Centers for Medicare & Medicaid Services

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

Version 3.0

October, 2012

TABLE OF CONTENTS

Chapter 1: Resident Assessment Instrument (RAI) (V1.09)

Chapter 2: Assessments for the Resident Assessment Instrument (RAI) (V1.09)

Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0

Appendices

CMS ACKNOWLEDGEMENTS

Contributions provided by the numerous people, organizations, and stakeholders listed below are very much acknowledged by CMS. Their collective hard work and dedication over the past several years in the development, testing, writing, formatting, and ongoing review and maintenance of the MDS 3.0 RAI Manual, MDS 3.0 Data Item Set, and MDS 3.0 Data Specifications have resulted in a new RAI process that increases clinical relevancy, data accuracy, clarity, and notably adds more of the resident voice to the assessment process. We wish to give thanks to all of the people that have contributed to making this manual possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.

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Special Recognition for the development of the RAI Manual goes to Ellen Berry, PT and Stella Mandl, BSW, BSN, PHN, RN. Without their dedication, drive, and endless hours of work this manual would not have come to fruition.

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/Downloads/MDS30Appendix_B.pdf

CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

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

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

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

1.2 Content of the RAI for Nursing Homes

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

[1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/images/stories/documents/inhc.pdf.

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

- **Minimum Data Set.** 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., admission, quarterly, annual, significant change, significant correction, discharge, entry tracking, PPS assessments, etc.) 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 (CAA)** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The **CAA** resources 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 are not mandatory and represent neither an all-inclusive list nor government endorsement.
  - **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.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose is an assessment tool used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the 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 the Skilled Nursing Facility Prospective Payment System (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 www.cms.gov/Manuals/IOM/list.asp 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 Medicaid-certified nursing home in the country. The Nursing Home Compare tool (http://www.medicare.gov/NHCompare) 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

(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative).

b. **Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered care areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.

c. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and care plan interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' active participation in the process.

d. **Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

e. **Implementation**—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the "how" and "when" of resident care.

f. **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.

The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, care plan development, care plan implementation, and finally to evaluation. This manual will refer to this process throughout several chapter discussions.

If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using

all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to successfully using the RAI process is understanding that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), and the interdisciplinary team, residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases.
- **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing the CAAs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is accommodated in the care plan.
- **Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident goals, needs, interests, strengths, problems, preferences, and lifestyle choices. When considering all of this information, staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.
- **Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found

that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

The purpose of this manual is to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help nursing home staff achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. This tool assesses a resident's ability to perform daily life functions, identifies significant impairments in a resident's functional capacity, and provides opportunities for direct resident interview. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

Furthermore, with the consistent application of item definitions, the RAI ensures standardized communication both within the nursing home and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.5 MDS 3.0

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008).

Goals

The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement (via resource utilization group [RUG] classification).

In addition to improving the content and structure of the MDS, the RAND/Harvard team also aimed to improve user satisfaction. User attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the MDS are often cited as a reason that nursing homes have not fully implemented the information from the MDS into targeted care planning.

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

1.7 Layout of the RAI Manual

The layout of the RAI manual is as follows:

- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

APPENDICES

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (When Administered In Writing)
- Appendix F: Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Item Sets

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, 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.
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 Disease Diagnosis	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 and Procedures	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	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a 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.

1.8 Protecting the Privacy of the MDS Data

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

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

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

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Contractual Agreements

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

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility.

Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS (7/14/2005)

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**
   Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**
   This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.

3. **ROUTINE USES**
   The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.
   The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

4. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**
   For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of beneficiary services and resultant reimbursement may not be possible.
   Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

   _____ _____
   Signature of Resident or Sponsor Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the

Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

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 only 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 Readmission/Return assessment is also a scheduled 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 Readmission/Return	01 06	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.

Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

Codes for Assessments 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) A0310B = 01-07 and 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
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
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.

— 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.

- 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 or readmission/return 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 classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and experiences a planned or unplanned discontinuation of therapy services for three or more consecutive calendar days and the resident is discharged from the facility ***on*** the third day of missed therapy services, then no EOT OMRA is required. If the facility chooses to complete an EOT OMRA in this situation, it may be combined with the discharge assessment.
- 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.
- 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.

4. 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 any amount of skilled therapy services 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 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 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 discharge assessment.
- The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's current RUG-IV therapy classification.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)
- Establishes a new RUG-IV category. Payment begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other PPS assessment.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Significant Change in Status Assessment (SCSA)

- Is an OBRA required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification.
- When a SCSA for a SNF PPS resident is not combined with a PPS assessment (A0310A = 04 and A0310B = 99), the RUG-IV classification and associated payment rate begin on the ARD. For example, a SCSA is completed with an ARD of day 20 then the RUG-IV classification begins on day 20.
- When the SCSA is completed with a scheduled Medicare-required assessment and grace days are not used when setting the ARD, the RUG-IV classification begins on the ARD. For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.
- When the SCSA is completed with a scheduled Medicare-required assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. For example, the SCSA is combined with the Medicare-required 30-day scheduled assessment, which pays for days 31 to 60, and the ARD is set at day 33, the RUG-IV classification begins day 31.

Swing Bed Clinical Change Assessment

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

Significant Correction to Prior Comprehensive Assessment

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

Coding Tips and Special Populations

- When coding a standalone 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.

2.10 Combining Medicare Scheduled and Unscheduled Assessments

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

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

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in 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.

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.

PPS Scheduled Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within the ARD window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.

- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 1
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and End of Therapy OMRA

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

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 2
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Start and End of Therapy OMRA

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

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 3
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Change of Therapy OMRA

- If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS Assessment, then a SNF must elect to either combine the COT OMRA with the scheduled PPS assessment or choose to complete the scheduled PPS assessment alone, as described in Section 2.9. If the scheduled PPS assessment is to be completed alone, then the ARD for the scheduled PPS assessment must be set for ***on or prior*** to Day 7 of the COT observation period. If the SNF chooses to combine the scheduled PPS assessment with the COT OMRA, then the ARD of the combined assessment must be set for Day 7 of the COT observation period.
- Must complete the scheduled PPS assessment item set.
- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current standard payment period and the next payment period appropriate to the given scheduled assessment, assuming no intervening assessments. For example:
  - Based on her 14-day assessment, Mrs. T is currently classified into group RVB. Based on the ARD set for the 14-day assessment, a change of therapy evaluation for Mrs. T is necessary on Day 28. The change of therapy evaluation reveals that the therapy services Mrs. T received during that COT observation period were only sufficient to qualify Mrs. T for RHB. Therefore, a COT OMRA is required. Since the facility has not yet completed a 30-day assessment for Mrs. T, the facility must combine the 30-day assessment with the required COT OMRA. The combined assessment confirms Mrs. T's appropriate classification into RHB. The payment for the revised RUG classification will begin on Day 22 and, assuming no intervening assessments, will continue until Day 60.

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- If the ARD for the Swing Bed Clinical Change Assessment falls within the ARD (including grace days) of a PPS scheduled assessment that has not been completed yet, the assessments MUST be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99 (only value allowed for Swing Beds)
  A0310B = 01, 02, 03, 04, 05, or 06, as appropriate
  A0310C = 0
  A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

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

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

Swing Bed Clinical Change Assessment and End of Therapy OMRA

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

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

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

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 07
  A0310C = 3
  A0310D = 1

2.11 Combining Medicare Assessments and OBRA Assessments[7]

SNF providers are required to meet two assessment standards in a Medicare certified nursing facility:

- The OBRA standards are designated by the reason selected in Item A0310A, **Federal OBRA Reason for Assessment**, and Item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, and Item A0310C, **PPS Other Medicare Required Assessment - OMRA** and are required for resident's whose stay is covered by Medicare Part A.

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

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

The following tables provide the item set for each type of assessment or tracking record. When two or more assessments are combined then the appropriate item set contains all items that would be necessary if each of the combined assessments were being completed individually.

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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.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

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

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

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS	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) • PPS Readmission/Return • Clinical Change Assessment	• 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
Assessment Type Combinations	• Clinical Change and any Medicare-required • Any Medicare-required and any Discharge	N/A

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

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

2.12 Medicare and OBRA Assessment Combinations

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

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required 14-Day and OBRA Admission Assessment

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

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

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

- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Medicare-required Scheduled Assessment and Annual Assessment

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

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- Must be completed (Item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

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

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

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

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

Medicare-required Scheduled Assessment and Discharge Assessment

- PPS item set.

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

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion

Start of Therapy OMRA and OBRA Quarterly Assessment

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

Start of Therapy OMRA and Annual Assessment

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

Start of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).

- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment

Start of Therapy OMRA and Discharge Assessment

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set 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 for requirements for CAA process and care plan completion.

End of Therapy OMRA and OBRA Quarterly Assessment

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

End of Therapy OMRA and Annual Assessment

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

End of Therapy OMRA and Significant Change in Status Assessment

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

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

End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and Discharge Assessment

- OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). 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 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and OBRA Quarterly Assessment

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

Start and End of Therapy OMRA and Annual Assessment

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

- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

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

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

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

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

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

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

Start and End of Therapy OMRA and Discharge Assessment

- OMRA-Start of Therapy and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge falls within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). 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 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must meet the requirements for an OBRA Quarterly assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.

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

Change of Therapy OMRA and Annual Assessment

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

Change of Therapy OMRA and Significant Change in Status Assessment

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

- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and Discharge Assessment

- COT OMRA and 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 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 Discharged Before or On the Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or transferred to another payer source before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). When the beneficiary is discharged from the SNF, the provider must also complete a Discharge assessment (see Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a discharge assessment).

Short Stay

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

Resident is Admitted to an Acute Care Facility and Returns

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted. The type of entry on the Entry Tracking record (as described in Section 2.6) completed by the provider determines whether a Medicare-required 5-day or a Medicare Readmission/Return assessment should be completed.

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

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

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

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

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

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

Resident 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 of whether an 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.

Resident Leaves the Facility and Returns During an Observation Period

The ARD is not altered if the beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3) but may not extend the observation period.

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

In the situation when a beneficiary is discharged from Medicare Part A services but remains in the facility in a Medicare and/or Medicaid certified bed with another pay source, the OBRA schedule will be continued. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. If and when the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

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

Delay in Requiring and Receiving Skilled Services

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

Non-Compliance with the PPS Assessment Schedule

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

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. **If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance.** For example, a Medicare-required 14-Day assessment with

an ARD of day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

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.

DEFINITIONS

INTERVENING ASSESSMENT

Refers to an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment.

DAYS OUT OF COMPLIANCE

Refers 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) of an 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 + Medicare Assessment

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

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

2.14 Expected Order of MDS Records

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

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

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

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

Expected Order of MDS Records

	Prior Record												
Next Record	**Entry**	**OBRA admission**	**OBRA annual**	**OBRA quarterly**	**PPS 5-day or read-mission/ return**	**PPS 14-day**	**PPS 30-day**	**PPS 60-day**	**PPS 90-day**	**PPS unscheduled**	**Discharge**	**Death in facility**	**No prior record**
Entry	no	no	no	no	no	no	no	no	no	no		no	
OBRA admission		no	no	no			no	no	no		no	no	no
OBRA annual		no	no								no	no	no
OBRA quarterly, sign. change, sign correction											no	no	no
PPS 5-day or readmission/return					no	no	no	no	no		no	no	no
PPS 14-day	no					no	no	no	no		no	no	no
PPS 30-day	no				no		no	no	no		no	no	no
PPS 60-day	no	no			no	no		no	no		no	no	no
PPS 90-day	no	no			no	no	no		no		no	no	no
PPS unscheduled											no	no	no
Discharge											no	no	no
Death in facility											no	no	no

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

2.15 Determining the Item Set for an MDS Record

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

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

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	ISC	Description
01	01,02,06,99	0	10,11,99	NC	Comprehensive
01	01,02,06,07	1,2,3	10,11,99	NC	Comprehensive
01	02,07	4	10,11,99	NC	Comprehensive
03	01 thru 06,99	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 06,99	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 06	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

Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C= 0 and Item A0310F = 99 (a standalone admission assessment), then these values are matched in row 2 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected

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

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

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

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	ISC	Description
99	01 thru 06	0,1,2,3	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	SP	PPS
99	02 thru 05	4	0	10,11,99	SP	PPS
99	02 thru 05,07	4	1	10,11,99	SP	PPS
99	07	1	0	99	SS	SOT OMRA
99	07	1	0	10,11	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	SO	EOT, EOT-R or COT OMRA
99	07	2,3,4	0	10,11	SOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	SD	Discharge
99	99	0	0	01,12	ST	Tracking

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

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

Item Rationale

Health-Related Quality of Life

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

Planning for Care

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

Steps for Assessment

There are two look-back periods for this section:

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

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

   Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

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

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

DEFINITIONS

ACTIVE DIAGNOSES

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

FUNCTIONAL LIMITATIONS

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

NURSING MONITORING

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

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

- Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300 UTI.
- Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

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

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

Cancer

- I0100, cancer (with or without metastasis)

Heart/Circulation

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

K0200: Height and Weight (cont.)

