DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare-Required SNF PPS Assessments

Skilled Nursing Facilities (SNFs) must assess the clinical condition of residents by completing required Minimum Data Set (MDS) 3.0 assessments. You must complete them for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF Prospective Payment System (PPS) in a covered Part A stay.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This educational tool provides the following information for SNF providers:

- MDS 3.0 background;
- Assessments overview (including scheduled, unscheduled, and combined assessments);
- Factors affecting the assessment schedule;
- Assessment results reporting; and
- A table of resources.

Helpful Terms

Admission – The date an individual enters the facility and admits as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m.

Assessment Indicator (AI) – A code used on a Medicare claim to indicate the type of assessment billed on the claim.

Assessment Reference Date (ARD) – The last day of the observation period the assessment covers.

ARD Window – The defined days when you must set the ARD. This does **not** include grace days.

Grace Days – The date range when you may set the ARD without penalty. Grace days apply only for scheduled assessments.

Assessment Window – The defined days when you may set the ARD. This includes grace days as applicable.

ICN 909067 February 2016

MDS 3.0 Background

The MDS 3.0 is a core set of 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 screening, clinical, and functional status items in the MDS 3.0 standardize communication about resident problems and conditions. The MDS 3.0 contains items that reflect the acuteness of the resident's condition, including diagnoses, treatments, and functional status. MDS 3.0 assessment data is personal information SNFs must collect and keep confidential according to Federal law.

State Assessment Requirements

Check your State requirements to ensure you meet them. Contact your State RAI coordinator with questions. For State RAI contact information, refer to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30Appendix_B.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The MDS 3.0 is one of three components of the Resident Assessment Instrument (RAI). The other two components include:

- **Care Area Assessment (CAA) Process** – Assists with systematic interpretations of the completed MDS 3.0; and
- **RAI Utilization Guidelines** – Provides guidance on when and how to use the RAI.

The complete RAI yields information about a resident's functional status, strengths, weaknesses, and preferences and offers guidance on further assessment once you identify problems.

The MDS 3.0 classifies residents into a Resource Utilization Group Version IV (RUG-IV) based on the average resources needed to care for someone with similar care needs. RUG-IV classifications help Medicare determine the Part A SNF PPS payment. The RUG-IV classification system includes eight major classification categories:

- Rehabilitation Plus Extensive Services;
- Rehabilitation;
- Extensive Services;
- Special Care High;
- Special Care Low;
- Clinically Complex;
- Behavioral Symptoms and Cognitive Performance Problems; and
- Reduced Physical Function.

HIPPS Codes

All SNF claims must include Health Insurance Prospective Payment System (HIPPS) codes for the assessments billed on the claim. This is a five-digit code that consists of a three-digit RUG-IV code and a two-digit AI.

For more information on the MDS 3.0 RAI and RUG-IV categories, refer to the "MDS 3.0 RAI Manual," Chapter 6, available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website.

Assessments Overview

The SNF PPS establishes a Medicare-required PPS assessment schedule. Each required assessment supports reimbursement for a range of days of a Part A covered stay. The schedule includes assessments performed around Days 5, 14, 30, 60, and 90 of the stay. Additional unscheduled assessments are required under specific circumstances. The next sections discuss the types of scheduled and unscheduled assessments.

Scheduled Medicare-Required PPS Assessments

The Medicare-required PPS assessment schedule includes **5-day**, **14-day**, **30-day**, **60-day**, and **90-day** scheduled assessments. Except for the first assessment (5-day assessment), each assessment is scheduled according to the resident's length of stay in Medicare-covered Part A care.

Complete the **Medicare-required 5-Day Assessment** when:

- The Part A resident admits to the SNF;
- The Part A resident readmits following a discharge assessment when return was not anticipated;
- The Part A resident returns more than 30 days after a discharge assessment when return was anticipated; and
- The resident leaves a Medicare Advantage (MA) Plan and becomes covered by Medicare Part A (the Medicare PPS schedule starts over as the resident now begins a Medicare Part A stay).

Conducting the Assessment

Each assessment must:

- Accurately reflect the resident's status;
- Be conducted or coordinated by a registered nurse with the appropriate participation of health care professionals;
- Include direct observation, as well as communication with the resident and direct care staff on all shifts; and
- Cover the Observation (Look Back) Period. The Observation Period is the time period when the resident's condition is captured by the MDS assessment. Do not code anything on the MDS that did not occur during the Observation Period.

