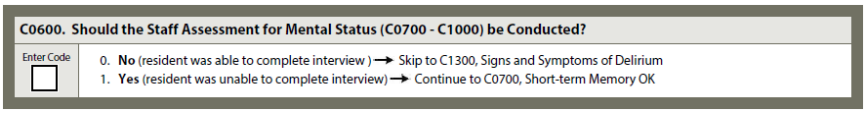
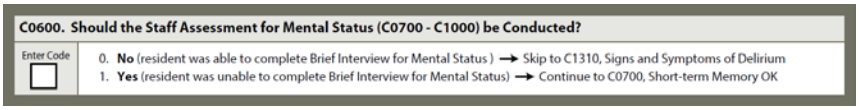
C0500. Summary Score / **C0500. BIMS Summary Score**

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

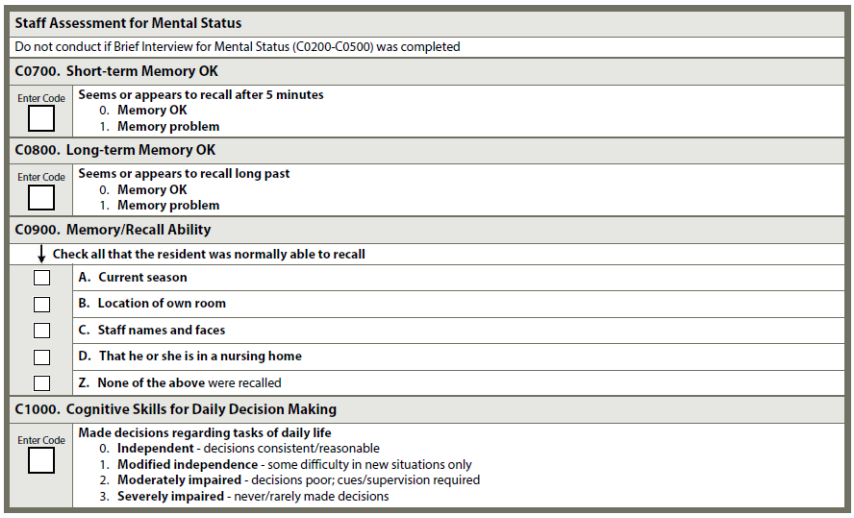
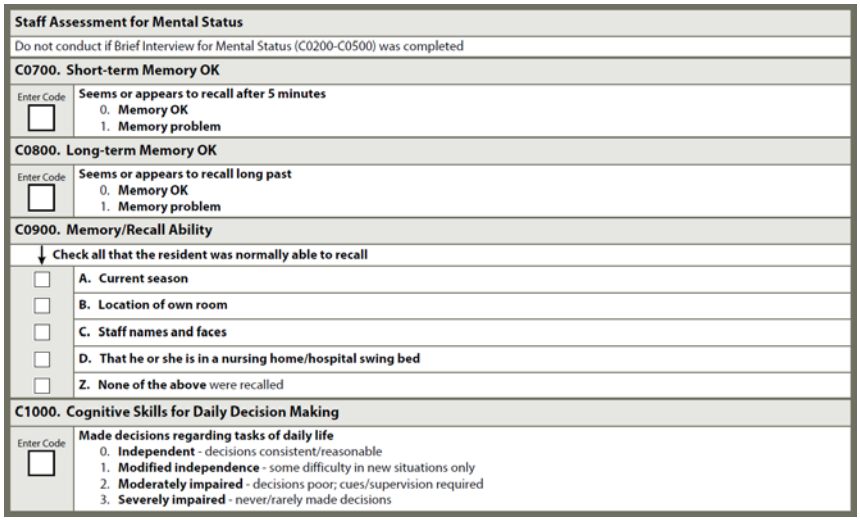
Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C0200–C0500	C-3	• The BIMS is an opportunity to observe residents for signs and symptoms of delirium (~~C1300~~C1310).
3	C0200	C-6	*Basic BIMS interview instructions are shown on pages C-~~5~~3 and C-4.*
3	C0300	C-9	*Basic BIMS interview instructions are shown on pages C-~~5~~3 and C-4.*
3	C0400	C-12	*Basic BIMS interview instructions are shown on pages C-~~5~~3 and C-4.*
3	C0400	C-12	3. For any word that is not correctly recalled after 5 seconds, provide a category cue (refer to "Steps for Assessment," pages C-~~7~~6–C-~~8~~7 for the definition of category cue). Category cues should be used only after the resident is unable to recall one or more of the three words.
3	C0500	C-14	C0500: BIMS Summary Score
3	C0500	C-14	Replaced screenshot. OLD  NEW 
3	C0500	C-15	C0500: BIMS Summary Score (cont.)
3	C0500	C-15	• To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-~~6~~4 for residents who choose not to participate at all.

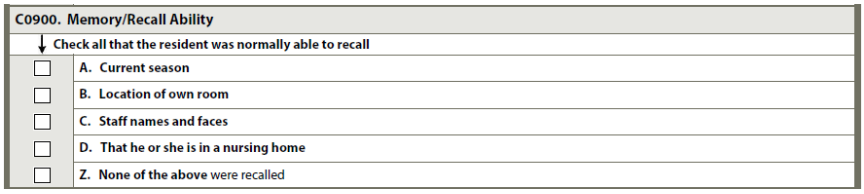
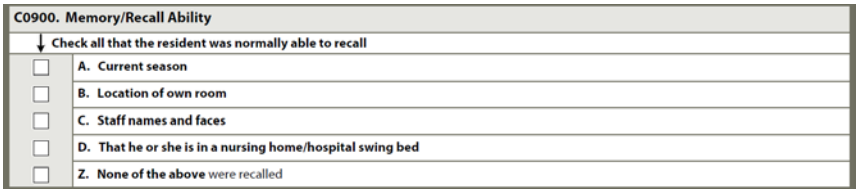
Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C0500	C-15	**Coding Tips** Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, **BIMS Summary Score**, and complete the staff assessment of mental status.
3	C0500	C-16	C0500: BIMS Summary Score (cont.)
3	C0600	C-16	Replaced screenshot. OLD  NEW 
3	C0600	C-17	**Steps for Assessment** 1. Review whether **BIMS Summary Score** item (C0500), is coded 99, unable to complete interview.
3	C0600	C-17	**Coding Instructions** Code 0, no: if the BIMS was completed and scored between 00 and 15. Skip to ~~C1300~~C1310.