- If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

K0300: Weight Loss

K0300. Weight Loss	
Enter Code ☐	**Loss of 5% or more in the last month or loss of 10% or more in last 6 months** 0. **No** or unknown 1. **Yes, on** physician-prescribed weight-loss regimen 2. **Yes, not on** physician-prescribed weight-loss regimen

Item Rationale

Health-related Quality of Life

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

Planning for Care

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS
Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

10% WEIGHT GAIN IN 180 DAYS
Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

Steps for Assessment

This item compares the resident's weight in the 7-day look back period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

K0300: Weight Loss (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is less than the previous weight, calculate the percentage of weight loss.
4. Complete the same process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the 7-day look back period to his or her weight in the observation period 30 days ago.
2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss.
3. From the medical record, compare the resident's weight in the 7-day look back period to his or her weight in the observation period 180 days ago.
4. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss.

DEFINITIONS

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.

BODY MASS INDEX (BMI)
Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as **1**.

The most recent postoperative weight of 110 lbs (110 lbs, taking the amputated limb into account) is >10% weight loss (significant at 180 days).

Present weight of 110 lbs >10% weight loss (significant at 180 days).

Coding: K0300 would be coded 2, yes, weight change is significant; not on physician-prescribed weight-loss regimen.

Rationale: The resident had a significant weight loss of >5% in 30 days and did have a weight loss of >10% in 180 days, the item would be coded as 2, yes weight change is significant; not on physician-prescribed weight–loss regime, with one of the items being triggered. This item is coded for either a 5% 30-day weight loss or a 10% 180-day weight loss. In this example both items, the criteria are met but the coding does not change as long as one of them are met.

K0310: Weight Gain

K0310. Weight Gain	
Enter Code ☐	**Gain of 5% or more in the last month or gain of 10% or more in last 6 months** 0. **No** or unknown 1. **Yes, on** physician-prescribed weight-gain regimen 2. **Yes, not on** physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the resident's health status or environment.
- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroidals), or changed fluid volume status.
- Weight gain should be monitored on a continuing basis; weight gain should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the 7-day look back period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS
Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

10% WEIGHT GAIN IN 180 DAYS
Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

K0310: Weight Gain (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight gain assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.
4. Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the 7-day look back period to his or her weight in the observation period 30 days ago.
2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain.
3. From the medical record, compare the resident's weight in the 7-day look back period to his or her weight in the observation period 180 days ago.
4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- Code 1, yes on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as **1**.
- Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

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

Coding Instructions

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

- Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Items M0300–M0800.
- Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).

Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer. Each ulcer should be coded only once, either as a pressure ulcer or an ulcer due to another cause.
- If a pressure ulcer is surgically repaired with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2 and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

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

1. Observe the base of any pressure ulcers present to determine the depth of tissue layers involved.
2. Ulcer staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. Nursing homes that carefully document and track ulcers will be able to more accurately code this item.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging. However, if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured, do not code as unstageable.
2. Pressure ulcers that have necrotic or eschar (tan, black, or brown) tissue present such that the tissue layers involved with the pressure ulcer cannot be determined, should be classified as unstageable, as illustrated at http://www.npuap.org/images/NPUAP-Unstage2.jpg
3. Pressure ulcers in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) are unstageable.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/images/NPUAP-SuspectDTI.jpg
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

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
On admission is defined as: 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. If the pressure ulcer was present on admission/entry or reentry and subsequently worsened to a higher 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."**

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

3. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes stageable later, it should be considered as "present on admission" at the stage at which it first becomes stageable. If it subsequently worsens to a higher stage, that higher stage **should not be considered "present on admission."**
4. If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer **should not be coded as "present on admission**" because it was present at the facility prior to the hospitalization.
5. If a current pressure ulcer worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as "present on admission."**

M0300A: Number of Stage 1 Pressure Ulcers

M0300. **Current Number of Unhealed** (non-epithelialized) **Pressure Ulcers at Each Stage**	
Enter Number ☐	**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

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. Look for temperature or color changes.

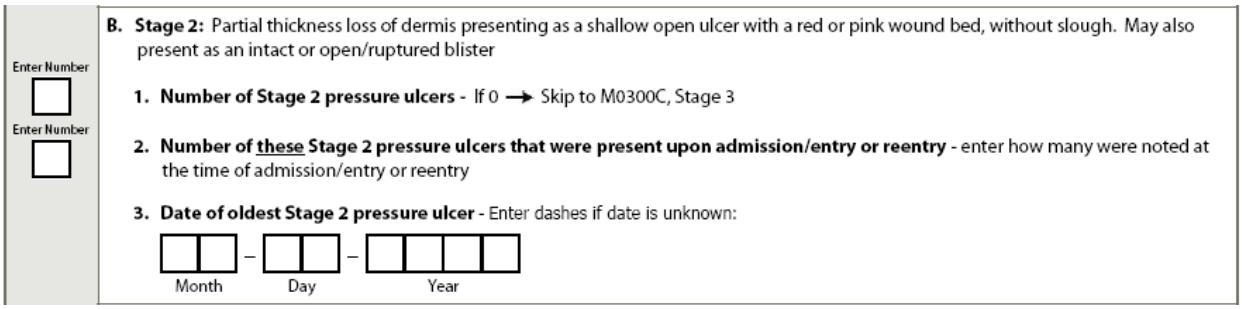
Coding Instructions for M0300A

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

Coding Tips

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

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).
- 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.

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.)

- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
- 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 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

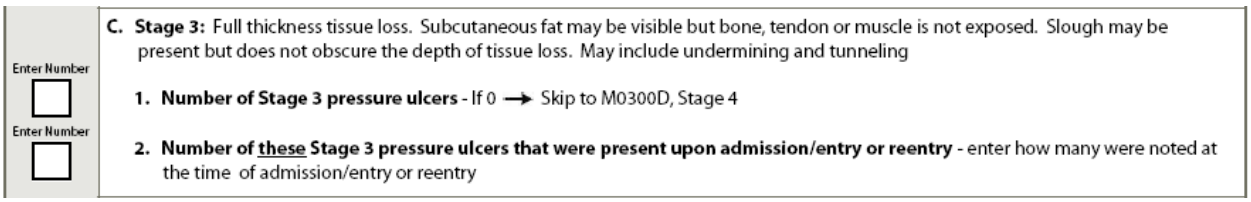
- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- Enter 0 if no Stage 2 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C).
- Enter the number of Stage 2 pressure ulcers that 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.
- 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, 2011, should be entered as 01-02-2011.

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, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here.
- When a lesion that is related to pressure presents with 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

- 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).
- Enter the number of 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, 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 worsened to a deeper anatomical 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 it worsened to a Stage 3 during hospitalization it should be coded as a Stage 3, present on admission/entry or reentry.

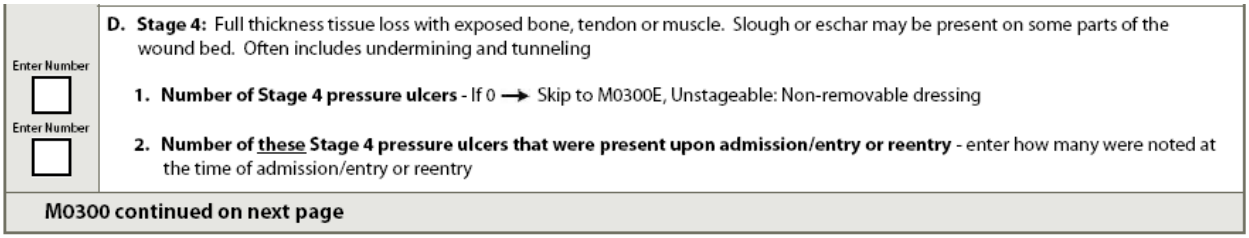
3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has worsened to a Stage 3 pressure ulcer.

   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 to a Stage 3 has increased in stage since admission and hence cannot be coded in M0300C2 as 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 developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 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



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.

DEFINITIONS

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

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.

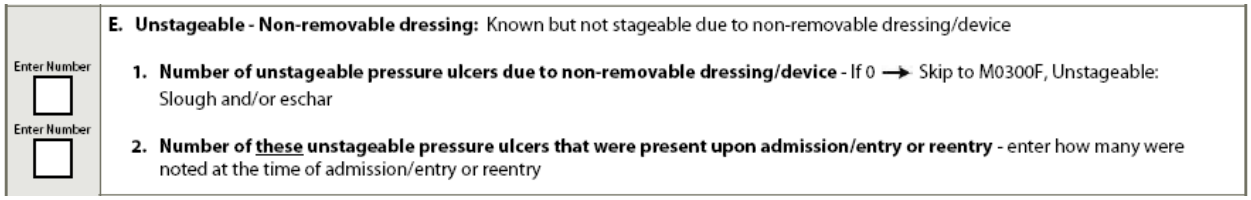
M0300D: Stage 4 Pressure Ulcers (cont.)

- Enter 0 if no Stage 4 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E).
- Enter the number of 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.

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.

DEFINITIONS

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).

DEFINITIONS

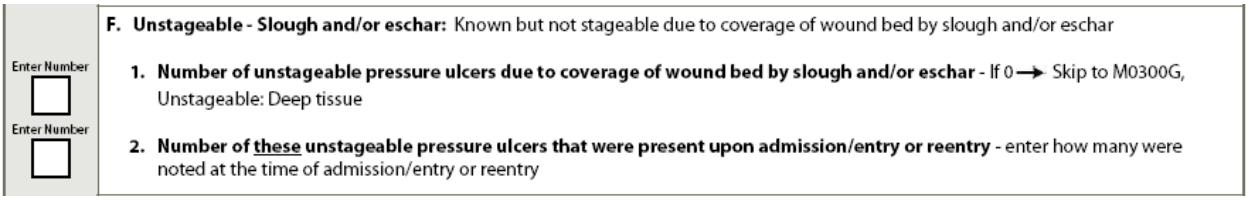
SLOUGH TISSUE
Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

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.

Coding Instructions for M0300E

- 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).
- Enter the number of 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



M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

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 the necrotic tissue is removed.

DEFINITION

FLUCTUANCE
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable due to slough/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

- 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).
- Enter the number of 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).
- 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

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true depth (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the depth of the tissue layers involved, can the stage of the wound be determined.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

- 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 tissues 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 it is covered with eschar so it is unstageable. It 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.

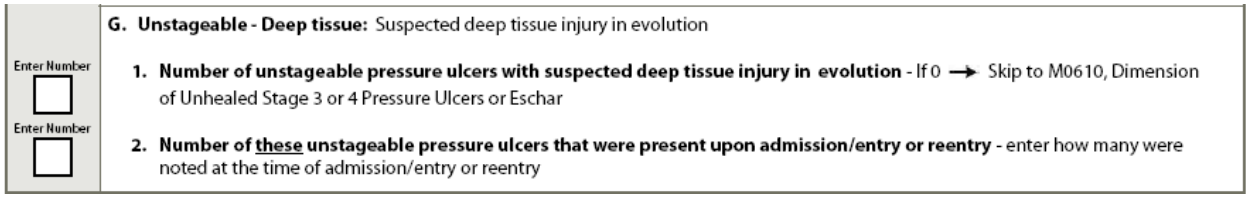
   Rationale: After debridement, the pressure ulcer is no longer unstageable because it can be observed to be a Stage 4 pressure ulcer and should be coded at M0300D. This pressure ulcer's dimensions would also be entered at M0610 if this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident.