SNF providers must complete these scheduled assessments according to the schedule and information in Table 1.

REMEMBER: Assessment Window = ARD Window + Grace Days

Table 1. Scheduled Assessments

Assessment Type	AI	ARD Window	Grace Days	Medicare Payment Days
5-day	10	Days 1–5	Days 6–8	Days 1–14
14-day	20	Days 13–14	Days 15–18	Days 15–30
30-day	30	Days 27–29	Days 30–33	Days 31–60
60-day	40	Days 57–59	Days 60–63	Days 61–90
90-day	50	Days 87–89	Days 90–93	Days 91–100

Scheduled Assessment Calendar

Using the tool below, enter the first day of Part A care in the field under Day 1 (mm/dd/yy). Dates when you can set the ARD, grace days, and dates when you cannot set the ARD will populate for you. The calendar is organized according to the Medicare payment period. To assure proper functionality of the Scheduled Assessment Calendar, please download a copy of this file.

5-day Assessment Payment Period

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14

14-day Assessment Payment Period

Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Day 22	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28
Day 29	Day 30					

30-day Assessment Payment Period

Day 31	Day 32	Day 33	Day 34	Day 35	Day 36	Day 37
Day 38	Day 39	Day 40	Day 41	Day 42	Day 43	Day 44
Day 45	Day 46	Day 47	Day 48	Day 49	Day 50	Day 51
Day 52	Day 53	Day 54	Day 55	Day 56	Day 57	Day 58
Day 59	Day 60					

60-day Assessment Payment Period

Day 61	Day 62	Day 63	Day 64	Day 65	Day 66	Day 67
Day 68	Day 69	Day 70	Day 71	Day 72	Day 73	Day 74
Day 75	Day 76	Day 77	Day 78	Day 79	Day 80	Day 81
Day 82	Day 83	Day 84	Day 85	Day 86	Day 87	Day 88
Day 89	Day 90					

90-day Assessment Payment Period

Day 91	Day 92	Day 93	Day 94	Day 95	Day 96	Day 97
Day 98	Day 99	Day 100				

Color Key

Green Days	Yellow Days	Red Days
Scheduled assessment ARD days	Grace days for scheduled assessment ARD days	ARD for scheduled assessment will incur penalty if set on these days

Unscheduled Assessments

You must complete assessments outside of the scheduled Medicare-required assessments in the situations described in Table 2.

Table 2. Unscheduled Assessment Types

Assessment Type	Assessment Acronym	Description
Significant Change in Status Assessment Called the Swing Bed Clinical Change Assessment for swing bed providers	SCSA	Complete when the SNF interdisciplinary team (IDT) determines a resident meets the **significant change** guidelines for either decline or improvement. A **significant change** is a decline or improvement in a resident's status that: • Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not "self-limiting" (for declines only); • Impacts more than one area of the resident's health status; and • Requires interdisciplinary review or revision of the care plan. A significant change may require referral for a Pre-admission Screening and Resident Review evaluation if a mental illness, intellectual disability, or related condition is present or suspected.
Significant Correction to Prior Comprehensive Assessment	SCPA	Complete when a **significant error** was made in the prior comprehensive assessment. A **significant error** is an error in an assessment where: • The resident's overall clinical status is not accurately represented (that is, miscoded) on the erroneous assessment; and • The error was not corrected via submission of a more recent assessment. A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and **not** incorrect coding of the MDS 3.0.
Start of Therapy-Other Medicare Required Assessment	SOT-OMRA	Complete only to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation group, CMS will not accept the assessment and you may not use it for Medicare billing. **This is an optional assessment.**
End of Therapy-Other Medicare Required Assessment	EOT-OMRA	Complete when: • The resident was in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group; • The resident does not receive any therapy services for 3 or more consecutive calendar days; and • The resident continues to require Part A SNF-level services.
EOT-OMRA with Resumption	EOT-R	Complete when: • Therapy resumes after the EOT-OMRA; • Therapy resumes within 5 days after the last day of therapy; and • Therapy services resumed at the same RUG-IV classification level with the same therapy plan of care.

Table 2. Unscheduled Assessment Types (cont.)

