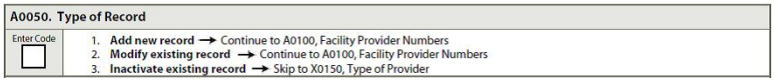
Track Changes
from Chapter 3 Section A V1.05
to Chapter 3 Section A V1.08

Chapter	Section	Page	Change
3	A	A-1 & A-2	

A0050: Type of Record



Coding Instructions for A0050, Type of Record

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

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

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

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

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

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

Chapter	Section	Page	Change
			modification record will be rejected and not accepted in the QIES ASAP system. The "fatal" error(s) will be reported to the facility on the Final Validation Report. 4. If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP database. The prior record will be moved to a history file in the QIES ASAP database. • Code 3, Inactivate existing record: if this is a **request to inactivate** a record that already has been submitted and accepted in the QIES ASAP system. If this item is **coded as 3**, skip to X0150, Type of Provider. When an inactivation request is submitted, the QIES ASAP system will take the following steps: 1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items. 2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a "fatal" error will be reported to the facility on the Final Validation Report. 3. All items in Section X of the submitted record will be edited. If there are any fatal errors, the current inactivation request will be rejected and no record will be inactivated in the QIES ASAP system. 4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file. **Identification of Record to be Modified/Inactivated** The Section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information **EXACTLY** as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the database.

Chapter	Section	Page	Change
			Example: A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record. When the encoder "data entered" the prior assessment for Joan L Smith, he typed "John" by mistake. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under Identification of Record to be Modified/Inactivated. When completing X0200A, the Resident First Name, "John" will be entered in this item. This will permit the MDS system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" were entered, the QIES ASAP system would not locate the prior assessment. The correction to the name from "John" to "Joan" will be made by recording "Joan" in the "normal" A0500A, Resident First Name in the modification record. The modification record must include all items appropriate for that assessment, not just the corrected name. This modification record will then be submitted and accepted into the QIES ASAP system which causes the desired correction to be made.
3	A	A-3	Page length change.
3	A	A-4	A0310: Type of Assessment *For Comprehensive, Quarterly, and PPS Assessments, Entry and Discharge~~Tracking~~ Records.*

3	A	A-4	Replaced screen shot.

OLD

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. **Not OBRA required** assessment

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
06. **Readmission/return** 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. **Not PPS** assessment

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

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, PPS, or Discharge) **since the most recent admission?**
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. **Not entry/discharge** tracking record

NEW

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
06. **Readmission/return** 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**

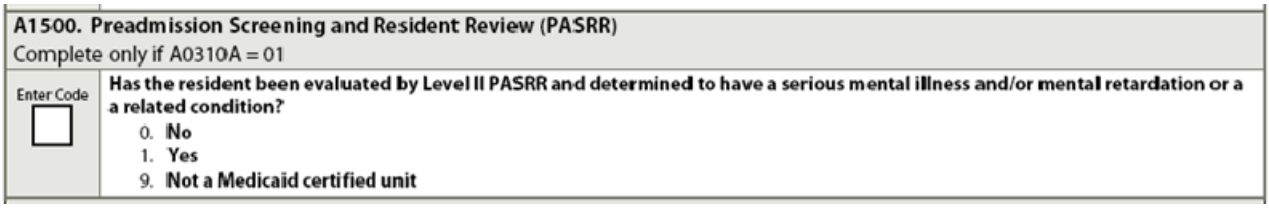
Enter Code

G. **Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

3	A	A-5	Page length change.
3	A	A-6	**Coding Instructions for A0310C** • Code 1, S~~s~~tart 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, E~~e~~nd of therapy assessment: with an ARD that is 1 to 3 days after the last day therapy services were provided. • Code 3, both the S~~s~~tart and E~~e~~nd 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.
3	A	A-6	**Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?** • Code 0, no: if this assessment is not the first assessment since the most recent admission/entry or reentry~~of any kind (admission or reentry)~~. • Code 1, yes: if this assessment is the first assessment since the most recent admission/entry or reentry~~of any kind (admission or reentry)~~.
3	A	A-7	**Coding Instructions for A0310G, Type of Discharge** • Code 1: if type of discharge is a planned discharge. • Code 2: if type of discharge is an unplanned

			discharge.
3	A	A-8 through A-15	Page length change.
3	A1500	A-16	Replaced screen shot.