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 is coded as unstageable due to coverage of the wound bed by slough but 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.
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).

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

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

- Enter the number of unstageable pressure ulcer 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).
- Enter the number of 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 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 (non-epithelialized) 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)

N0350: Insulin (cont.)

Planning for Care

- Orders for insulin may have to change depending on the resident's condition (e.g., fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections take into account meals, activity, etc., based on individualized resident assessment.
- Monitor for adverse effects of insulin injections (e.g., hypoglycemia).
- Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.

Steps for Assessment

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or insulin orders changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders.

Coding Tips and Special Populations

- For sliding scale orders:
  - A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
  - If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.
- For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

N0410: Medications Received

N0410. Medications Received	
Indicate the number of DAYS the resident received the following medications 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** (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.)

- 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

DEFINITION

SLEEP HYGIENE
Practices, habits and environmental factors that promote and/or improve sleep patterns.

- 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.
- 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.

N0410: Medications Received (cont.)

- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
  - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at http://www.cms.gov/Manuals/IOM/list.asp]), which may
    - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
    - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm

Example

1. The Medication Administration Record for Mrs. P. reflects the following:

- Resperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
- Lorazepam 1 mg PO QAM: Received every day.
- Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

Coding: Medications in N0410, would be checked as follows: A. Antipsychotic, resperidone is an antipsychotic medication, B. Antianxiety, lorazepam is an antianxiety medication, and D. Hypnotic, 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.

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

- **O0100I, transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0100J, dialysis**

Code peritoneal or renal dialysis that occurs at the nursing home or at another facility in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0500A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.

- **O0100K, hospice care**

Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided 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.

- **O0100L, respite care**

Code only when the resident's care program involves a short-term stay in the facility for the purpose of providing relief to a primary home-based caregiver(s) in this item.

- **O0100M, isolation for active infectious disease (does not include standard precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "single room isolation" only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.

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

4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf

SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Content/NavigationMenu/PracticeGuidance/APIC-SHEA_Guideline.pdf

As the CDC guideline noted, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care facility setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's plan of care will likely need to be completed.

- **O0100Z, none of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

O0250: Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ – ☐☐ – ☐☐☐☐
Month – Day – Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0400: Therapies (cont.)

application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.

- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

Coding:
O0400C1 would be coded 287, O0400C2 would be coded 100, O0400C3 would be coded 0, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes.

Rationale:
Individual minutes totaled 287 over the 7-day look-back period [(30 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 0 = 0). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

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

Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

Coding:
O0400D1 would be coded 50, O0400D2 would be coded 0.

Rationale:
Total minutes were 50 over the 7-day look-back period (10 × 5 = 50). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.

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

Psychological therapy services were not provided at all over the 7-day look-back period.

Coding:
O0400E1 would be coded 0, O0400E2 would be left blank.

Rationale:
There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

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

Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.

SECTION X: CORRECTION REQUEST

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

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

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

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

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

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

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

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

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

X0600: Type of Assessment/Tracking (cont.)

Coding Instructions for X0600A, Federal OBRA Reason for Assessment

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

Coding Instructions for X0600B, PPS Assessment

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

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

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

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

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

X0600: Type of Assessment/Tracking (cont.)

- Note that the code in X0600D must match the current value of A0310D on a modification request.
- If item A0310D was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

Coding Instructions for X0600F, Entry/discharge reporting

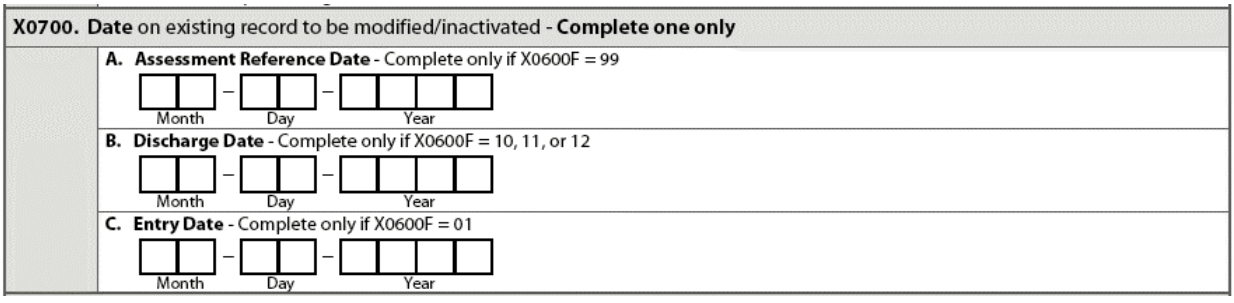
- Enter the number corresponding to the entry/discharge code exactly as submitted for item A0310F "Entry/discharge reporting" on the prior erroneous record to be modified/inactivated.

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

- Note that the Entry/discharge code in X0600F must match the current value of A0310F on a modification request.
- If item A0310F was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.

X0700: Date on Existing Record to Be Modified/Inactivated – Complete one only

The item that is completed in this section is the event date for the prior erroneous record to be modified/inactivated. The event date is the assessment reference date for an assessment record, the discharge date for a discharge record, or the entry date for an entry record. In the QIES ASAP system, this date is often referred to as the "target date." Enter only one (1) date in X0700



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

Coding Instructions for X0700A, Assessment Reference Date—Complete Only if X0600F = 99

- If the prior erroneous record to be modified/inactivated is an OBRA assessment or a PPS assessment, where X0600F = 99, enter the assessment reference date here exactly as submitted in item A2300 "Assessment Reference Date" on the prior record.
- Note that the assessment reference date in X0700A must match the current value of A2300 on a modification request.

Coding Instructions for X0700B, Discharge Date—Complete Only If X0600F = 10, 11, or 12

- If the prior erroneous record to be modified/inactivated is a discharge record (indicated by X0600F = 10, 11, or 12), enter the discharge date here exactly as submitted for item A2000 "Discharge Date" on the prior record. If the prior erroneous record was a discharge combined with an OBRA or PPS assessment, then that prior record will contain both a completed assessment reference date (A2300) and discharge date (A2000) and these two dates will be identical. If such a record is being modified or inactivated, enter the prior discharge date in X0700B and leave the prior assessment reference date in X0700A blank.
- Note that the discharge date in X0700B must match the current value of A2000 on a modification request.

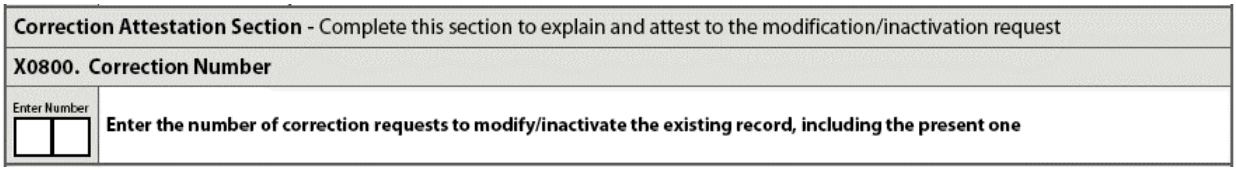
Coding Instructions for X0700C, Entry Date—Complete Only If X0600F = 01

- If the prior erroneous record to be modified/inactivated is an entry record (indicated by X0600F = 01), enter the entry date here exactly as submitted for item A1600 "Entry Date [date of admission/reentry into the facility]" on the prior record.
- Note that the entry date in X0700C must match the current value of A1600 on a modification request.

X0800: Correction Attestation Section

The items in this section indicate the number of times the QIES ASAP database record has been corrected, the reason for the current modification/inactivation request, the person attesting to the modification/inactivation request, and the date of the attestation.

This item may be populated automatically by the nursing home's date entry software, however, if it is not, the nursing home should enter this information.



X0900: Reasons for Modification (cont.)

Coding Instructions for X0900C, Software Product Error

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

Coding Instructions for X0900D, Item Coding Error

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

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

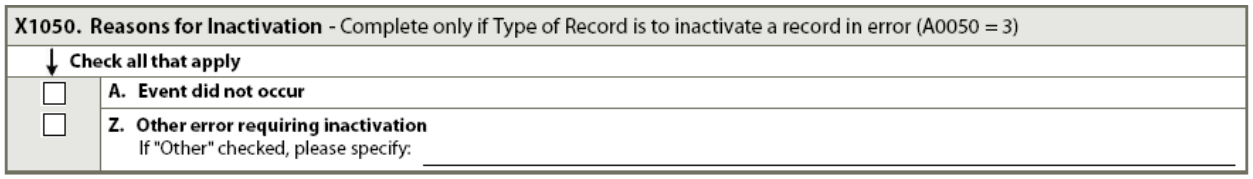
- Check the box if the End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not indicating a resumption of therapy date in item O0450B).
- Do not check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

Coding Instructions for X0900Z, Other Error Requiring Modification

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

X1050: Reasons for Inactivation

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



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. Worsening mental status is indicated by the BIMS summary score having a non-missing value of 00 to 15 on both 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

((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

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 a worsening or an acute change in 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, altered level of consciousness or psychomotor retardation as indicated by:

   (C1300A = 1 OR C1300A = 2) OR

   (C1300B = 1 OR C1300B = 2) OR

   (C1300C = 1 OR C1300C = 2) OR

   (C1300D = 1 OR C1300D = 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:

9. **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

1. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

   B0700 >= 1 AND B0700 <= 3

2. 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,

toileting, changing position in bed, 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.

14. Dehydration/Fluid Maintenance

Dehydration is a condition in which there is an imbalance of water and related electrolytes in the body. As a result, the body may become less able to maintain adequate blood pressure and electrolyte balance, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. In older persons, diagnosing dehydration is accomplished primarily by a detailed history, laboratory testing (e.g., electrolytes, BUN, creatinine, serum osmolality, urinary sodium), and to a lesser degree by a physical examination. Abnormal vital signs, such as falling blood pressure and an increase in the pulse rate, may sometimes be meaningful symptoms of dehydration in the elderly.

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

Dehydration/Fluid Maintenance CAT Logic Table

Triggering Conditions (any of the following):

1. Fever is selected as a problem health condition as indicated by:

   J1550A = 1

2. Vomiting is selected as a problem health condition as indicated by:

   J1550B = 1

3. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

4. Internal bleeding is selected as a problem health condition as indicated by:

   J1550D = 1

5. Infection present as indicated by:

   (I1700 = 1) OR
   (I2000 = 1) OR
   (I2100 = 1) OR
   (I2200 = 1) OR
   (I2300 = 1) OR
   (I2400 = 1) OR
   (I2500 = 1) OR
   ((M1040A = 1))

6. Constipation present as indicated by:

   H0600 = 1

7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510A1 = 1 OR K0510A2 = 1

8. 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 whether the resident is dehydrated or at risk for dehydration, 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 prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration.

15. Dental Care

The ability to chew food is important for adequate oral nutrition. Having clean and attractive teeth or dentures can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions. Medical illnesses and medication-related adverse consequences may increase a resident's risk for related complications such as impaired nutrition and communication deficits. The dental care CAA addresses a resident's risk of oral disease, discomfort, and complications.

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 indicators of an oral/dental issue and/or condition.

Dental Care CAT Logic Table

Triggering Conditions (any of the following):

1. Any dental problem indicated by:

(L0200A = 1) OR
(L0200B = 1) OR
(L0200C = 1) OR
(L0200D = 1) OR
(L0200E = 1) OR
(L0200F = 1)

The information gleaned from the assessment should be used to identify the oral/dental issues and/or conditions and to identify any related possible causes and/or contributing 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 of the resident's issues and/or conditions.