Assessment Type	Assessment Acronym	Description
Change of Therapy-Other Medicare Required Assessment	COT-OMRA	Generally, complete when: ▸ The resident received a level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation RUG-IV category; and ▸ The intensity of therapy (as indicated by the total reimbursable therapy minutes 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 based on the most recent assessment used for Medicare payment. Effective October 1, 2014, you may complete a COT-OMRA for a resident who is not currently classified into a RUG-IV therapy group in those rare cases where: ▸ The resident had qualified for a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay; and ▸ No discontinuation of therapy services occurred between Day 1 of the COT observation period for the COT-OMRA that classified the resident into the current non-therapy RUG-IV group and the ARD of the COT-OMRA that reclassified the resident into a RUG-IV therapy group. **NOTE:** The COT observation periods are successive 7-day windows. The first observation period begins on the day following the ARD set for the most recent scheduled or unscheduled assessment.* For example, if the ARD for a patient's Medicare-required 30-Day Assessment is set for day 30 and there are no intervening assessments, then the COT observation period ends on day 37.** * This does not apply when the most recent assessment was an EOT-R. For more information, refer to the "MDS 3.0 RAI Manual," Chapter 2, Section 2.9, available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website. ** Payment for a COT-OMRA would continue to the end of the standard Payment window, assuming that no intervening assessment occurred.

Complete these unscheduled assessments according to the requirements described in Table 3. Unlike the defined payment days for scheduled assessments, Medicare payment days for unscheduled assessments vary depending on the situation.

REMEMBER: Unscheduled assessments do not have grace days.

Table 3. Unscheduled Assessments

Assessment Type	AI	ARD Window	Medicare Payment Period: Start	Medicare Payment Period: End
SCSA **or** SCPA	01	No later than 14 days after significant change/error identified	The payment begins on the ARD of the assessment	End of standard payment period
SOT-OMRA	02	5–7 days after the start of therapy	Date of the first therapy evaluation	End of standard payment period
EOT-OMRA	04	1–3 days after all therapy discontinued	The day after all therapy discontinued – use HIPPS code Z0150A	End of standard payment period – use HIPPS code Z0150A
EOT-R	0A	1–3 days after all therapy discontinued	N/A*	N/A*
COT-OMRA	0D	Day 7 (last day) of the COT observation period	The first day of the COT observation period	End of standard payment period, or until interrupted by the next COT-OMRA assessment

* The EOT-R unscheduled assessment does not affect the Medicare payment period in a manner that has a start and end date. However, you must use applicable HIPPS codes to indicate when therapy stopped and started:

- 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); and
- 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 when the resumption of therapy occurs.

Medicare-Required Assessment Combinations

A Medicare unscheduled assessment that falls within a scheduled Medicare-required assessment window cannot be followed by the scheduled assessment later in that window—you must combine the two assessments with an ARD appropriate to the unscheduled assessment. If you completed a scheduled assessment and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. Table 4 provides guidance about combining assessments, including setting the ARD.

Table 4 does not cover every potential situation, just those that occur most commonly. For more information, refer to the "MDS 3.0 RAI Manual" available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website, or contact your Medicare Administrative Contractor (MAC). For MAC contact information, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

NOTE: You may never combine two Medicare-required scheduled assessments.

Table 4. Assessment Combinations

Assessment Type	AI	Assessment Window	Medicare Payment Period: Start	Medicare Payment Period: End
SCSA or SCPA **and** 5-day	11	▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 1–8	Earlier of ARD or beginning of standard payment period	Day 14
SCSA or SCPA **and** 14-day	21	▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 13–18	Earlier of ARD or beginning of standard payment period	Day 30
SCSA or SCPA **and** 30-day	31	▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 27–33	Earlier of ARD or beginning of standard payment period	Day 60
SCSA or SCPA **and** 60-day	41	▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 57–63	Earlier of ARD or beginning of standard payment period	Day 90
SCSA or SCPA **and** 90-day	51	▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 87–93	Earlier of ARD or beginning of standard payment period	Day 100
SOT-OMRA **and** 14-day	22	▸ 5–7 days after the start of therapy; **and** ▸ Within Days 13–18	Date of the first therapy evaluation	Day 30
SOT-OMRA **and** 30-day	32	▸ 5–7 days after the start of therapy; **and** ▸ Within Days 27–33	Date of the first therapy evaluation	Day 60
SOT-OMRA **and** 60-day	42	▸ 5–7 days after the start of therapy; **and** ▸ Within Days 57–63	Date of the first therapy evaluation	Day 90
SOT-OMRA **and** 90-day	52	▸ 5–7 days after the start of therapy; **and** ▸ Within Days 87–93	Date of the first therapy evaluation	Day 100
SOT-OMRA **and** SCSA or SCPA	03	▸ 5–7 days after the start of therapy; **and** ▸ No later than 14 days after change/error identified	Date of the first therapy evaluation	End of standard payment period
SOT-OMRA **and** SCSA or SCPA **and** 14-day	23	▸ 5–7 days after the start of therapy; **and** ▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 13–18	Date of the first therapy evaluation	Day 30
SOT-OMRA **and** SCSA or SCPA **and** 30-day	33	▸ 5–7 days after the start of therapy; **and** ▸ No later than 14 days after significant change/error identified; **and** ▸ Within Days 27–33	Date of the first therapy evaluation	Day 60