OLD



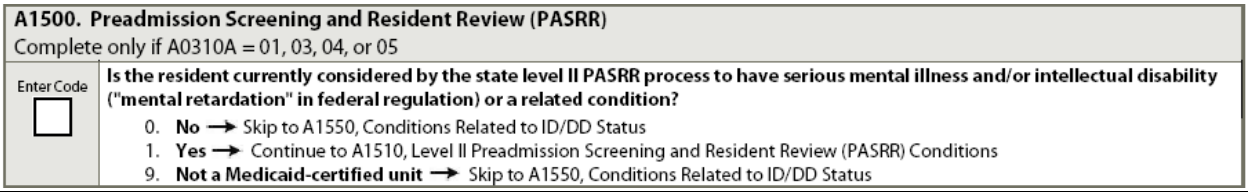
A1500. Preadmission Screening and Resident Review (PASRR)
Complete only if A0310A = 01

Enter Code ☐

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a a related condition?

0. **No**
1. **Yes**
9. **Not a Medicaid certified unit**

NEW



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?

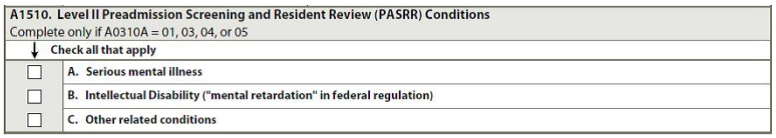
0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

3	A1500	A-16	**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" (~~MI/~~MR) in federal regulation), 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). • A resident with MI or ID~~MR~~ 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 MDS assessment is completed for a resident with MI or ID~~MR~~, the nursing home is required to notify the State mental health authority, intellectual disability~~mental retardation~~ or developmental delay disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.
3	A1500	A-17	**Planning for Care** • The State is responsible for providing specialized services to individuals with MI/ID~~MR~~. 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.
3	A1500	A-17	**Steps for Assessment** 1. Complete if A0310A = 01, 03, 04 or 05 ~~(Admission Assessment).~~ (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).
3	A1500	A-17	**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 disability~~mental retardation~~ or related condition, or
3	A1500	A-18	• Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual disability or ~~mental retardation~~ 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.

<table>
<tr>
<td>3</td>
<td>A1510</td>
<td>A-18</td>
<td>

A1510: Level II Preadmission Screening and Resident Review (PASRR) 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): if resident has been diagnosed with intellectual disability (or "mental retardation").
- Code C, Other related conditions: if resident has been diagnosed with other related conditions.

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<tr>
<td>3</td>
<td>A1550</td>
<td>A-19</td>
<td>

A1550: Conditions Related to Intellectual Disability~~Mental Retardation~~/ Developmental Delay (~~MR~~ID/DD) Status

</td>
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</table>

3	A1550	A-19	**DEFINITIONS** **DOWN SYNDROME** A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, ~~mental retardation~~ 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.

3	A1550	A-19	Replaced screen shot.

OLD

A1550. Conditions Related to MR/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 MR/DD status** that were manifested before age 22, and are likely to continue indefinitely

	MR/DD With Organic Condition
☐	A. Down syndrome
☐	B. Autism
☐	C. Epilepsy
☐	D. Other organic condition related to MR/DD
	MR/DD Without Organic Condition
☐	E. MR/DD with no organic condition
	No MR/DD
☐	Z. None of the above

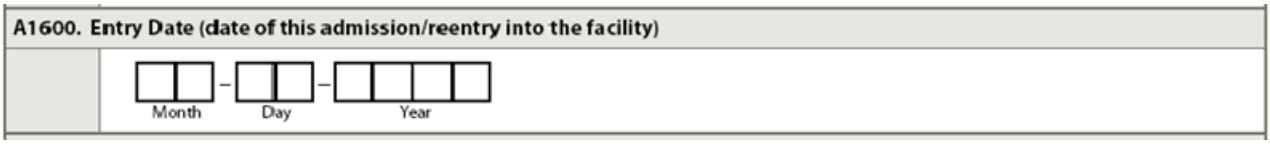
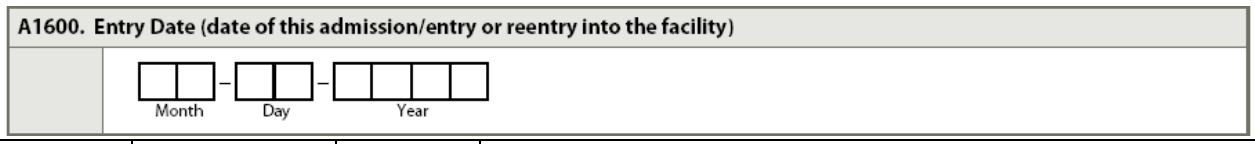
NEW