16. Pressure Ulcer

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

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

Pressure Ulcer CAT Logic Table

Triggering Conditions (any of the following):

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

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

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel continence as indicated by:

   H0400 = 2 OR H0400 = 3

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

   K0300 = 2

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

   M0150 = 1

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

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

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

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

   M0300A > 0 AND M0300A <= 9

8. Resident has one or more pressure ulcer(s) that has gotten worse since prior assessment as indicated by:

(M0800A > 0 AND M0800A <= 9) OR

(M0800B > 0 AND M0800B <= 9) OR

(M0800C > 0 AND M0800C <= 9)

9. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

10. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications, prescribed primarily to affect cognition, mood, or behavior, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

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

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication, in consultation with the physician and the consultant pharmacist, and to identify any adverse consequences, as well as any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.

Psychotropic Medication Use CAT Logic Table

Triggering Conditions (any of the following):

1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410A>= 1 AND N0410A<=7

2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C>= 1 AND N0410C<=7

4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410D>= 1 AND N0410D<=7

18. Physical Restraints

A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. This category also includes the use of passive restraints such as chairs that prevent rising.

Physical restraints are only rarely indicated, and at most, should be used only as a short-term, temporary intervention to treat a resident's medical symptoms. They should not be used for purposes of discipline or convenience. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Restraints are often associated with negative physical and psychosocial outcomes (e.g., loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence). Adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation.

The physical restraint CAA identifies residents who are physically restrained during the look-back period. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Physical Restraints CAT Logic Table

Triggering Conditions (any of the following):

1. Bed rail restraint used in bed has value of 1 or 2 as indicated by:

   P0100A = 1 OR P0100A = 2

2. Trunk restraint used in bed has value of 1 or 2 as indicated by:

   P0100B = 1 OR P0100B = 2

3. Limb restraint used in bed has value of 1 or 2 as indicated by:

   P0100C = 1 OR P0100C = 2

4. Other restraint used in bed has value of 1 or 2 as indicated by:

   P0100D = 1 OR P0100D = 2

5. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100E = 1 OR P0100E = 2

6. Limb restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100F = 1 OR P0100F = 2

7. Chair restraint that prevents rising used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100G = 1 OR P0100G = 2

8. Other restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100H = 1 OR P0100H = 2

The information gleaned from the assessment should be used to identify the specific reasons for, and the appropriateness of the use of, the restraint and any adverse consequences caused by or risks related to restraint use.

The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or psychological condition(s) that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The ultimate goal is to eliminate restraint use by employing alternatives. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

19. Pain

Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." Pain can be affected by damage to various organ systems and tissues. For example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain

can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep.

As with all symptoms, pain symptoms are subjective and require a detailed history and additional physical examination, and sometimes additional testing, in order to clarify pain characteristics and causes and identify appropriate interventions. This investigation typically requires coordination between nursing staff and a health care practitioner.

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 active symptoms of pain.

Pain CAT Logic Table

Triggering Conditions (any of the following):

1. Pain has made it hard for resident to sleep at night over the past 5 nights as indicated by:

   J0500A = 1

2. Resident has limited day-to-day activity because of pain over past 5 days as indicated by:

   J0500B = 1

3. Pain numeric intensity rating has a value from 7 to 10 as indicated by:

   J0600A >= 07 AND J0600A <=10

4. Verbal descriptor of pain is severe or very severe as indicated by a value of 3 or 4 as as follows:

   J0600B = 3 OR J0600B = 4

5. Pain is frequent as indicated by a value of 1 or 2 and numeric pain intensity rating has a value of 4 through 10 or verbal descriptor of pain has a value of 2 through 4 as indicated by:

   (J0400 = 1 OR J0400 = 2) AND

   ((J0600A >= 04 AND J0600A <= 10) OR

   (J0600B >= 2 AND J0600B <= 4))

6. Staff assessment reports resident indicates pain or possible pain in body language as indicated by:

   (J0800A = 1) OR

   (J0800B = 1) OR

   (J0800C = 1) OR

   (J0800D = 1)

The information gleaned from the assessment should be used to identify the characteristics and possible causes, contributing factors, and risk factors related to the pain. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to alleviate symptoms and, to the extent possible, address the underlying condition(s) that cause the pain.

Management of pain may include various interventions, including medications and other treatments that focus on improving the person's quality of life and ability to function. Therefore, it is important to tailor an individualized care plan related to pain to the characteristics, causes, and consequences of pain in the context of a resident's whole picture, including medical conditions, cognitive capabilities, goals, wishes, and personal and psychosocial function.

20. Return to Community Referral

All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. This ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments (Federal and State) have a responsibility to enforce and support these choices.

An individual in a nursing home with adequate decision making capacity can choose to leave the facility and/or request to talk to someone about returning to the community at any time. The return to community referral portion of MDS 3.0 uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long-term care in the last restrictive setting possible. The CAA associated with this portion of MDS 3.0 focuses on residents who want to talk to someone about returning to the community and promotes opening the discussion about the individual's preferences for settings for receipt of services.

Individual choices related to returning to community living will vary, e.g., returning to a former home or a different community home, or, the individual may choose to stay in the nursing home. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.

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 expresses interest in returning to the community.

Return to Community Referral CAT Logic Table

Triggering Conditions (any of the following):

1. Referral is or may be needed but has not been made to local contact agency as indicated by:

Q0600 = 1

The information gleaned from the assessment should be used to assess the resident's situation and begin appropriate care planning, discharge planning, and other follow-up measures. The next step is to develop an individualized care plan based directly on these findings.

The goal of care planning is to initiate and maintain collaboration between the nursing facility and the local contact agency (LCA) to support the individual's expressed interest in being transitioned to community living. The nursing home staff is responsible for making referrals to the LCAs under the process that the State has established. The LCA is, in turn, responsible for contacting referred residents and assisting with transition services planning. This includes facility support for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. The LCA is the entity that does the necessary community support planning (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, arranging of care support, etc.)This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

4.11 Reserved

CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act required (OBRA) MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).

5.1 Transmitting MDS Data

All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans. After completion of the required assessment and/or tracking record information, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:

http://www.cms. gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp

In addition, providers must be certain they are submitting MDS assessments under the appropriate authority. There must be a federal and/or state authority to submit MDS assessment data to the QIES ASAP system. The software used by providers should have a prompt for confirming the authority to submit each record.

The provider indicates the submission authority for a record in the MDS Submission Requirement item (A0410).

- Value = 1 Neither federal nor state required submission.
- Value = 2 State but not federal required submission
- (FOR NURSING HOMES ONLY).
- Value = 3 Federal required submission.

See Chapter 3 for details concerning the coding of the Submission Requirement item (A0410). Note: CMS certified Swing Bed units are always Value 3, Federal required submission.

Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office web site at:

https://www.qtso.com

Once communication is established with the QIES ASAP system, the provider can access the CMS MDS Welcome Page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The Minimum Data Set (MDS) 3.0 Provider User's Guide provides more detailed information about the MDS system. It is available on the QTSO MDS 3.0 web site.

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

5.2 Timeliness Criteria

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

- **Completion Timing:**
  - For all non-comprehensive OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days from the Assessment Reference Date (ARD) (A2300).
  - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no more than 14 days from the Entry Date (A1600).
  - For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300).
  - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the signification correction respectively.
  - Entry and Death in Facility tracking records must be completed within 7 days of the Event Date (A1600 for an entry record; A2000 for a death-in-facility record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)
- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking information, the provider should encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:

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

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

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

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

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

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a quarterly assessment record (A0310A = 02) with no intervening discharge record (A0310F = 10, 11 or 12). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

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

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and the Minimum Data Set (MDS) 3.0 Provider User's Guide on the QTSO MDS 3.0 web site.

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

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS "are required to submit the resident assessment data described at §483.20…. in the manner necessary to administer the payment rate methodology described in §413.337." This provision includes the

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

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

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate: Type of Provider (Item A0200), Type of Assessment (A0310), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.

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

For instances when the provider determines that an event date (ARD, entry date, and discharge date) or type of assessment item (A0310) is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment, ensuring that the clinical information is accurate.

5.8 Special Manual Record Correction Request

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

1. The record is a test record inadvertently submitted as production.
2. The record has the wrong submission requirement in item A0410.
3. The record has the wrong facility ID in the control item FAC_ID.

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility **must** submit the completed form to the State Agency via certified mail through the United States Postal Service (USPS). The State Agency **must** approve the provider's request and submit a signed form to the QIES Help Desk via certified mail through the USPS.

- In cases of an EOT-R 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 patient's last therapy session 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.

Examples:

1. When rehabilitation therapy begins during the middle of a Medicare Part A stay, a Start of Therapy OMRA may optionally be performed with an ARD set for within 5 to 7 days after the earliest start of therapy date (items O0400A5, O0400B5, or O0400C5). The Start of Therapy OMRA changes the RUG payment rate previously established by a previous PPS assessment from the earliest start of therapy date through the end of the standard payment period. **Consider Example 1**.

    - EXAMPLE 1. The 14-Day assessment is performed with an ARD on Day 14. This assessment establishes the RUG payment for Days 15 through 30. Rehabilitation therapy starts on Day 18 and a Start of Therapy OMRA is performed with an ARD 6 days later on Day 24. The Start of Therapy OMRA will change the RUG payment starting on Day 18 until Day 30 (the end of the standard payment period).

2. The unscheduled Start of Therapy assessment changes the RUG payment rate for days prior to the ARD of that Start of Therapy assessment. Because of this policy, there are cases where a Start of Therapy OMRA can change the RUG payment rate for an entire standard payment period. **Consider Example 2**.

    - EXAMPLE 2. The scheduled 14-day assessment is performed with ARD on Day 14 of the stay. This 14-day assessment establishes the RUG payment rate for the standard Day 15 to Day 30 payment period. Rehabilitation therapy had started on Day 13. The facility opts to perform a Start of Therapy OMRA with ARD on Day 19 (6 days after the start of therapy). This Start of Therapy OMRA will change the RUG payment beginning with Day 13 through Day 30 (the end of the standard payment period). In this case, the HIPPS code from the Start of Therapy OMRA will be used for the entire Day 15 through Day 30 payment period and the 14-day assessment will not be used for billing. If the entire set of claims for the stay is reviewed, then there will be no HIPPS code with an Assessment Indictor code for the 14-day assessment. This does not present a SNF billing compliance problem. Examination of all the assessments and claims will indicate that a 14-day assessment was performed but that the Start of Therapy OMRA controlled the payment rate for the entire Day 15 to Day 30 payment period.

    Example 2 also illustrates that there are cases where a single Start of Therapy OMRA can change the RUG payment rate in 2 separate payment periods. In Example 2, the Start of

Therapy OMRA changes the RUG payment rate for the last 2 days (Days 13 and 14) of the 5-Day assessment payment period and all of the days (Days 15 through 30) of the 14-Day assessment payment period.

3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed with an ARD set for within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. **Example 3** presents the most common situation.

    - EXAMPLE 3. Rehabilitation therapy ends on Day 20 of a Medicare stay. An End of Therapy OMRA is performed with ARD on Day 22 and the Medicare Non-Therapy RUG (Z0150A) is billed from Day 21 (day after the last day therapy provided) to the end of the current payment period of Day 30.

4. Consider Example 4 where a scheduled PPS assessment has set the payment rate for the next payment period and then an End of Therapy OMRA is conducted before the beginning of that payment period.

    - EXAMPLE 4. The PPS 30-day assessment is performed with ARD on Day 27 to establish a Medicare RUG (Z0100A) for the Day 31 to Day 60 payment period. Rehabilitation therapy ends on Day 26 and an End of Therapy OMRA is performed with ARD on Day 29. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 27 through Day 30. The Medicare ***Non-Therapy*** RUG from the 30-day assessment is then billed for the next payment period. The Non-Therapy RUG from the 30-day assessment is used since all therapy had previously ended.

5. Consider Example 5 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment.

    - EXAMPLE 5. The End of Therapy OMRA assessment is performed with an ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25 through Day 30. The Medicare ***Non-Therapy*** RUG (Z150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.

6. Consider Example 6, a complicated example where an End of Therapy OMRA is performed, followed shortly by a scheduled PPS assessment, and then therapy is resumed at the prior level and this is reported with the Resumption of Therapy items

(O0450A and O0450B) being added to the End of Therapy OMRA converting it to an End of Therapy OMRA reporting Resumption of Therapy (EOT-R).

- EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30-Day assessment is then performed with an ARD on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and the EOT-R items (O0450A, and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.

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.

The first Change of Therapy OMRA evaluation occurs on Day 7 after the most recent assessment ARD (except in cases where the last assessment is an EOT-R, as outlined in Chapter 2) and the provision of therapy services are evaluated for the first COT observation period (Day 1 through Day 7 after the assessment ARD). If the provision of therapy services during this 7 day period no longer reflects the RUG-IV classification category on the most recent PPS assessment (as described in Chapter 2), then a Change of Therapy OMRA must be performed with the ARD on Day 7 of the COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed and changes in the provision of therapy services would next be evaluated on Day 14 after the most recent assessment ARD using the second COT observation period (Day 8 through Day 14 after the assessment ARD). If a different RUG-IV classification category results for Day 14, then a Change of Therapy OMRA must be performed with an ARD on Day 14, which is Day 7 of that COT observation period, and payment is set retroactively back to the beginning of that COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed with an ARD on Day 14 and the evaluation of the change in therapy services provided would next be evaluated on Day 21 after the most recent assessment ARD using the third COT observation period (Day 15 through Day 21 after the assessment ARD). This process continues until the next scheduled or unscheduled PPS assessment used for payment. When a new PPS assessment is performed (Change of Therapy OMRA, any other unscheduled PPS assessment, or scheduled PPS assessment), then the COT OMRA

evaluation process restarts the day following the ARD of that intervening assessment. If at any point, rehabilitation therapy ends before the last day of a COT observation period and an End of Therapy OMRA is performed with an ARD set for on or prior to Day 7 of the COT observation period, then the change of therapy evaluation process ends until the next PPS assessment used for payment reflecting the utilization of skilled therapy services.

7. Example 7 presents a case where a Change of Therapy OMRA is performed.
    - EXAMPLE 7. The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were reflective of the RUG-IV classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed with an ARD set for Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different Rehabilitation category results and a Change of Therapy OMRA is performed with an ARD set for Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the COT observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA.
8. If a new PPS assessment used for payment occurs with an ARD set for on or prior to the last day of a COT observation period, then a Change of Therapy OMRA is not required for that observation period. Example 8 illustrates this case.
    - EXAMPLE 8. An SCSA is performed with an ARD of Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed with an ARD on Day 17. Rather, the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22.
9. Example 9 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a COT observation period.
    - EXAMPLE 9. The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No Change of Therapy OMRA is performed with an ARD on Day 21 and the change of therapy evaluation process is discontinued.

Table 3 presents the types of unscheduled assessments, the second AI digit associated with each assessment type, and the payment impact for standard payment periods.

Table 3. Assessment Indicator Second Digit Table

Second Digit Values	Assessment Type	Impact on Standard Payment Period
0	Either a scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment OR an OBRA assessment not coded as a PPS assessment	• No impact on the standard payment period (the assessment is not unscheduled). • If the second digit value is 0, then the first digit must be 1 through 6, indicating a scheduled PPS assessment or an OBRA assessment not coded as a PPS assessment. • If the first digit value is a 6, then the second digit value must be 0.
1	Either an unscheduled OBRA assessment **or** Swing Bed CCA Do NOT use if • Combined with any OMRA • Medicare Short Stay assessment	• If the ARD of the unscheduled assessment is not within the ARD window of any scheduled PPS assessment, including grace days (the first digit is 0): — Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. • If the ARD of the unscheduled assessment is within the ARD window of a scheduled PPS assessment, not using grace days: — Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period. • If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment: — Use the Medicare RUG (Z0100A) from the start of the standard payment period.
2	Start of Therapy OMRA Do NOT use if • Medicare Short Stay assessment • Combined with End of Therapy OMRA • Combined with unscheduled OBRA • Combined with Swing Bed CCA	• If the unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): — Use the Medicare RUG (Z0100A) from the unscheduled assessment's earliest start of therapy date (speech-language pathology services in O0400A5, occupational therapy in O0400B5, or physical therapy in O0400C5) through the end of standard payment period. • If the unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of standard payment period. This is not a valid assessment and it will not be accepted by CMS.
3	Start of Therapy OMRA combined with either an unscheduled OBRA assessment **or** a Swing Bed CCA Do NOT use if • Medicare Short Stay assessment • Combined with End of Therapy OMRA	• If unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A): — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the end of standard payment period. • If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.

(continued)

Table 3. Assessment Indicator Second Digit Table (continued)

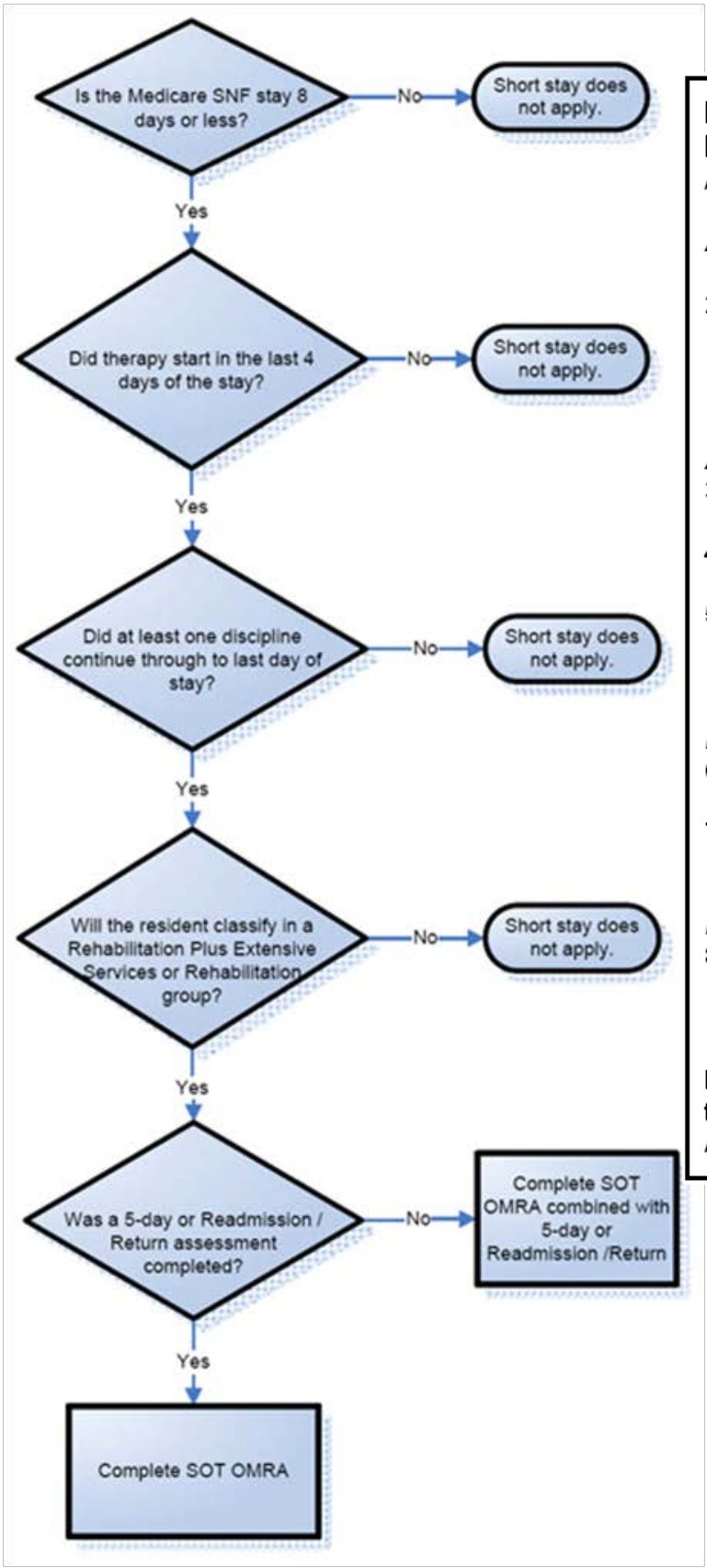
Second Digit Values	Assessment Type	Impact on Standard Payment Period
A	End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R); **whether or not** combined with unscheduled OBRA assessment and **whether or not** combined with Swing Bed CCA Do NOT use if • Combined with Start of Therapy OMRA • Medicare Short Stay assessment	• Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date (speech-language pathology services in O0400A6, occupational therapy in O0400B6, or physical therapy in O0400C6) through the day before the resumption of therapy date (O0450B). • Use the Medicare RUG (Z0100A) from the assessment (used for SNF/PPS) immediately preceding this End of Therapy OMRA, and bill this RUG from the resumption of therapy date (O0450B) through the end of the standard payment period in which the resumption of therapy occurs.
B	Start of Therapy OMRA combined with End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R) Do NOT use if • Medicare Short Stay assessment • Combined with unscheduled OBRA • Combined with Swing Bed CCA	• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.
C	Start of Therapy OMRA combined with End of Therapy OMRA **reporting** Resumption of Therapy (EOT-R) and combined with either an unscheduled OBRA assessment **or** Swing Bed CCA Do NOT use if • Medicare Short Stay assessment	• If unscheduled assessment gives a therapy group Medicare RUG (Z0100A): — Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date. — Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the day before the resumption of therapy date (O0450B). — Use the unscheduled assessment Medicare RUG (Z0100A) from the resumption of therapy date through the end of the standard payment period. • If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.

(continued)

special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but not combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.
2. **A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A covered stay (including weekends).** The end of Medicare stay date (A2400C) minus the earliest start date for the three therapy disciplines (O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). Therapy is considered to be ongoing when:
   - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
   - The resident's SNF benefit exhausted and therapy continued to be provided, or
   - The resident's payer source changed and therapy continued to be provided.
8. **The RUG group assigned to the Start of Therapy OMRA must be Rehabilitation Plus Extensive Services or a Rehabilitation group (Z0100A).** If the RUG group assigned is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, the assessment will be rejected.

Medicare Short Stay Assessment Algorithm



Medicare Short Stay Assessment Requirements:
All 8 must be true

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

ARD Requirements:
3. Must be Day 8 or earlier of Part A stay
4. Must be last day of Part A stay (see Item 2400 instructions)
5. Must be no more than 3 days after the start of therapy, not including the start of therapy date.

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

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

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

CALCULATION OF TOTAL REHABILITATION THERAPY MINUTES

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and all minutes in group therapy for non-Medicare classification. For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes.

Skip this section if therapy is not provided.

In Steps #1 through #3 in calculating Rehabilitation Therapy Minutes, retain all decimal places in the calculated values. Values where decimal points are retained are indicated by an asterisk (*).

STEP # 1

Calculate the total minutes for speech-language pathology services as follows:

> Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.
>
> Total Minutes* = _____

For Medicare classification the 25% group therapy limitation applies as follows:

> If allocated group minutes (one-quarter of O0400A3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.
>
> Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Speech-Language Pathology Services Minutes* = _____

STEP # 2

Calculate the total minutes for occupational therapy as follows:

Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400B3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes* = _____

STEP # 3

Calculate the total minutes for physical therapy as follows:

Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or one-quarter of the group minutes for Medicare classification and record as Total Minutes.

Total Minutes* = _____

For Medicare classification, the 25% group therapy limitation applies as follows:

If allocated group minutes (one-quarter of O0400C3) divided by Total Minutes is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes* = _____

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes* = _____

MEDICARE SHORT STAY ASSESSMENT
RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

STEP # 1

Set the Medicare Short Stay Indicator (Z0100C) as follows:

RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment. To be considered a Medicare Short Stay assessment and use the special RUG-IV short stay rehabilitation therapy classification, all eight of the following conditions must be met:

1. **The assessment must be a Start of Therapy OMRA (Item A0310C = 1).** This assessment may be performed alone or combined with any OBRA assessment or combined with a PPS 5-day or readmission/return assessment. The Start of Therapy OMRA may not be combined with a PPS 14-day, 30-day, 60-day, or 90-day assessment. The Start of Therapy OMRA should also be combined with a discharge assessment when the end of Part A stay is the result of discharge from the facility, but should not be combined with a discharge if the resident dies in the facility or is transferred to another payer source in the facility.
2. **A PPS 5-day (Item A0310B = 01) or readmission/return assessment (A0310B = 06) has been performed.** The PPS 5-day or readmission/return assessment may be performed alone or combined with the Start of Therapy OMRA.
3. **The ARD (Item A2300) of the Start of Therapy OMRA must be on or before the 8th day of the Part A Medicare covered stay.** The ARD minus the start of Medicare stay date (A2400B) must be 7 days or less.
4. **The ARD (Item A2300) of the Start of Therapy OMRA must be the last day of the Medicare Part A stay (A2400C).** See instructions for Item A2400C in Chapter 3 for more detail.
5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6. **Rehabilitation therapy (speech-language pathology services, occupational therapy or physical therapy) started during the last 4 days of the Medicare Part A stay (including weekends).** The end of Medicare stay date (Item A2400C) minus the earliest start date for the three therapy disciplines (Items O0400A5, O0400B5, or O0400C5) must be 3 days or less.
7. **At least one therapy discipline continued through the last day of the Medicare Part A stay.** At least one of the therapy disciplines must have a dash-filled end of therapy date (Items O0400A6, O0400B6, or O0400C6) indicating ongoing therapy or an end of therapy date equal to the end of covered Medicare stay date (Item A2400C). Therapy is considered to be ongoing when:
    - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
    - The resident's SNF benefit exhausted and therapy continued to be provided, or
    - The resident's payer source changed and therapy continued to be provided.

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an 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 (AAA) 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 Assessment

An assessment must be completed according to the designated Medicare PPS assessment schedule**. If a scheduled Medicare-required assessment or an OMRA 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. 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 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 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 is no longer a SNF Part A resident, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.

However, there are instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP system. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

In situations 2-6, the provider may use the OBRA Admission assessment to bill for all days of covered care associated with Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. The ARD of the OBRA Admission assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day assessment.

When an OBRA Admission assessment does not exist, 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 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for days 1-14 **or** days 15-30. This assessment may only cover **one** payment period. If the ARD of the valid OBRA assessment falls outside the ARD window of the 5-day and 14-day PPS assessments (including grace days), the

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 PPS assessment. 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.

Term	Abbreviation	Definition
Comatose (Coma)		Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he or she may or may not open his or her eyes, does not speak, and does not move his or her extremities on command or in response to noxious stimuli (e.g., pain).
Comprehensive Assessment		Requires completion of the MDS and review of CAAs, followed by development and/or review of the comprehensive care plan.
Confusion Assessment Method	**CAM**	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.
Constipation		A condition of more than short duration where someone has fewer than three bowel movements a week or stools that are usually hard, dry, and difficult and/or painful to eliminate.
Continence		Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.
Daily Decision Making		Includes: choosing clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.
Delirium		Acute onset or worsening of impaired brain function resulting in cognitive and behavioral symptoms such as worsening confusion, disordered expression of thoughts, frequent fluctuation in level of consciousness, and hallucinations.
Delusion		A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.

(continued)

Term	Abbreviation	Definition
Designated Local Contact Agency		Each state has designated a local contact agency responsible for contacting the individual with information about community living options. This local contact agency may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state contractor.
Disorganized Thinking		Having thoughts that are fragmented or not logically connected.
Dose		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."
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.
Dually Certified Facilities		Nursing facilities that participate in both the Medicare and Medicaid programs.
Duplicate Assessment Error		A fatal record error that results from a resubmission of a record previously accepted into the CMS MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.
Entry Date		The initial date of admission/entry to the nursing home, or the date on which the resident most recently re-entered the nursing home after being discharged (whether or not the return was anticipated).
Epilepsy		A chronic neurological disorder that is characterized by recurrent unprovoked seizures, as a result of abnormal neuronal activity in the brain.
External Condom Catheter		Device attached to the shaft of the penis like a condom and connected to a drainage bag.

(continued)

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
1	—	1-1	~~2011 Edition~~
1	—	1-1	Contributions provided by the numerous people, organizations, and stakeholders listed below are very much acknowledged by CMS. Their collective hard work and dedication over the past several years in the development, testing, writing, formatting, and ongoing review and maintenance of the MDS 3.0 RAI Manual, MDS 3.0 Data Item Set, and MDS 3.0 Data Specifications have resulted in a new RAI process that increases clinical relevancy, data accuracy, clarity, and notably adds more of the resident voice to the assessment process. We wish to give thanks to all of the people that have contributed to making this manual possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.
1	—	1-1	**Experts in Long Term Care** Elizabeth Ayello, PhD, RN Barbara Bates-Jensen, PhD, RN, CWOCN Robert P. Connolly, MSW Kate Dennison, RN, RAC-MT Linda Drummond, MSN Rosemary Dunn, RN Elaine Hickey, RN, MS Karen Hoffman, RN, MPH Christa Hojlo, PhD Carol Job, RN RAC-CT Sheri Kennedy, RN, BA, MSEd., RAC-MT Steve Levenson, MD, CMD Carol Maher, RN-BC, RAC-CT Michelle McDonald, RN, MPH Jan McCleary, MSA, RN Dann Milne, PhD Tracy Burger Montag, RN, BSN, RAC-CT Teresa M. Mota, BSN, RN, CALA, WCC, CPEHR John Morris, PhD, MSW Diane Newman, RNC MSN, CRNP, FAAN Terry Raser, RN, CRNAC, RAC-CT Therese Rochon, RNP, MSN, MA Debra Saliba, MD, MPH Rena Shephard, MHA, RN, RAC-MT, C-NE Ann Spenard, MSN, RNC, WCC Pauline (Sue) Swalina, RN Mary Van de Kamp, MS/CCC-SLP Nancy Whittenberg Sheryl Zimmerman, PhD

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
1	—	1-2	**Organizations and Stakeholders** Academy of Nutrition and Dietetics ~~American Association of Homes & Services for the Aging~~ American Association of Nurse Assessment Coordinators American Health Care Association American Health Information Management Association American Hospital Association American Medical Directors Association American Nurses Association Association of Health Facility Survey Agencies – RAI Panel Commonwealth Fund interRAI Kansas Department on Aging Leading Age National Association of Directors of Nursing Administration/Long Term Care National Association of Subacute and Post Acute Care The National Consumer Voice for Quality Long Term Care ~~formerly NCCNHR~~ State Agency RAI Coordinators and RAI Automation Coordinators State Quality Improvement Organizations US Department of Veterans Affairs
1	—	1-3	**Contractors** **RTI International** Roberta Constantine, RN, PhD Rajiv Ramakrishnan, BA Karen Reilly, Sc.D.
1	—	1-3	**Stepwise Systems, ~~INC~~Inc** Robert Godbout, PhD David Malitz, PhD **CMS** Ellen M. Berry, PT CMS Regional Office RAI Coordinators Thomas Dudley, MS, RN Penny Gershman, MS, CCC-SLP Lori Grocholski, MSW, LCSW Renee Henry, MSN, RN Alice Hogan, PMP Alesia Hovatter, MPP Melissa Hulbert, Director—Division of Advocacy and Special

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
			Issues John Kane Jeanette Kranacs, Director - Division of Institutional Post-Acute Care Sheila Lambowitz, Director (Retired)—Division of Institutional Post Acute Care Shari Ling, MD Stella Mandl, BSW, BSN, PHN, RN Mary Pratt, MSN, RN~~, MSN~~, Director—Division of Chronic and Post-~~-~~Acute Care MaryBeth Ribar, MSN, RN Karen Schoeneman, ~~Deputy Technical~~ Director (Retired)—Division of Nursing Homes John E. V. Sorensen Christina Stillwell-Deaner, RN, MPH, PHP Michael Stoltz Daniel Timmel John Williams, Director—Division of National Systems Cheryl Wiseman, MPH, MS ~~State RAI Coordinators~~ ~~State Automation Coordinators~~ ~~AHFSA RAI Panel~~
1	—	1-4	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/Downloads/MDS30Appendix_B.pdf ~~http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.~~
1	1.1	1-5	The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction,

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
			clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations[1]. [1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/images/stories/documents/inhc.pdf.
1	1.2	1-5 & 1-6	The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization ~~guidelines~~Guidelines. The utilization of the 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:
1	1.2	1-6	• **Minimum Data Set.** 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., admission, quarterly, annual, significant change, significant correction, discharge, entry tracking, PPS assessments, etc.) 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** ~~(CAA)~~ is the further investigation of triggered areas, ~~and is completed~~ to determine if the care

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
			area triggers ~~are issues that~~ require interventions and care planning. The~~re are~~ **CAA** r~~R~~esources provided as a courtesy to facilities in Appendix C. These resources include ~~are~~ a compilation of checklists ~~of~~ and Web links ~~resources~~ that may be helpful in performing the assessment of a triggered care area. The use of these resources are not mandatory and ~~are included in Appendix C and~~ represent neither an all-inclusive list nor government endorsement. — **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.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).
1	1.3	1-6& 1-7	Over time, the various uses of the MDS have expanded. While its primary purpose i~~a~~s an assessment tool ~~is~~ used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the 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 ~~the hospital swing bed program.~~ ~~N~~non-critical access hospitals with a swing bed agreement. ~~Swing bed providers~~ They are required to complete the MDS for reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS).
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 ~~the~~ 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

Chapter	Section	Page	Change
			provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at ~~(~~www.cms.gov/Manuals/IOM/list.asp~~)~~ for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing. ~~(The Medicare Benefit Policy Manual is located at www.cms.gov/Manuals/IOM/itemdetail.asp)~~ • **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and Medicaid-certified nursing home in the country. The Nursing Home Compare tool (http://www.medicare.gov/NHCompare) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.
1	1.3	1-8	Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide an RN to ~~conduct or~~ conduct or coordinate the assessment and sign off the assessment as complete. In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT ~~member~~ completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's

Chapter	Section	Page	Change
			problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.
1	1.4	1-8	Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.
1	1.4	1-9	**b. Decision Making~~/Diagnosis~~**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs ~~problems~~. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered care areas in the CAA ~~decision-making~~ process. Understanding the causes and relationships between a resident's clinical issues and needs ~~problems~~ and discovering the "whats" and "whys" of the resident's clinical issues ~~problems~~ and needs; finding out who the resident is and consideration for incorporating ~~putting the~~ his or her needs, interests, and lifestyle choices ~~of the resident~~ into the ~~at the center of care~~ delivery of care is key to this step of the process. **c. Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and care plan interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' active participation in the process. **d.~~c.~~ Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other

Track Changes
from Chapter 1 V1.08
to Chapter 1 V1.09

Chapter	Section	Page	Change
			legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care. ~~**d. Identification of Outcomes** – Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting residents' participation in the process.~~ **f. Evaluation—Critically** reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.
1	1.4	1-9 & 1-10	The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, ~~to~~ care plan development, ~~to~~ care plan implementation, and finally to evaluation. This manual will ~~feature~~ refer to this process ~~this pathway~~ throughout several ~~the~~ chapter discussions. If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor. The key to ~~understanding and~~ successfully using the RAI process ~~and successfully using it~~ is ~~believing~~ understanding that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care.

Chapter	Section	Page	Change
			In short, it works.
1	1.4	1-10	• **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), and the ~~an~~ interdisciplinary team, ~~and appropriate resident-specific approaches to care,~~ residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases. • **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing ~~using~~ the CA~~T~~As) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is ~~must be~~ accommodated in the care plan.
1	1.5	1-11	**Goals** The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for ~~quality indicators,~~ quality measure~~s~~ reporting~~,~~ and Medicare SNF PPS reimbursement (via resource utilization group~~s~~ [RUG~~s~~] classification).
1	1.6	1-12	The MDS is completed for all residents in Medicare- or Medicaid-

Chapter	Section	Page	Change
			certified nursing homes and non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).
1	1.7	1-13	Appendix H: MDS 3.0 Item Sets ~~Forms~~
1	1.7	1-14	Page length change.
1	1.8	1-15	MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities ~~under the Conditions of Participation (COP). B~~by regulation at CFR 483.75(l)(2)(3) and 483.75(l)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by: Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html. The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember

Chapter	Section	Page	Change
			that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes. **Contractual Agreements** Providers, who are part of a ~~chain~~ corporation, may release data to their corporate office or parent company but not to other providers within their ~~chain~~ corporate organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).
1	1.8	1-16	~~https://www.cms.gov/MDSPrivacyActStatement.pdf~~
1	1.8	1-17	Page length and page number change.

Track Changes
from Chapter 2 V1.08
to Chapter 2 V1.09

Chapter	Section	Page	Change
2	2.8	2-40	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.
2	2.8	2-44	Discharge Assessment A0310F = 10 or 11 | Must be set ~~on~~ for the day of discharge.
2	2.9	2-48	• In cases where a resident is classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and experiences a planned or unplanned discontinuation of therapy services for three or more consecutive calendar days and the resident is discharged from the facility ***on*** the third day of missed therapy services, then no EOT OMRA is required. If the facility chooses to complete an EOT OMRA in this situation, it may be combined with the discharge assessment. • 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.
2	2.9	2-49 & 2-50	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 ~~that~~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: NOTE: When an EOT-R is completed, the Therapy S~~s~~tart D~~d~~ate (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. ~~the date of the Resumption of therapy on the EOT-R (O0450B).~~ If therapy is ongoing, the Therapy E~~e~~nd D~~d~~ate (O0400A6, O0400B6, and O0400C6) would be filled out with dashes. 4. 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

Chapter	Section	Page	Change
			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.
2	2.8	2-51	• If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS Assessment, the SNF may choose to complete the PPS Assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is ***on or prior to*** ~~***before***~~ Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS Assessment ARD. Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10. • In cases where a resident is discharged from the SNF ***on or prior to*** Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the discharge assessment.
2	2.9	2-52	**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), ~~unscheduled PPS assessment (COT, EOT, SOT),~~ the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used. • 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

Chapter	Section	Page	Change
			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.
2	2.9	2-53	If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in ~~Chapter 2 of~~ this manual and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software the coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15). 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

Chapter	Section	Page	Change
			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.
2	2.9	2-53	Added new definition box. 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.
2	2.10 to 2.12	2-54 to 2-60	Page length change.
2	2.12	2-61	***Medicare-required Scheduled Assessment and Discharge Assessment*** • ARD (Item A2300) must be set ~~on a~~for ~~day~~the day of discharge (Item A2000) **and** the date of discharge falls within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
2	2.12	2-62	***Start of Therapy OMRA and Discharge Assessment*** • ARD (Item A2300) must be set ~~on~~ for the day of discharge (Item A2000) and the date of discharge must fall~~s~~ within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). The ARD must set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
2	2.12	63	Page length change.
2	2.12	2-64	***End of Therapy OMRA and Discharge Assessment*** • ARD (Item A2300) must be set ~~on~~ for the day of discharge (Item A2000) **and** the date of discharge falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The ARD must set by no more than two days after the date of discharge.

Track Changes
from Chapter 2 V1.08
to Chapter 2 V1.09

Chapter	Section	Page	Change
			(See Section 2.8 for further clarification.)
2	2.12	65	Page length change.
2	2.12	66	Page length change.
2	2.12	2-67	***Start and End of Therapy OMRA and Discharge Assessment*** • ARD (Item A2300) must be set ~~on~~ for the day of discharge (Item A2000) **and** the date of discharge falls within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). The ARD must set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
2	2.12	2-68	Page length change.
2	2.12	2-69	***Change of Therapy OMRA and Discharge Assessment*** • ~~EOT~~ COT OMRA and Discharge item set. • ARD (Item A2300) must be set ~~on~~ for the day of discharge (Item A2000) **and** be on the last day of a COT 7-day observation period. The ARD must set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
2	2.13	2-70	Page length change.
2	2.13	2-71	***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.

Chapter	Section	Page	Change
			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.
2	2.13	2-72	Page length change.
2	2.13	2-72 & 2-73	***Early PPS Assessment*** 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.
2	2.13	2-73 & 2-74	***Late PPS Assessment*** If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the ~~omission~~ error was identified. If the ARD on the late assessment is set for **prior to the end of the ~~payment~~ period during which the late assessment would have controlled the payment,** had the ARD been set timely, and/or **no intervening assessments have occurred**, ~~for the Medicare-required assessment that was missed,~~ **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 ~~all covered days up to the ARD at the default rate and on and after the~~**

Chapter	Section	Page	Change
			~~ARD at~~ 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 days~~for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. ~~31 through 40 and at the HIPPS code from the assessment beginning on day 41.~~ 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 ~~payment period~~** ~~for the Medicare-required assessment that was missed~~ **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 ~~an~~ the assessment. The ARD can be no earlier than the day the error~~omission~~ was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely ~~for that payment period~~ at the default rate regardless of the HIPPS code calculated from the late assessment**. For example, a Medicare-required 14-day assessment with an ARD of D~~d~~ay 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace a different ~~the next regularly scheduled~~ Medicare-required assessment. In the example above, ~~T~~the SNF would ~~then~~also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover D~~d~~ays 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF

Chapter	Section	Page	Change
			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. ~~beginning with the day the assessment would have controlled payment ninesbeginning with the day the assessment would have controlled payment~~
2	2.13	2-74	***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. ~~may be used to bill for some Part A days.~~ 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

Chapter	Section	Page	Change
			policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

<table>
<tr><td>2</td><td>2.13</td><td>2-74</td><td>Added new definitions box.

DEFINITIONS

INTERVENING ASSESSMENT

Refers to an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment.

DAYS OUT OF COMPLIANCE

Refers 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) of an assessment.</td></tr>
<tr><td>2</td><td>2.13</td><td>2-75</td><td>Errors on a + Medicare Assessment</td></tr>
<tr><td>2</td><td>2.14</td><td>2-76</td><td>Page number change.</td></tr>
</table>

2	2.15	2-77	Replaced table.

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

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	ISC	Description
01	01,02,06,99	0	10,11,99	NC	Comprehensive
01	01,02,06,07	1,2,3	10,11,99	NC	Comprehensive
01	02,07	4	10,11,99	NC	Comprehensive
03	01 thru 06,99	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 06,99	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 06	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

2	2.15	2-78	Replaced table.

~~OBRA RFA (A0310A)~~	~~PPS RFA (A0310B)~~	~~OMRA (A0310C)~~	~~SB Clinical Change (A0310D)~~	~~Entry/ Discharge (A0310F)~~	~~ISC~~	~~Description~~
~~99~~	~~01 thru 06~~	~~0,1,2,3,4~~	~~0~~	~~10,11,99~~	~~SP~~	~~PPS~~
~~99~~	~~01 thru 07~~	~~0,1,2,3,4~~	~~1~~	~~10,11,99~~	~~SP~~	~~PPS~~
~~99~~	~~07~~	~~1~~	~~0~~	~~99~~	~~SS~~	~~SOT OMRA~~
~~99~~	~~07~~	~~1~~	~~0~~	~~10,11~~	~~SSD~~	~~SOT OMRA and Discharge~~
~~99~~	~~07~~	~~2,3~~	~~0~~	~~99~~	~~SO~~	~~EOT , EOT-R or COT OMRA~~
~~99~~	~~07~~	~~2,3~~	~~0~~	~~10,11~~	~~SOD~~	~~EOT , EOT-R or COT OMRA and Discharge~~
~~99~~	~~99~~	~~0~~	~~0~~	~~10,11~~	~~SD~~	~~Discharge~~
~~99~~	~~99~~	~~0~~	~~0~~	~~01,12~~	~~ST~~	~~Tracking~~

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	ISC	Description
99	01 thru 06	0,1,2,3	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	SP	PPS
99	02 thru 05	4	0	10,11,99	SP	PPS
99	02 thru 05,07	4	1	10,11,99	SP	PPS
99	07	1	0	99	SS	SOT OMRA
99	07	1	0	10,11	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	SO	EOT, EOT-R or COT OMRA
99	07	2,3,4	0	10,11	SOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	SD	Discharge
99	99	0	0	01,12	ST	Tracking

Track Changes
from Chapter 3, Section I V1.08
to Chapter 3, Section I V1.09

Chapter	Section	Page	Change
3	I	I-3 & I-4	2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. ~~Do not include conditions that have been resolved or have no **longer** affected the resident's current functioning or plan of care, or that the resident has adjusted to as their "new normal," during the last 7 days.~~ Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. • 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.
3	I	I-4	**Coding Instructions** • If a disease or condition is **not** specifically listed, enter ~~check the "Other" box (I8000) and write in~~ the diagnosis and ~~the~~ ICD code ~~and name for that diagnosis~~ in item I8000, Additional active diagnoses.

Track Changes
from Chapter 3, Section K V1.08
to Chapter 3, Section K V1.09

Chapter	Section	Page	Change
3	K	K-4	**Steps for Assessment** *This item compares the resident's weight in the ~~current~~7-day look back period ~~observation period~~ with his or her weight at two snapshots in time:*
3	K	K-5	**For Subsequent Assessments** 1. From the medical record, compare the resident's weight in the ~~current~~7-day look back period ~~observation period~~ to his or her weight in the observation period 30 days ago. 3. From the medical record, compare the resident's weight in the ~~current~~7-day look back period ~~observation period~~ to his or her weight in the observation period 180 days ago.
3	K	K-8	**Steps for Assessment** *This item compares the resident's weight in the ~~current~~7-day look back period ~~observation period~~ with his or her weight at two snapshots in time:*
3	K	K-8	Added Definitions box. DEFINITIONS 5% WEIGHT GAIN IN 30 DAYS Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight. 10% WEIGHT GAIN IN 180 DAYS Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.
3	K	K-9	**For Subsequent Assessments** 1. From the medical record, compare the resident's weight in the ~~current~~7-day look back period ~~observation period~~ to his or her weight in the observation period 30 days ago. 3. From the medical record, compare the resident's weight in the ~~current~~7-day look back period ~~observation period~~ to his or her weight in the observation period 180 days ago.

Track Changes
from Chapter 3, Section M, V1.08
to Chapter 3, Section M, V1.09

Chapter	Section	Page	Change
3	M0210	M-5	Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2 and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
3	—	M-6 to M-19	Page length change.

Track Changes
from Chapter 3, Section N V1.08
to Chapter 3, Section N V1.09

Chapter	Section	Page	Change
3	N	N-3	**Steps for Assessment** 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws ~~and Medicare~~) changed the resident's insulin orders during the look-back period.
3	N	N-4	**Health-related 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 ~~reduce the~~ medications wherever possible ~~need for or maximize the effectiveness of medications for all residents~~ and ensure that the medication is the most effective for the resident's assessed condition. ~~Therefore, a~~ • 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.
3	N	N-6	• N0410D, Hypnotic: Record the number of days ~~an~~ 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).
3	N	N-8	• 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 herbal and alternative medicine ~~such~~ products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm

Track Changes
from Chapter 3, Section O, V1.08
to Chapter 3, Section O, V1.09

Chapter	Section	Page	Change
3	O0100	O-4	Code only when the resident requires transmission-based precautions and ~~strict~~ single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections. Code for "~~strict~~ single room isolation" only when all of the following conditions are met:
3	O0100	O-5	If a facility transports a resident who meets the criteria for ~~strict~~ single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room ~~strict~~ isolation since it is still being maintained while the resident is in the facility.
3	O0400	O-28	Coding: O0400E1 would be coded 0, O0400E2 would be ~~coded 0~~left blank.

Track Changes
from Chapter 3, Section X V1.08
to Chapter 3, Section X V1.09

Chapter	Section	Page	Change
3	X	X-1	An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Item A0050 and the Section X items. All other MDS sections are skipped.
3	X	X-5	**Coding Instructions for X0600A, Federal OBRA Reason for Assessment** • Note that the Federal OBRA reason for assessment/tracking code in X0600A ~~does not have to~~must match the current value of A0310A on a modification request.~~ The entries may be different if the modification is correcting the Federal OBRA reason for assessment/tracking code.~~ • If item A0310A was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted. **Coding Instructions for X0600B, PPS Assessment** • Note that the PPS assessment code in X0600B does ~~not have to~~must match the current value of A0310B on a modification request.~~ The entries may be different if the modification is correcting the PPS assessment code.~~ • If item A0310B was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted. **Coding Instructions for X0600C, PPS Other Medicare Required Assessment—OMRA** • Fill in the boxes with the PPS OMRA code exactly as submitted for item A0310C "PPS—OMRA" on the prior erroneous record to be modified/inactivated. • Note that the PPS OMRA code in X0600C ~~does not have to~~must match the current value of A0310C on a modification request.~~ The entries may be different if the modification is correcting the PPS OMRA code.~~

Track Changes
from Chapter 3, Section X V1.08
to Chapter 3, Section X V1.09

Chapter	Section	Page	Change
			• If item A0310C was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.
3	X	X-5 & X-6	**Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)** • ~~Note that the code in X0600D does not have to match the current value of A0310D on a modification request. The entries may be different if the modification is correcting the Swing Bed clinical change assessment code.~~ • 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 we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.
3	X	X-6	**Coding Instructions for X0600F, Entry/discharge reporting** • Note that the Entry/discharge code in X0600F ~~does not have to~~must match the current value of A0310F on a modification request.~~ The entries may be different if the modification is correcting the Entry/discharge reason for completing the assessment or tracking record.~~ • If item A0310F was incorrect on an assessment that we previously submitted and accepted by the ASAP system, then the original assessment must be inactivated and a new record with a new date must be submitted.
3	X	X-7	**Coding Instructions for X0700A, Assessment Reference Date—Complete Only if X0600F = 99** • Note that the assessment reference date in X0700A ~~does not have to~~must match the current value of A2300 on a modification request. ~~The entries may be different if the modification is correcting the assessment reference date. The entries may also be different if the type of assessment/tracking record is being changed.~~ • ~~For example, if the incorrect QIES ASAP database record~~

Chapter	Section	Page	Change
			~~indicates an admission assessment but the record should have been an entry record, then the assessment reference date for the prior record is entered in Item X0700A (Assessment Reference Date). However, the new assessment reference date in A2300 would be blank. The assessment reference date is not active on an entry record. Instead, the entry date would be entered in item A1600.~~
3	X	X-7	**Coding Instructions for X0700B, Discharge Date—Complete Only If X0600F = 10, 11, or 12** • Note that the discharge date in X0700B ~~does not have to~~must match the current value of A2000 on a modification request.~~ The entries may be different if the modification is correcting the discharge date. The entries may also be different if the type of assessment/tracking record is being changed.~~
3	X	X-7	**Coding Instructions for X0700C, Entry Date—Complete Only If X0600F = 01** • Note that the entry date in X0700C ~~does not have to~~must match the current value of A1600 on a modification request.~~ The entries may be different if the modification is correcting the entry date. The entries may also be different if the type of assessment/tracking record is being changed.~~
3	X	X-9	**Coding Instructions for X0900D, Item Coding Error** • 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.
3	X	X-9	**Coding Instructions for X0900E, End of Therapy-Resumption (EOT-R) date** • Check the box if the ~~error in the prior QIES ASAP record was caused by an erroneous~~ End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the

Track Changes
from Chapter 3, Section X V1.08
to Chapter 3, Section X V1.09

Chapter	Section	Page	Change
			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.

Track Changes
from Chapter 4 V1.08
to Chapter 4 V1.09

Chapter	Section	Page	Change
4	4.10	4-16	**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.
4	4.10	4-17 to 4-24	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. Page length changes.
4	4.10	4-25	4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities: **F0800Q = 0~~not checked~~**
4	4.10	4-26 to 4-28	Page length change.
4	4.10	4-29	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~~not checked~~**
4	4.10	4-29	**11. Falls** 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.
4	4.10	4-30	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**

Track Changes
from Chapter 4 V1.08
to Chapter 4 V1.09

Chapter	Section	Page	Change
4	4.10	4-31	Page length change.
4	4.10	4-32	**13. Feeding Tubes** 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. 1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by: **K0510B1 = 1 OR K0510B2 = 1**
4	4.10	4-33 to 4-35	Page length change.
4	4.10	4-36	2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410B>= 1 AND N0410B<=7** 3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410C>= 1 AND N0410C<=7** 4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410D>= 1 AND N0410D<=7**
4	4.10	4-37 to 4-41	Page length change.

Track Changes
from Chapter 5 V1.08
to Chapter 5 V1.09

Chapter	Section	Page	Change
5	5.1	5-1	All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans. After completion of the required assessment and/or tracking record information, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:
5	5.2	5-2	• **Completion Timing:** — For all non-comprehensive OBRA and PPS assessments, the MDS Completion Date (Z0500B) ~~may~~ must be no later than 14 days from the Assessment Reference Date (ARD) (A2300). — For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) ~~should~~ must be no more than 14 days from the Entry Date (A1600). — For the Annual assessment, the CAA Completion Date (V0200B2) ~~may~~ must be no later than 14 days from the ARD (A2300). — For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) ~~may~~ must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the signification correction respectively.
5	5.3	5-5	1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.
5	5.7	5-12	When errors in an OBRA comprehensive or quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or quarterly assessment (Item ~~A0130A~~ A0310A = 01through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status

Chapter	Section	Page	Change
			or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.
5	5.7	5-12	When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

Track Changes
from Chapter 6 V1.08
to Chapter 6 V1.09

Chapter	Section	Page	Change
6	6.4	6-10	• In cases of an EOT-R 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 patient's last therapy session 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.
6	6.4	6-11 to 6-14	Page length change.
6	6.4	6-16	• Use the Medicare RUG (Z0100A) from the assessment (used for SNF/PPS) immediately preceding this End of Therapy OMRA, and bill this RUG from the resumption of therapy date (O0450B) through the end of the standard payment period in which the resumption of therapy occurs.
6	6.4	6-18	5. **The ARD (A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date.** This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6	6.4	6-20	Added text to text box. 5. Must be no more than 3 days after the start of therapy, not including the start of therapy date.
6	6.6	6-25	For Speech-Language Pathology Services (Items at O0400A), Occupational Therapy (Items at O0400B), and Physical Therapy (Items at O0400C), the MDS 3.0 separately captures minutes that the resident was receiving individual, concurrent, and group therapy (see Chapter 3, Section O for definitions) during the last 7 days. For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy. The total minutes used for RUG-IV classification include all minutes in individual therapy, one-half of the minutes in concurrent therapy, and all minutes in group therapy for

Track Changes
from Chapter 6 V1.08
to Chapter 6 V1.09

Chapter	Section	Page	Change
			~~FY2011 Medicare Part A and~~ non-Medicare classification. ~~Beginning with federal FY2012~~ For Medicare Part A classification, the total minutes used for RUG-IV classification include all minutes in individual therapy, one-half the minutes in concurrent therapy, and the group time is allocated among 4 residents and only one-fourth of the minutes of group time are included for the resident in the total minutes for RUG-IV classification. For Medicare Part A ~~(both FY2011 and FY2012)~~ there is a limitation that the group minutes cannot exceed 25% of the total minutes, a limitation that is applied by the grouper software. This limitation is applied after allocation of group minutes~~.for FY2012 Medicare in FY2012 but after no allocation of group minutes for FY2011 Medicare.~~
6	6.6	6-25	**STEP # 1** Add the individual minutes (O0400A1) and one-half of the concurrent minutes (O0400A2). Add all of the group minutes (O0400A3) for non-Medicare classification or ~~If classification is for Medicare for FY2011 add all of the group minutes (O0400A3) and record as Total Minutes. Otherwise beginning with FY 2012, add~~ one-quarter of the group minutes for Medicare classification and record as Total Minutes. Total Minutes* = _____ ~~When~~ For Medicare classification the 25% group therapy limitation applies ~~(i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes~~ as follows: If ~~total group minutes (O0400A3) for FY2011 Medicare classification or~~ allocated group minutes (one-quarter of O0400A3) ~~beginning with FY2012 Medicare classification~~divided by Total Minutes ~~(using group minutes allocation only for Medicare FY2012 classification)~~ is greater than 0.25, then add individual minutes (O0400A1) and one-half of concurrent minutes (O0400A2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes. Adjusted Minutes* = _____
6	6.6	6-26	**STEP # 2** Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). Add all of the group minutes (O0400B3) for non-Medicare classification or ~~If~~

Track Changes
from Chapter 6 V1.08
to Chapter 6 V1.09

Chapter	Section	Page	Change
			~~classification is for Medicare for FY2011 add all of the group minutes (O0400B3) and record as Total Minutes. Otherwise beginning with FY 2012, add~~ one-quarter of the group minutes for Medicare classification and record as Total Minutes. Total Minutes* = _____ For Medicare classification, ~~When~~ the 25% group therapy limitation applies ~~(i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes~~ as follows: If ~~total group minutes (O0400B3) for FY2011 Medicare classification or~~ allocated group minutes (one-quarter of O0400B3) ~~for FY2012 Medicare classification~~ divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.
6	6.6	6-26	**STEP # 3** Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). Add all of the group minutes (O0400C3) for non-Medicare classification or ~~If classification is for Medicare for FY2011 add all of the group minutes (O0400C3) and record as Total Minutes. Otherwise beginning with FY 2012, add~~ one-quarter of the group minutes for Medicare classification and record as Total Minutes. Total Minutes* = _____ ~~When~~ For Medicare classification, the 25% group therapy limitation applies ~~(i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes~~ as follows: If ~~total group minutes (O0400C3) for FY2011 Medicare classification or~~ allocated group minutes (one-quarter of O0400C3) ~~for FY2012 Medicare classification~~ divided by Total Minutes ~~(using group minutes allocation only for Medicare FY2012 classification)~~ is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.
6	6.6	6-29	5. **The ARD (Item A2300) of the Start of Therapy OMRA may not be more than 3 days after the start of therapy date**

Chapter	Section	Page	Change
			(Items O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date. This is an exception to the rules for selecting the ARD for a SOT OMRA, as it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy since therapy must have been able to be provided only 1-4 days.
6	6.8	6-52 to 6-54	**Early Assessment** 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. 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 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

Chapter	Section	Page	Change
			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

Chapter	Section	Page	Change
			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. ~~The SNF must complete a late assessment if the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare-required assessment (including the grace days) or an OMRA when the resident is still on Part A coverage. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for which the Medicare-required assessment would have been effective, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of Day 41 would be paid the default rate for Days 31 through 40 and at the HIPPS classification from the assessment beginning on Day 41.~~ ~~If the ARD of the late assessment is set after the end of the payment period for which the Medicare-required assessment would have been effective and the resident is still on Part A, the provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period at the default rate regardless of the HIPPS code calculated from the late assessment. For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment that covers Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services.~~

Track Changes
from Chapter 6 V1.08
to Chapter 6 V1.09

Chapter	Section	Page	Change
			Missed 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 is no longer a SNF Part A resident, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.
6	6.8	6-55	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.

Track Changes
from Appendix A V1.08
to Appendix A V1.09

Chapter	Section	Page	Change	
Appendix A	—	A-5	**Continence**	~~The capacity to hold urine or stool until it can be eliminated in a socially appropriate manner and location (e.g. commode, urinal, bedpan).~~ Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.
Appendix A	—	A-6	**Designated Local Contact Agency**	Each state has designated a local contact agency responsible for contacting the individual with information about community living options. This local contact agency may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state contractor.

Track Changes
from Appendix B V1.07
to Appendix B V1.08

Chapter	Section	Page	Change
Appendix B	All	B-1	~~Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts is located on the following website: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp.~~ Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts is located on the following website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30Appendix_B.pdf