Table 4. Assessment Combinations (cont.)

Assessment Type	AI	Assessment Window	Medicare Payment Period: Start	Medicare Payment Period: End
SOT-OMRA **and** SCSA or SCPA **and** 60-day	43	5–7 days after the start of therapy; **and** No later than 14 days after significant change/error identified; **and** Within Days 57–63	Date of the first therapy evaluation	Day 90
SOT-OMRA **and** SCSA or SCPA **and** 90-day	53	5–7 days after the start of therapy; **and** No later than 14 days after significant change/error identified; **and** Within Days 87–93	Date of the first therapy evaluation	Day 100
EOT-OMRA **and** 14-day	24	1–3 days after all therapy discontinued; **and** Within Days 13–18	Day after all therapy discontinued	Day 30
EOT-OMRA **and** 30-day	34	1–3 days after all therapy discontinued; **and** Within Days 27–33	Day after all therapy discontinued	Day 30
EOT-OMRA **and** 60-day	44	1–3 days after all therapy discontinued; **and** Within Days 57–63	Day after all therapy discontinued	Day 90
EOT-OMRA **and** 90-day	54	1–3 days after all therapy discontinued; **and** Within Days 87–93	Day after all therapy discontinued	Day 100
COT-OMRA **and** 14-day	2D	Day 7 (last day) of the COT observation period; **and** Within Days 13–18	The first day of the COT observation period	Day 30
COT-OMRA **and** 30-day	3D	Day 7 (last day) of the COT observation period; **and** Within Days 27–33	The first day of the COT observation period	Day 60
COT-OMRA **and** 60-day	4D	Day 7 (last day) of the COT observation period; **and** Within Days 57–63	The first day of the COT observation period	Day 90
COT-OMRA **and** 90-day	5D	Day 7 (last day) of the COT observation period; **and** Within Days 87–93	The first day of the COT observation period	Day 100

Factors Affecting the Assessment Schedule

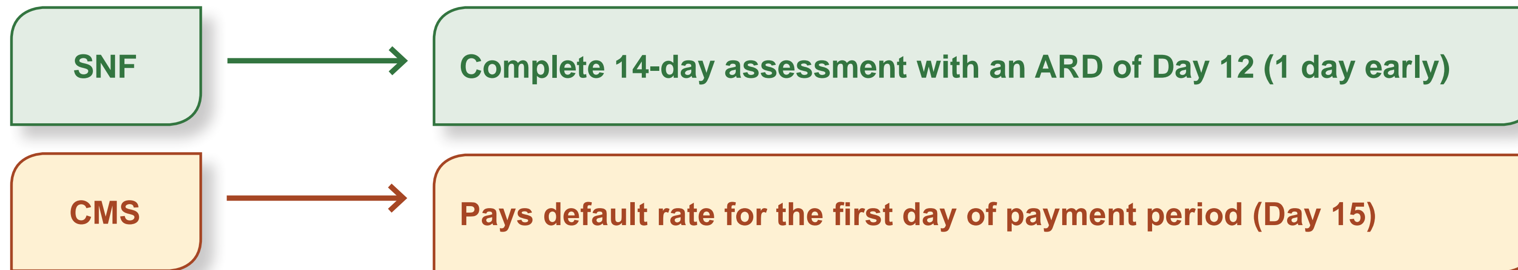
Noncompliance With Assessment Schedule

Medicare will pay the default rate for an assessment with an ARD outside the prescribed assessment window for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in review.

> **Default Rate**
> The default rate takes the place of the otherwise applicable Federal rate. It equals the rate paid for the RUG-IV group reflecting the lowest acuity level (generally lower than the Medicare rate payable if the SNF submitted a timely assessment).