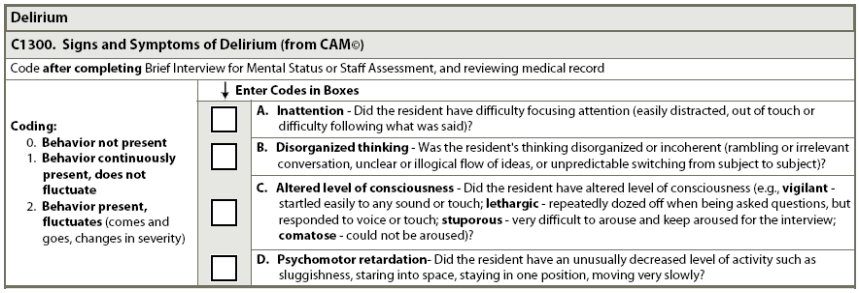
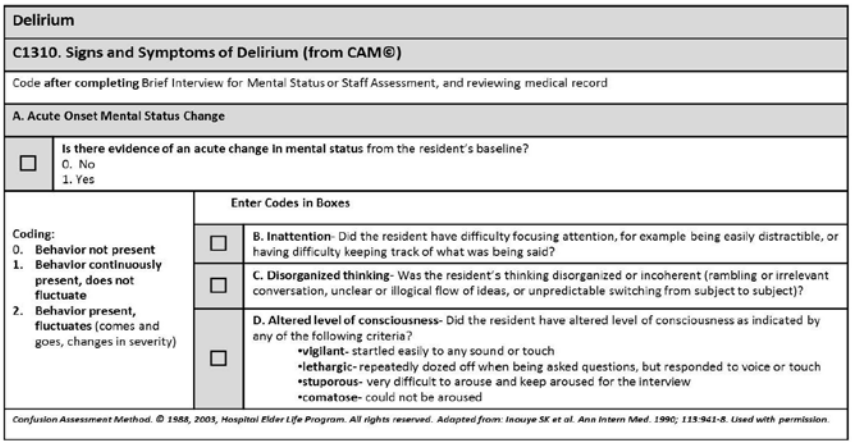
Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C0700–C1000	C-17	Replaced screenshot. OLD  NEW 

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C0900	C-21	Replaced screenshot. OLD  NEW 
3	C0900	C-22	• Check C0900D, that he or she is in a nursing home/hospital swing bed: if resident is able to determine that he or she is currently living in a nursing home. To check this item, it is not necessary that the resident be able to state the name of the nursing home, but he or she should be able to refer to the nursing home by a term such as a "home for older people," a "hospital for the elderly," "a place where people who need extra help live," etc.
3	C1310	C-26	~~C1300~~C1310: Signs and Symptoms of Delirium

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	C-26	Replaced screenshot. OLD  NEW 
3	C1310	C-26	~~*Disclaimer: Adapted from Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission. All rights reserved.*~~
3	C1310	C-27	~~C1300~~C1310: Signs and Symptoms of Delirium (cont.)

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	C-27	**Coding Instructions for C1310A, Acute Mental Status Change** • Code 0, no: if there is no evidence of acute mental status change from the resident's baseline. • Code 1, yes: if resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline. **Coding Tips** • Interview resident's family or significant others. • Review medical record prior to 7-day look-back to determine the resident's usual mental status. **Examples** 1. Resident was admitted to the nursing home 4 days ago. Her family reports that she was alert and oriented prior to admission. During the BIMS interview, she is lethargic and incoherent. Coding: Item C1310A would be coded 1, yes. Rationale: There is an acute change of the resident's behavior from alert and oriented (family report) to lethargic and incoherent during interview. 2. Nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place. Coding: Item C1310A would be coded 1, yes. Rationale: The new behaviors represent an acute change in mental status.
3	C1310	C-28	**Other Examples of Acute Mental Status Changes** • A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive. • A resident who is normally quiet and content suddenly becomes restless or noisy. • A resident who is usually able to find his or her way around the unit begins to get lost.

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	C-27–C-32	Page length change due to revised content.
3	C1310	C-28	**Steps for Assessment for ~~C1300A~~C1310B, Inattention** ~~*Basic delirium assessment instructions are on page C-33. In addition, for C1300 (Inattention):*~~
3	C1310	C-28	**Coding Instructions for ~~C1300A~~C1310B, Inattention**
3	C1310	C-29	**~~C1300~~C1310: Signs and Symptoms of Delirium (cont.)**
3	C1310	C-29	Coding: Item ~~C1300A~~C1310B would be coded 0, behavior not present. Rationale: The resident remained focused throughout the interview and this was constant during the look-back period.
3	C1310	C-29	Coding: Item ~~C1300A~~C1310B would be coded 1, behavior continuously present, does not fluctuate. Rationale: The resident's attention consistently wandered throughout the 7-day look-back period. The resident's dementia diagnosis does not affect the coding.
3	C1310	C-29	Coding: Item ~~C1300A~~C1310B would be coded 2, behavior present, fluctuates. Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, ~~C1300A~~C1310B cannot be coded as 0, Behavior not present.
3	C1310	C-29	Coding: Item ~~C1300A~~C1310B would be coded 2, behavior present, fluctuates. Rationale: Resident's attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be coded 2.
3	C1310	C-30	**~~C1300~~C1310: Signs and Symptoms of Delirium (cont.)**

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	C-30	**Coding Instructions for ~~C1300B~~C1310C, Disorganized Thinking**
3	C1310	C-30	Coding: ~~C1300B~~C1310C would be coded 1, behavior continuously present, does not fluctuate. Rationale: All sources agree that the disorganized thinking is constant.
3	C1310	C-30	Coding: ~~C1300B~~C1310C would be coded 0, behavior not present. Rationale: The resident's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.
3	C1310	C-30	Coding: ~~C1300B~~C1310C would be coded 2, behavior present, fluctuates. Rationale: The resident's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be coded 2.
3	C1310	C-31	**~~C1300~~C1310: Signs and Symptoms of Delirium (cont.)**
3	C1310	C-31	**Coding Instructions for ~~C1300C~~C1310D, Altered Level of Consciousness**
3	C1310	C-31	Coding: ~~C1300C~~C1310D would be coded 0, behavior not present. Rationale: All evidence indicates that the resident is alert during conversation, interview(s) and activities.
3	C1310	C-31	Coding: ~~C1300C~~C1310D would be coded 1, behavior continuously present, does not fluctuate. Rationale: The resident's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.
3	C1310	C-32	**~~C1300~~C1310: Signs and Symptoms of Delirium (cont.)**