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

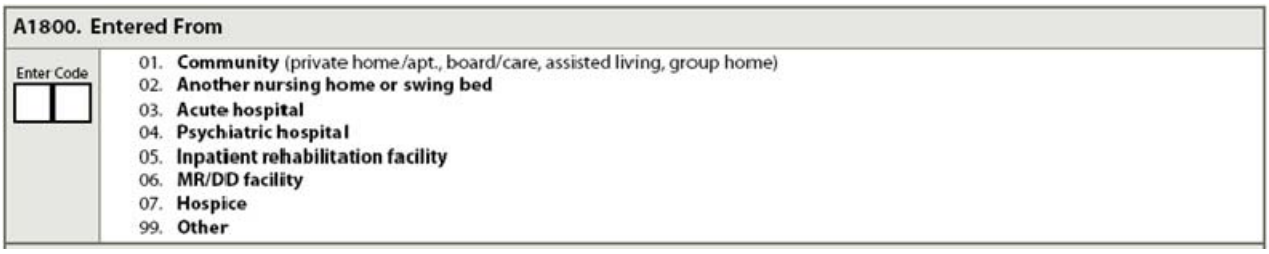
↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

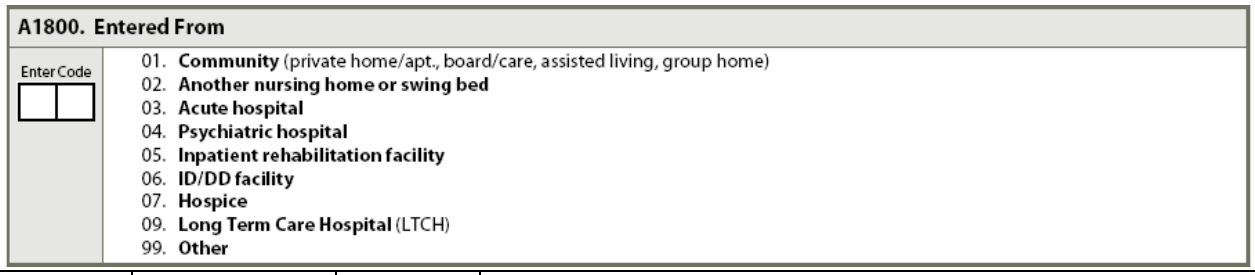
	ID/DD With Organic Condition
☐	A. Down syndrome
☐	B. Autism
☐	C. Epilepsy
☐	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
☐	E. ID/DD with no organic condition
	No ID/DD
☐	Z. None of the above

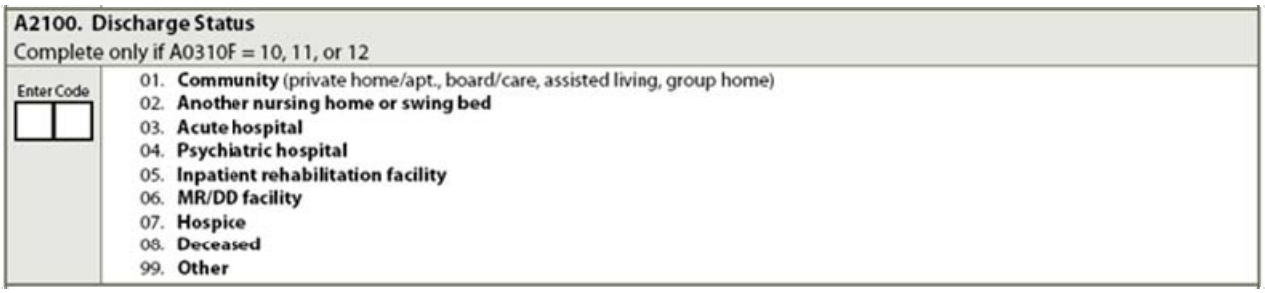
3	A1550	A-19	**Item Rationale** • To document conditions associated with intellectual ~~mental retardation~~ or developmental delay disabilities.
3	A1550	A-19 & A-20	**Coding Instructions** • Check all conditions related to ~~MR~~ID/DD status that were present before age 22. • Code D: if other organic condition related to ~~MR~~ID/DD is present. • Code E: if an ~~MR~~ID/DD condition is present but the resident does not have any of the specific conditions listed. • Code Z: if ~~MR~~ID/DD condition is not present.

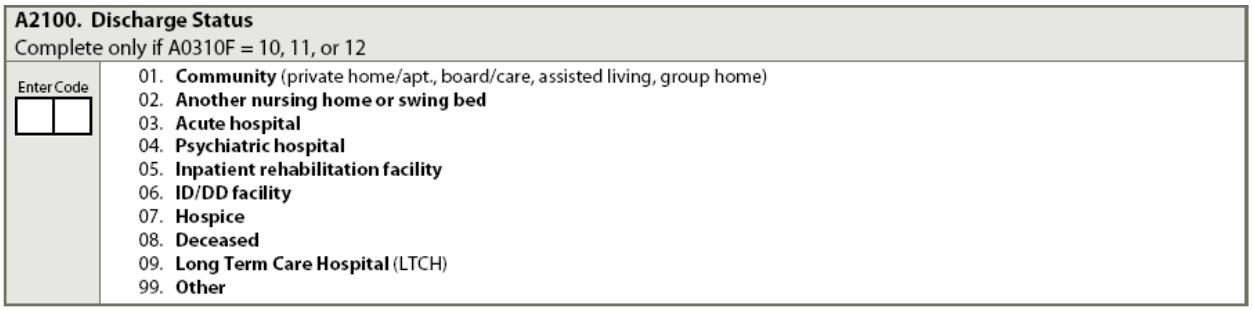
3	A1550	A-20	**DEFINITION** **OTHER ORGANIC CONDITION RELATED TO ~~MR~~ID/DD** Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.
3	A1600	A-20	A1600: Entry Date (date of this admission/entry or reentry into the facility)
3	A1600	A-20	Replaced screen shot. OLD  NEW 
3	A1600	A-20	**Item Rationale** • To document the date of admission/entry or reentry into the nursing home. **Coding Instructions** Enter the most recent date of admission/entry or reentry to this nursing home. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
3	A1700	A-20	**Item Rationale** • Captures whether date in A1600 is an

<table>
<tr><td></td><td></td><td></td><td>admission/entry ~~date~~ or ~~a~~ reentry date.

Coding Instructions
• Code 1, admission/entry: when one of the following occurs:</td></tr>
<tr><td>3</td><td>A1800</td><td>A-21</td><td>Replaced screen shot.
OLD
 

NEW
 
</td></tr>
<tr><td>3</td><td>A1800</td><td>A-22 & A-23</td><td>Coding Instructions
• Code 06, ID~~MR~~/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 ~~are mentally retarded~~ or ~~who have~~developmental delay 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 patient was discharged 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</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>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.</td></tr>
<tr><td>3</td><td>A2100</td><td>A-23</td><td>Replaced screen shot.
OLD
 

NEW
 
</td></tr>
<tr><td>3</td><td>A2100</td><td>A-24 & A-25</td><td>Coding Instructions
• Code 06, ID~~MR~~/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~~are mentally retarded~~ or ~~who have~~developmental delay disabilities.
• Code 09, long term care hospital (LTCH): if the patient 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.</td></tr>
<tr><td>3</td><td>A</td><td>A-26</td><td>Page length change.</td></tr>
</table>

<table>
<tr><td>3</td><td>A2400</td><td>A-27</td><td>Coding Instructions for A2400A

• Code 0, no: if the resident has not had a covered Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.
• Code 1, yes: if the resident has had a Medicare Part A covered stay since the most recent admission/entry or reentry. Continue to A2400B.</td></tr>
<tr><td>3</td><td>A2400</td><td>A-27</td><td>DEFINITIONS

MOST RECENT MEDICARE STAY
This is a Medicare Part A covered stay that has started on or after the most recent ~~entry (admission or renetry)~~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.</td></tr>
<tr><td>3</td><td>A</td><td>A-28</td><td>Page number change.</td></tr>
<tr><td>3</td><td>A</td><td>A-29</td><td>Page number change.</td></tr>
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