Early Assessments

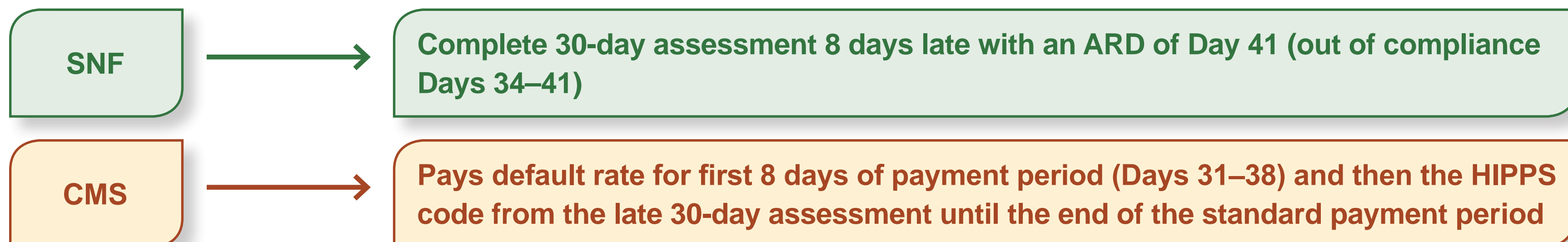
If you conduct an assessment earlier than the schedule indicates (that is, the ARD is not in the assessment window), you'll receive the default rate for the number of days the assessment was out of compliance.



Late Assessments

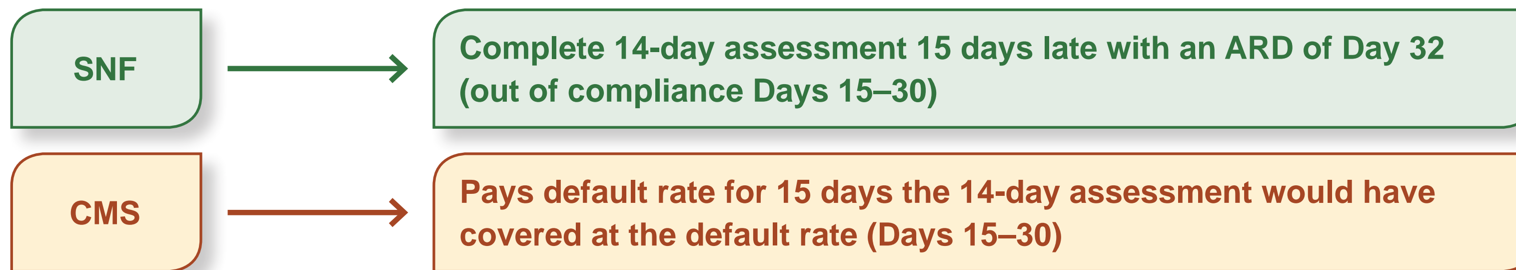
If you fail to set the ARD within the assessment window and the resident is still in a Part A covered stay, you must complete a late assessment.

If you set the ARD of the late assessment **prior** to the end of the period during which the late assessment would have controlled the payment (had the ARD been set timely) and no intervening assessments occurred, Medicare will pay the default rate for the number of days the assessment is out of compliance.



In this example, if there are no other assessments until the Medicare-required 60-day Assessment, bill the remaining 22 days (Days 39–60) using the HIPPS code on the late assessment.

If you set the ARD of the late assessment **after** the end of the period when the late assessment would have controlled payment (had the assessment been completed timely) or an intervening assessment occurred and the resident is still in a Part A covered stay, you must still complete the assessment. Bill all covered days when the late assessment would have controlled payment (had the ARD been set timely) at the default rate.



A late assessment cannot replace a different Medicare-required assessment. In this example, the SNF also needs to complete the 30-day Medicare-required assessment within Days 27–33, which includes grace days. The 30-day assessment would cover Days 31–60 as long as the beneficiary has SNF days remaining and is in a Part A covered stay.

Missed Assessments

If you do not set the ARD prior to the end of the last day of the assessment window and the resident is no longer in a Part A covered stay, **you may not bill for those days**. Medicare will not pay for these days because no Medicare-required assessment exists in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for the payment period.