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	C-32	Coding: ~~C1300C~~C1310D would be coded 2, behavior present, fluctuates. Rationale: The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be coded 2, fluctuating.
3	C1310	C-31	Deleted definition box.
			~~DEFINITION~~ ~~PSYCHOMOTOR RETARDATION~~ ~~Greatly reduced or slowed level of activity or mental processing. Psychomotor retardation differs from altered level of consciousness. Resident need not be lethargic (altered level of consciousness) to have slowness of response. Psychomotor retardation may be present with normal level of consciousness; also residents with lethargy or stupor do not necessarily have psychomotor retardation.~~
3	C1310	C-32	Added CAM Assessment Scoring Methodology.
			CAM Assessment Scoring Methodology The indication of delirium by the CAM requires the presence of: Item A = 1 **OR** Item B, C or D = 2 **AND** Item B = 1 OR 2 **AND EITHER** Item C = 1 OR 2 **OR** Item D = 1 OR 2

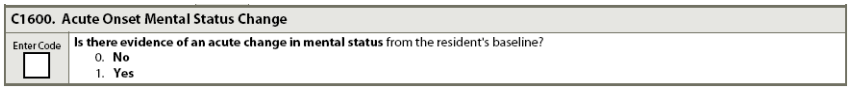
Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	—	~~**Coding Instructions for C1300D, Psychomotor Retardation**~~ • ~~Code 0, behavior not present: if the resident's movements and responses were noted to be appropriate during BIMS and across all information sources.~~ • ~~Code 1, behavior continuously present, did not fluctuate: if, during the interview and according to other sources, the resident consistently had an unusually decreased level of activity such as being sluggish, staring into space, staying in one position, or moving or speaking very slowly.~~ • ~~Code 2, behavior present, fluctuates: if, during the BIMS interview or according to other sources, the resident showed slowness or decreased movement and activity which varied during the interview(s) or during the look-back period.~~ ~~**Examples**~~ 1. ~~Resident answers questions promptly during interview and staff and medical record note similar behavior.~~ ~~Coding: Item C1300D would be coded 0, behavior not present.~~ ~~Rationale: There is no evidence of psychomotor retardation from any source.~~ 2. ~~The resident is alert, but has a prolonged delay before answering the interviewer's question. Staff reports that the resident has always been very slow in answering questions.~~ ~~Coding: C1300D would be coded 1, behavior continuously present, does not fluctuate.~~ ~~Rationale: The psychomotor retardation was continuously present according to sources that described the resident's response speed to questions.~~ 3. ~~Resident moves body very slowly (i.e., to pick up a glass). Staff reports that they have not noticed any slowness.~~ ~~Coding: C1300D would be coded 2, behavior present, fluctuates.~~ ~~Rationale: There is evidence that psychomotor retardation comes and goes.~~

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	—	Deleted C1600: Acute Onset of Mental Status Change.

~~C1600: Acute Onset of Mental Status Change~~



~~Item Rationale~~

~~Health-related Quality of Life~~

- ~~Acute onset mental status change may indicate delirium or other serious medical complications, which may be reversible if detected and treated in a timely fashion.~~

~~Planning for Care~~

- ~~Prompt detection of acute mental status change is essential in order to identify and treat or eliminate the cause.~~

~~Coding Instructions~~

- ~~`Code 0, no`: if there is no evidence of acute mental status change from the resident's baseline.~~
- ~~`Code 1, yes`: if resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline.~~

~~Coding Tips~~

- ~~Interview resident's family or significant others.~~
- ~~Review medical record prior to 7-day look-back.~~

Track Changes
from Chapter 3 Section C v1.13
to Chapter 3 Section C v1.14

Chapter	Section	Page	Change
3	C1310	—	**~~Examples~~** ~~1. Resident was admitted to the nursing home 4 days ago. Her family reports that she was alert and oriented prior to admission. During the BIMS interview, she is lethargic and incoherent.~~ ~~Coding: Item C1600 would be coded 1, yes.~~ ~~Rationale: There is an acute change of the resident's behavior from alert and oriented (family report) to lethargic and incoherent during interview.~~ ~~2. Nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place.~~ ~~Coding: Item C1600 would be coded 1, yes.~~ ~~Rationale: The new behaviors represent an acute change in mental status.~~
3	C1310	—	~~C1600: Acute Onset of Mental Status Change~~ ~~(cont.)~~ **~~Other Examples of Acute Mental Status Changes~~** • ~~A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.~~ • ~~A resident who is normally quiet and content suddenly becomes restless or noisy.~~ • ~~A resident who is usually able to find his or her way around the unit begins to get lost.~~

Track Changes
from Chapter 3 Section D v1.13
to Chapter 3 Section D v1.14

Chapter	Section	Page	Change
3	D0350	D-10	• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at ~~http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm~~ https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).
3	D0650	D-16	• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at ~~http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm~~ https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).

Track Changes
from Chapter 3 Section F v1.13
to Chapter 3 Section F v1.14

Chapter	Section	Page	Change
3	F0300	F-1	Added new step 2. Renumbered remaining steps. **Steps for Assessment** 1. Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences. 2. Conduct the interview during the observation period. 3. Review **Language** item (A1100) to determine whether or not the resident needs or wants an interpreter. • If the resident needs or wants an interpreter, complete the interview with an interpreter. 4. The resident interview should be conducted if the resident can respond: • verbally, • by pointing to their answers on the cue card, OR • by writing out their answers.
3	F0300	F-1–F-2	Page length changed due to revised content.
3	F0400	F-5	**Coding Tips and Special Populations** • The interview is considered incomplete if the resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500. If the interview is stopped because it is considered incomplete, fill the remaining F0400 and F0500 items with a 9 and proceed to F0600, Daily Activity Preferences Primary Respondent. • No look-back is provided for resident. He or she is being asked about current preferences while in the nursing home but is not limited to a 7-day look-back period to convey what ~~their~~his/her preferences are. • The facility is still obligated to complete the ~~assessment~~ interview within the 7-day look-back period.

Track Changes
from Chapter 3 Section I v1.13
to Chapter 3 Section I v1.14

Chapter	Section	Page	Change
3	—	I-4	• 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~~ http://library.ahima.org/doc?oid=107574.
3	—	I-9	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~~ http://www.cdc.gov/hai/

Track Changes
from Chapter 3 Section J v1.13
to Chapter 3 Section J v1.14

Chapter	Section	Page	Change
3	J1800	J-30	**Steps for Assessment** 1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3	J1900	J-31	**Planning for Care** • A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment. • It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.
3	J1900	J-31–J-34	Page length changed due to revised content.
3	J1900	J-32	**Steps for Assessment** 5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record. 6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.
3	J1900	J-33	**Coding Tip** • If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

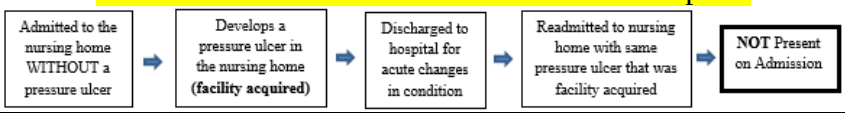
Track Changes
from Chapter 3 Section J v1.13
to Chapter 3 Section J v1.14

Chapter	Section	Page	Change
3	J1900	J-34	4. A resident fell, lacerated his head, and head CT scan indicated a subdural hematoma. Coding: J1900C would be coded 1, one. Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall. 5. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment. Original Coding: J1900B, Injury (except major) was coded 1, one. Rationale: Mr. R. had a fall-related injury that caused him to complain of pain. Modification of Quarterly assessment: J1900B, Injury (except major) is coded 0, none and J1900C, Major Injury, is coded 1, one. Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300	M-7	Numbering and content revised for Step 3: Determine "Present on Admission." 1. Review the medical record for the history of the ulcer. 2. Review for location and stage at the time of admission/entry or reentry. 3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."** 4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."** 5. If a resident who has a pressure ulcer that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as "present on admission**" because it was present and acquired at the facility prior to the hospitalization. 6. If a resident who has a pressure ulcer that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is **still coded as "present on admission"** because it was **originally acquired outside the facility** and has not changed in stage. 7. If a resident who has a ~~current~~ pressure ulcer is hospitalized and the ulcer increases in numerical stage during ~~a~~ the hospitalization, it ~~is coded at the higher stage upon reentry and~~ **should be coded as "present on admission~~.~~"** at that higher stage upon reentry.

Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300	M-7	Added example and graphic. **Examples** 1. Ms. K is admitted to the facility without a pressure ulcer. During the stay, she develops a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when she returns from the hospital. 
3	M0300–M0610	M-7–M-22	Page length changed due to revised content.
3	M0300	M-8	Added example and graphic. 2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed. 

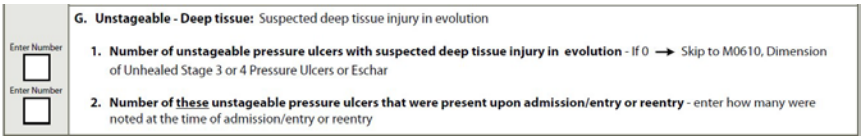
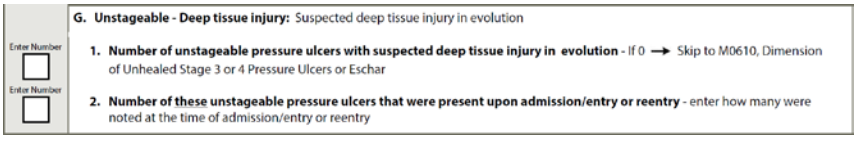
Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300B	M-10	**Coding Instructions for M0300B** **M0300B1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2. • **Enter 0** if no Stage 2 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C)~~M0300C, Stage 3. **M0300B2** • **Enter the number** of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital). • **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. **M0300B3** • **Enter the date of the oldest Stage 2 pressure ulcer.**
3	M0300C	M-12	**Coding Instructions for M0300C** **M0300C1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3. • **Enter 0** if no Stage 3 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressures Ulcers at Each Stage** item (M0300D)~~M0300D, Stage 4. **M0300C2** • **Enter the number** of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300D	M-14	Moved Definition box for Stage 4 Pressure Ulcer from M-13 to M-14 to be in alignment with content.
3	M0300D	M-14–M-15	**Coding Instructions for M0300D** **M0300D1** • **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4. • **Enter 0** if no Stage 4 pressure ulcers are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E)~~M0300E, Unstageable – Non-removable dressing. **M0300D2** • **Enter the number** of these Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
3	M0300E	M-16	**Coding Instructions for M0300E** **M0300E1** • **Enter the number** of pressure ulcers that are unstageable related to non-removable dressing/device. • **Enter 0** if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300F)~~M0300F, Unstageable – Slough and/or eschar. **M0300E2** • **Enter the number** of these unstageable pressure ulcers related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).

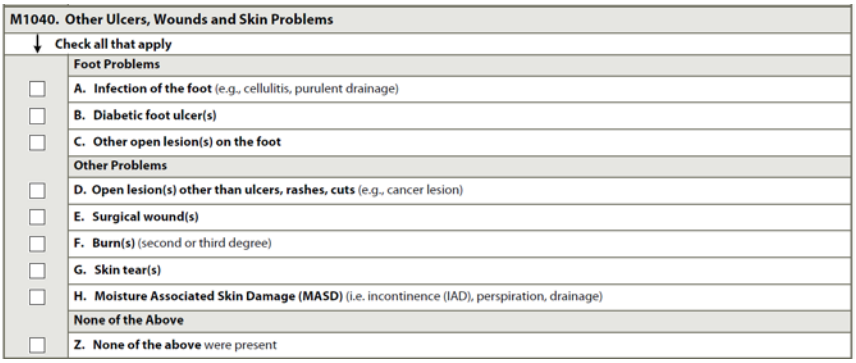
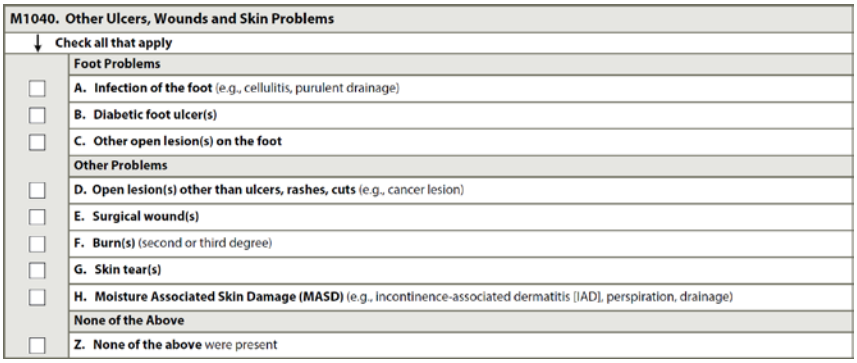
Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300F	M-17	**Coding Instructions for M0300F** **M0300F1** • **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar. • **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to ~~**Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300G)~~M0300G, Unstageable – Deep tissue injury. **M0300F2** • **Enter the number** of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
3	M0300G	M-19	Replaced screenshot. OLD  NEW 

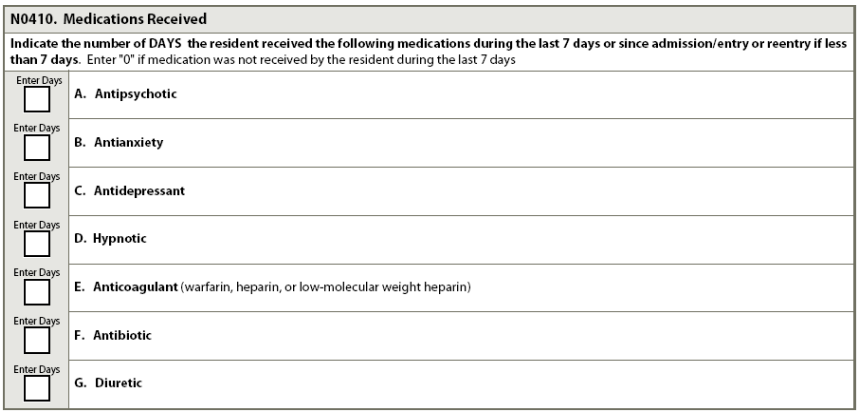
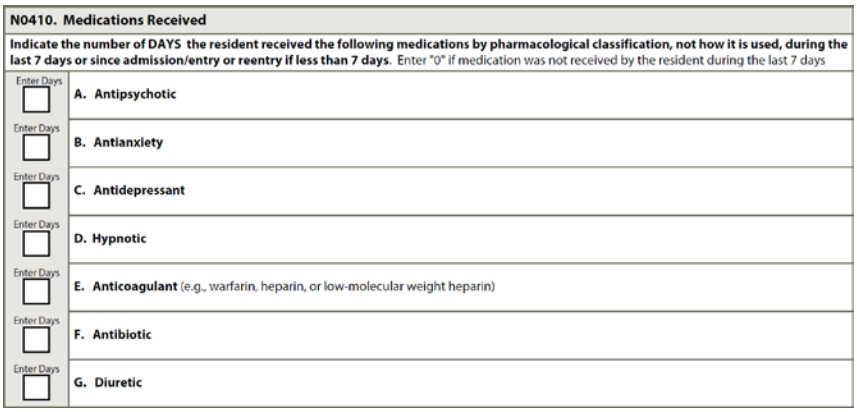
Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M0300G	M-20	**Coding Instructions for M0300G** **M0300G1** • **Enter the number** of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury. • **Enter 0** if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610). **M0300G2** • **Enter the number** of these unstageable pressure ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).

Track Changes
from Chapter 3 Section M v1.13
to Chapter 3 Section M v1.14

Chapter	Section	Page	Change
3	M1040	M-32	Replaced screenshot. OLD  NEW 
3	M1040	M-34	• M1040H, Moisture Associated Skin Damage (MASD) (~~i.e.~~e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
3	M1040	M-34	• Do **not** code rashes~~, skin tears,~~ or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
3	M1200	M-42	**Examples M0300, M0610, M0700 and M0800**

Track Changes
from Chapter 3 Section N v1.13
to Chapter 3 Section N v1.14

Chapter	Section	Page	Change
3	N0410	N-4	Replaced screenshot. OLD  NEW 
3	N0410	N-5	**Coding Instructions** • N0410A–G: Code medications according to the pharmacological classification, not how they are being used. • N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
3	N0410	N-5–N-9	Page length changed due to revised content on N-5.

Track Changes
from Chapter 3 Section N v1.13
to Chapter 3 Section N v1.14

Chapter	Section	Page	Change
3	N0410	N-8	• During the first year in which a resident on a psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications 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~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html).
3	N0410	N-8	— 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~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html]), which may
3	N0410	N-9	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~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html)].

Track Changes
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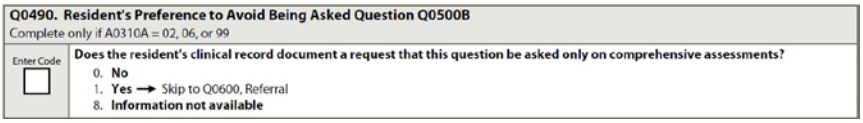
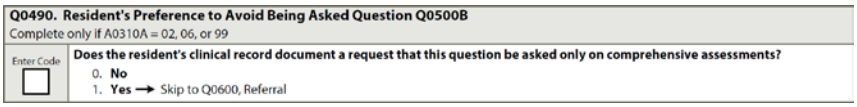
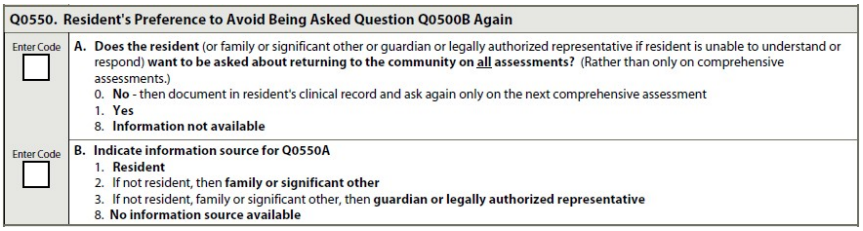
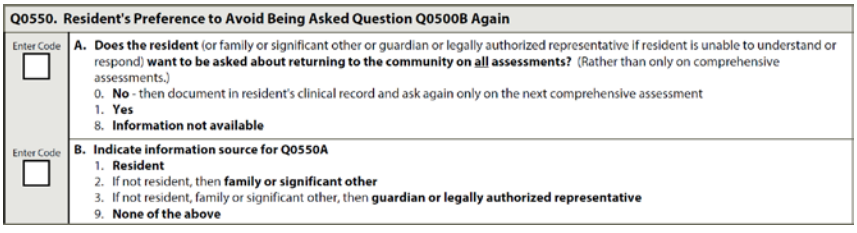
Chapter	Section	Page	Change
3	N0410	N-9	~~Additional information on medications can be found in:~~ ~~The Orange Book, http://www.accessdata.fda.gov/scripts/cder/ob/~~ ~~The National Drug Code Directory,~~ ~~http://www.fda.gov/drugs/informationondrugs/ucm142438.htm~~ The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information. • GlobalRPh Drug Reference, http://globalrph.com/drug-A.htm • USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)" • Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html • The DrugLib.com Index of Drugs by Category, http://www.druglib.com/drugindex/category/ This list is not all-inclusive. CMS is not responsible for the content or accessibility of the pages found at these sites. URL addresses were current as of the date of this publication.

Track Changes
from Chapter 3 Section O v1.13
to Chapter 3 Section O v1.14

Chapter	Section	Page	Change
3	O0250	O-7	• The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC: ~~http://www.cdc.gov/vaccinesafety/vaccine_monitoring/~~ http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html • Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (~~http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23~~ https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases) national goal of increasing to 90 percent, the percentage of adults aged 18 years or older in long-term care nursing homes who are vaccinated annually against seasonal influenza.
3	O0600	O-43	• ~~The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.~~ Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.

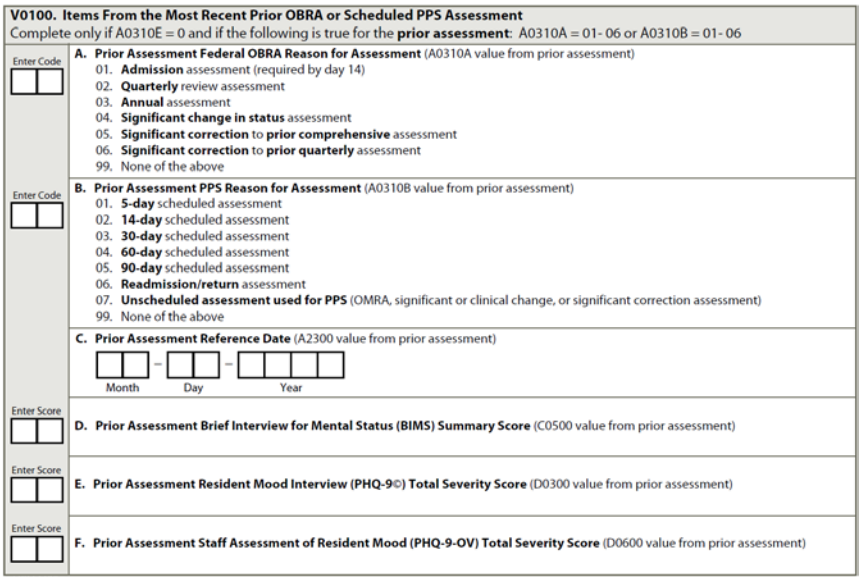
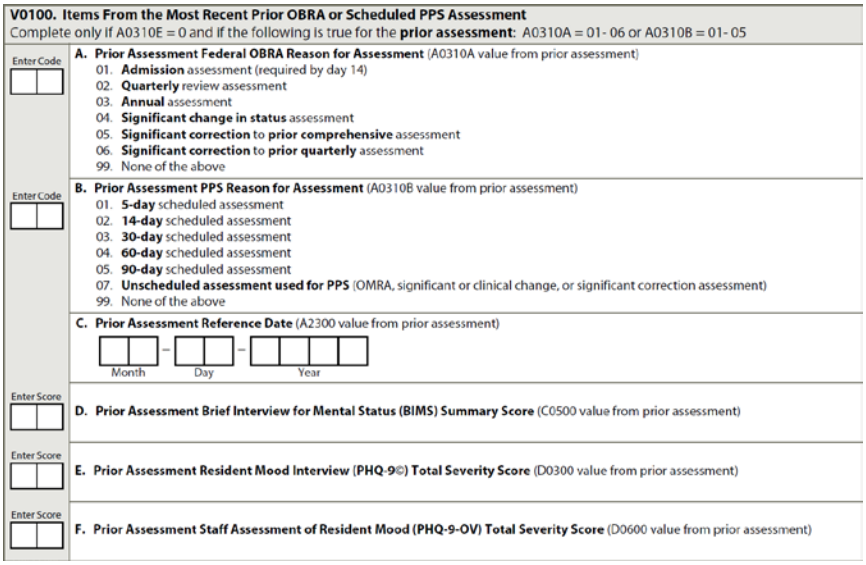
Track Changes
from Chapter 3 Section Q v1.13
to Chapter 3 Section Q v1.14

Chapter	Section	Page	Change
3	Q0400	Q-11	• For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at ~~http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf~~ https://www.medicare.gov/Pubs/pdf/11376.pdf
3	Q0490	Q-12	Replaced screenshot. OLD  **Q0490. Resident's Preference to Avoid Being Asked Question Q0500B** Complete only if A0310A = 02, 06, or 99 Enter Code ☐ **Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?** 0. **No** 1. **Yes** → Skip to Q0600, Referral 8. **Information not available** NEW  **Q0490. Resident's Preference to Avoid Being Asked Question Q0500B** Complete only if A0310A = 02, 06, or 99 Enter Code ☐ **Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?** 0. **No** 1. **Yes** → Skip to Q0600, Referral
3	Q0490	Q-13	• ~~Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment.~~
3	Q0550	Q-18	Replaced screenshot. OLD  **Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again** Enter Code ☐ **A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available** Enter Code ☐ **B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 8. **No information source available** NEW  **Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again** Enter Code ☐ **A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available** Enter Code ☐ **B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 9. **None of the above**

Track Changes
from Chapter 3 Section Q v1.13
to Chapter 3 Section Q v1.14

Chapter	Section	Page	Change
3	Q0550	Q-19	• Code 9, None of the above. • ~~Code 8, No information source available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.~~

Track Changes
from Chapter 3 Section V v1.13
to Chapter 3 Section V v1.14

Chapter	Section	Page	Change
3	V0100	V-2	Replaced screenshot. OLD  NEW 

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment
Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 06

Enter Code
A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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
B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)
Month – Day – Year

Enter Score
D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score
E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score
F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment
Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 05

Enter Code
A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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
B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)
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
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)
Month – Day – Year

Enter Score
D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

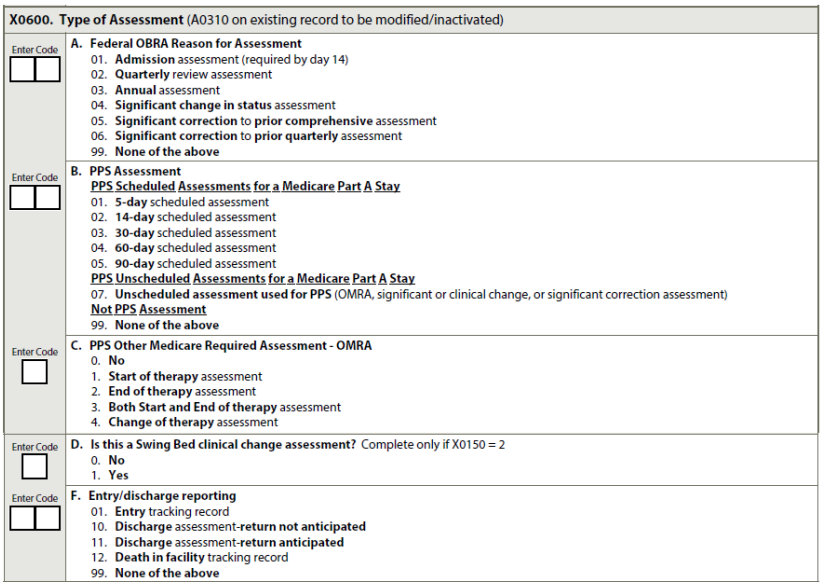
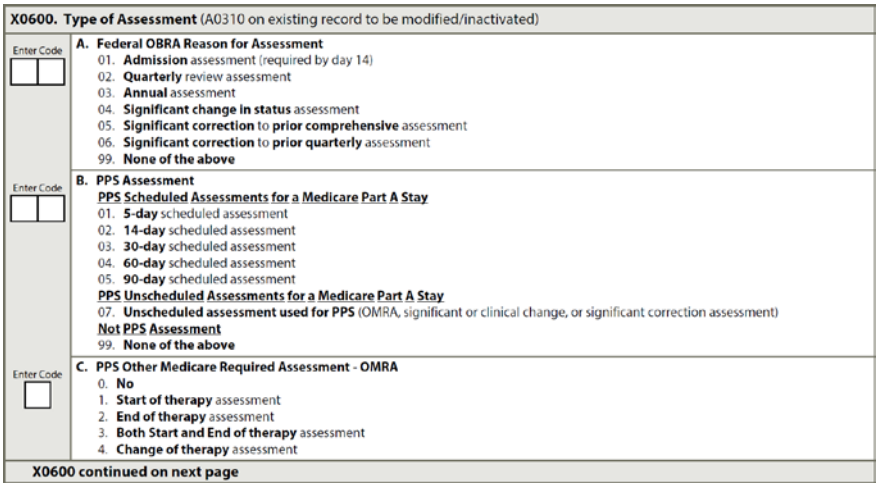
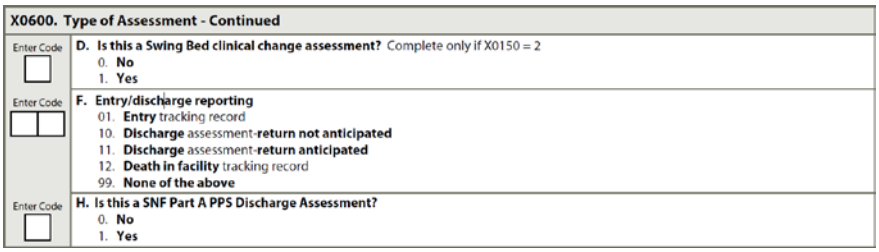
Enter Score
E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score
F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

Track Changes
from Chapter 3 Section V v1.13
to Chapter 3 Section V v1.14

Chapter	Section	Page	Change
3	V0100	V-3	**Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)** • Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 05 or 07 or 99) must be selected. **Note:** The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 through 05 or 07, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Track Changes
from Chapter 3 Section X v1.13
to Chapter 3 Section X v1.14

Chapter	Section	Page	Change
3	X0600	X-4–X-5	Replaced screenshot. OLD  NEW  

Track Changes
from Chapter 3 Section X v1.13
to Chapter 3 Section X v1.14

Chapter	Section	Page	Change
3	X0600	X-5	• If item A0310A was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X0600	X-5	• If item A0310B was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X0600	X-5	• If item A0310C was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X0600	X-6	• If item A0310D was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X0600	X-6	• If item A0310F was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X0600	X-6–X-7	**Coding Instructions for X0600H, Is this a Part A PPS Discharge Assessment?** • Enter the code exactly as submitted for item A0310H, "Is this a Part A PPS Discharge Assessment?" on the prior erroneous record to be modified/inactivated. • 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. • Note that the code in X0600H must match the current value of A0310H on a modification request. • If item A0310H was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).
3	X	X-5–X-12	Page length changed due to revised content on page X-5.

Track Changes
from Chapter 3 Section Z v1.13
to Chapter 3 Section Z v1.14

Chapter	Section	Page	Change
3	Z0100	Z-1	• The HIPPS code is a Skilled Nursing Facility (SNF) Part A billing code and is composed of a five-position code representing the RUG group code, plus a two-position assessment type indicator. For information on HIPPS, access: ~~http://www.cms.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp#TopOfPage~~ https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
3	Z0150	Z-3	• The HIPPS code is a SNF Part A billing code and is comprised of a five-position code representing the RUG code, plus a two-position assessment type indicator. For information on HIPPS, access ~~http://www.cms.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp#TopOfPage~~ https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.

Track Changes
from Chapter 4 v1.13
to Chapter 4 v1.14

Chapter	Section	Page	Change
4	4.7	4-8	The SOM can be found at: ~~http://www.cms.gov/Manuals/IOM/list.asp~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.
4	4.10	4-16–4-17	**Delirium CAT Logic Table** **Triggering Conditions (any of the following):** 1. ~~Worsening mental status is indicated by the BIMS summary score having a non-missing value of 00 to 15 on both~~ Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) ~~and the prior assessment, and the summary score on the current non-admission assessment being less than the prior assessment~~ as indicated by: ~~**(A0310A = 03, 04, OR 05) AND**~~ **(a)** **C1310A = 1** **AND** **C1310B = 1 or 2** **AND EITHER** **C1310C = 1 or 2 OR C1310D = 1 or 2** **(b)** **(C1310B, C1310C or C1310D = 2** **AND** **C1310B = 1 or 2** **AND EITHER** **C1310C = 1 or 2 OR C1310D = 1 or 2** ~~**((C0500 >= 0) AND (C0500 <= 15)) AND**~~ ~~**((V0100D >= 0) AND (V0100D <= 15)) AND**~~ ~~**(C0500 < V0100D)**~~ ~~2. Acute mental status change is indicated on the current comprehensive assessment as follows:~~ ~~**C1600 = 1**~~

Track Changes
from Chapter 4 v1.13
to Chapter 4 v1.14

Chapter	Section	Page	Change
4	4.10	4-16–4-32	Page length changed due to revised content.
4	4.10	4-17	When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting ~~a worsening or~~ an acute change in mental status and/or the presence of inattention, disorganized thinking or altered mental status.
4	4.10	4-18	4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by: **(C0500 = 99, -, OR ^) AND** **(C1000 >= 1 AND C1000 <= 3)** 5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking~~,~~ or altered level of consciousness ~~or psychomotor retardation~~ as indicated by: **(~~C1300A~~C1310B = 1 OR ~~C1300A~~C1310B = 2) OR** **(~~C1300B~~C1310C = 1 OR ~~C1300B~~C1310C = 2) OR** **(~~C1300C~~C1310D = 1 OR ~~C1300C~~C1310D = 2) ~~OR~~** **~~(C1300D = 1 OR C1300D = 2)~~**

Track Changes
from Chapter 6 v1.13
to Chapter 6 v1.14

Chapter	Section	Page	Change
6	6.8	6-56	**ARD Outside the Medicare Part A SNF Benefit** A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a scheduled PPS assessment, unless that scheduled PPS assessment is combined with an OBRA Discharge Assessment (see Section 2.12). For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.
6	6.8	6-56–6-57	Page length changed due to revised content.

Track Changes
from Appendix A v1.13
to Appendix A v1.14

Chapter	Section	Page	Change
Appendix A	—	A-16	Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added, or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following Web site: ~~http://www.cms.hhs.gov/Transmittals/2010Trans/list.asp~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Appendix A	—	A-21–A-22	~~**V Codes** A supplementary classification of ICD codes used to describe the circumstances that influence a resident's health status and identify the reasons for medical visits resulting from circumstances other than a disease or injury.~~ **Z Codes** ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00–Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.
Appendix A	—	A-21–A-22	Page length changed due to revised content.

Track Changes
from Appendix C v1.13
to Appendix C v1.14

Chapter	Section	Page	Change
Appendix C	—	C-5	• Pain CAA triggered (J0100, J0200) [review findings for relationship to delirium (~~C1300~~C1310)] • Pain frequency, intensity, and characteristics (time of onset, duration, quality) (J0400, J0600, J0800, J0850 and clinical record) indicate possible relationship to delirium (~~C1300~~C1310) • Adverse effect of pain on function (J0500A, J0500B) may be related to delirium (~~C1300~~C1310)
Appendix C	—	C-7	• Recent decline in ADL status (Section G0110) (may be related to delirium) (~~C1300~~C1310)
Appendix C	—	C-10	• Delirium (~~C1300~~C1310) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.)
Appendix C	—	C-10	• Identify components of Delirium assessment (~~C1300~~C1310) that are present and not new onset or worsening • Confusion, disorientation, forgetfulness (observation, clinical record) (C0200, C0300, C0400, C0500,C0700, C0800, C0900, ~~C1300~~C1310~~,C1600~~)
Appendix C	—	C-12	• Lack of frequent reorientation, reassurance, reminders to help make sense of things (C0900, ~~C1300~~C1310)
Appendix C	—	C-17	— Delirium (~~C1300~~C1310, I8000, clinical record)
Appendix C	—	C-18	— Difficulty putting sentence together (B0700, ~~C1300B~~C1310C, clinical record)
Appendix C	—	C-21	• Delirium (~~C1300~~C1310) (clinical record and Delirium CAA)
Appendix C	—	C-25	• Delirium (~~C1300~~C1310) (See Delirium CAA)
Appendix C	—	C-30	• Delirium (~~C1300~~C1310, ~~C1600~~C1310A = 1, Delirium CAA)
Appendix C	—	C-33	• Delirium (~~C1600~~C1310)
Appendix C	—	C-38	• Delirium (~~C1300~~C1310), clinical record (Delirium CAT)
Appendix C	—	C-47	— Delirium (~~C1300~~C1310)
Appendix C	—	C-52	• Delirium (~~C1600~~C1310)
Appendix C	—	C-55	— Delirium (~~C1600~~C1310)
Appendix C	—	C-58	• Confusion or change in mental status (delirium) (~~C1600~~C1310, V0100D) • Lethargy (~~C1300C~~C1310D)
Appendix C	—	C-59	• Recent change in mental status (~~C1600~~C1310)
Appendix C	—	C-66	• Delirium (~~C1600~~C1310)
Appendix C	—	C-70	• Delirium unrelated to medical illness or severe depression (~~C1600~~C1310, clinical record)
Appendix C	—	C-71	• Delirium unrelated to medical illness or severe depression (~~C1600~~C1310, clinical record)
Appendix C	—	C-71	• Delirium unrelated to medical illness or severe depression (~~C1600~~C1310, clinical record)
Appendix C	—	C-72	• Confusion, delirium unrelated to acute illness or severe depression (~~C1600~~C1310, clinical record)

Track Changes
from Appendix C v1.13
to Appendix C v1.14

Chapter	Section	Page	Change
Appendix C	—	C-75	• Inattention, easily distracted (~~C1300A~~C1310B) • Disorganized thinking (~~C1300B~~C1310C)
Appendix C	—	C-75	• Delirium (~~C1600~~C1310), including side effects of medications (clinical record)
Appendix C	—	C-80	• Delirium (~~C1600~~C1310)
Appendix C	—	C-84	• Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: ~~http://www.ahrq.gov/clinic/~~ http://www.ahrq.gov/professionals/clinicians-providers/index.html;
Appendix C	—	C-84	• American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version): ~~http://www.eatright.org/About/Content.aspx?id=8373~~ http://www.eatrightpro.org/resource/practice/position-and-practice-papers/position-papers/individualized-nutrition-approaches-for-older-adults;
Appendix C	—	C-84	• American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: ~~http://www.amda.com/tools~~ http://www.paltc.org/product-store;
Appendix C	—	C-84	• 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~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf;
Appendix C	—	C-84	• Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools: ~~http://www.hartfordign.org/resources~~ https://consultgeri.org/tools;
Appendix C	—	C-84	• Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: ~~http://www.hartfordign.org/practice/consultgerirn/~~ https://consultgeri.org/;
Appendix C	—	C-85	• University of Missouri's Geriatric Examination Tool Kit: ~~http://web.missouri.edu/~proste/tool/~~ http://geriatrictoolkit.missouri.edu/; and

Track Changes
from Appendix G v1.13
to Appendix G v1.14

Chapter	Section	Page	Change
Appendix G	—	G-2	Centers for Medicare & Medicaid Services: Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Jun. 22, 2007; retrieved Oct. 16, 2009, from ~~http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf~~ https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf
Appendix G	—	G-2	Centers for Medicare & Medicaid Services: State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Section 483.20(b) Utilization Guidelines for Completion of the RAI. Available from ~~http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
Appendix G	—	G-2	National Institute of Mental Health: Suicide and the Elderly. n.d. Available from ~~http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm~~ https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm
Appendix G	—	G-3	Saliba, D., and Buchanan, J.: Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0 Final Report to CMS. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA. Rand Corporation, April 2008. Available from ~~http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf~~ https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/mds30finalreport.pdf.
Appendix G	—	G-3	U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: Healthy People 2020. Available from ~~http://www.healthypeople.gov/2020/default.aspx~~ https://www.healthypeople.gov/2020/default