You may bill at the default rate for a Medicare-required assessment not in QIES only in the following situations:

- The stay is less than 8 days within a spell of illness;
- The SNF is notified on an untimely basis of, or is unaware of, a Medicare Secondary Payer denial;
- The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A;
- The SNF is notified on an untimely basis of the revocation of a payment ban;
- The beneficiary requests a demand bill; or
- The SNF is notified on an untimely basis of, or is unaware of, a beneficiary's disenrollment from an MA Plan.

For instructions on billing when one of these exceptions applies, refer to the "MDS 3.0 RAI Manual," Chapter 6, Section 6.8, available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website.

Other Factors Impacting the Assessment Schedule

The following events may require adjustment of the assessment schedule:

- The resident dies on or before Day 8 of the SNF stay;
- The resident transfers or discharges on or before Day 8 of the SNF stay;
- The resident has a Short Stay (described below);
- The resident admits to an acute care facility and returns;
- The resident goes to an acute care facility over a midnight and for less than 24 hours (without being admitted);
- The resident goes on a Leave of Absence (LOA) from the SNF;
- The resident discharges from Part A skilled services, remains in the facility, and then returns to SNF Part A skilled level services; or
- There is a delay before the resident requires and receives skilled services.

For instructions on how to bill when one of these situations applies, refer to the "MDS 3.0 RAI Manual," Chapter 2, Section 2.13, available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website.

Short Stay

If the resident dies, discharges from the SNF, or discharges from a Part A covered stay on or before Day 8 of a Part A covered SNF stay, the short stay policy may apply. The short stay policy allows assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident received rehabilitation therapy and was not able to receive 5 days of therapy due to discharge from Medicare Part A. For more information on the requirements for a short stay, refer to Chapter 6 of the "MDS 3.0 RAI Manual" available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website.

Assessment Results Reporting

Report to QIES ASAP System

SNFs must transmit MDS 3.0 data to a Federal data repository, the QIES ASAP system. Required MDS 3.0 records include the assessments and tracking records mandated under the Omnibus Budget Reconciliation Act (OBRA) and the SNF PPS. Do not submit assessments completed for purposes other than OBRA and SNF PPS requirements (for example, private insurance, including MA Plans). For more information on transmitting MDS 3.0 data to the QIES ASAP system, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html on the CMS website.

Report on Medicare Claims

The Medicare claim should:

- Include appropriate HIPPS codes, in the order in which the beneficiary received that level of care, with revenue code 0022; and
- Include occurrence code 50 with the ARD for each assessment period represented on the claim (except for the default HIPPS code AAAxx).

NOTE: Do not submit a Medicare Part A SNF claim until the QIES ASAP system accepts the corresponding assessment and you receive a Final Validation Report indicating the State accepted the assessment.

Correcting an Assessment

Once completed, edited, and accepted into the QIES ASAP system, you may not change a previously completed MDS 3.0 assessment as the resident's status changes during the course of the stay. The MDS must be accurate as of the ARD. You should note minor status changes in the resident's record. A significant change in the resident's status warrants a new comprehensive assessment.

The electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Medicare does not recognize corrections made to the electronic record after acceptance or to the paper copy maintained in the medical record as proper corrections. Submit any corrections to the QIES ASAP system according to the MDS 3.0 Correction Policy described in the "MDS 3.0 RAI Manual," Chapter 5, Section 5.5, available to download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html on the CMS website.

Resources

For more information for SNFs, visit https://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html on the CMS website. Table 5 provides additional resources about SNF services.

Table 5. Resources

Resource	Website
MDS 3.0 for Nursing Homes and Swing Bed Providers	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
"Medicare Benefit Policy Manual"	Chapter 8 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
"Medicare Claims Processing Manual"	Chapter 6 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf Chapter 7 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf
MLN Matters® Article MM8458, "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
Provider Compliance	Comprehensive Error Rate Testing (CERT) Outreach and Education Task Force https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html Medicare Learning Network® (MLN) Provider Compliance https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
"Skilled Nursing Facility Consolidated Billing" Web-Based Training (WBT) Course	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
Skilled Nursing Facility section in the MLN Guided Pathways (GPs)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
Skilled Nursing Facility section of "Medicare Billing Information for Rural Providers and Suppliers"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html
SNF Consolidated Billing	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html

Table 5. Resources (cont.)

Resource	Website
"Skilled Nursing Facility Prospective Payment System" Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
"Swing Bed Services" Fact Sheet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html

The Medicare Learning Network® Disclaimers are available at http://go.cms.gov/Disclaimer-MLN-Product on the CMS website.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Check out CMS on: