Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	—	—	Updated language throughout to be gender neutral.
2	2.1	2-1	MDS assessments are also required to be completed and submitted to the iQIES system for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Other payors (e.g., Medicare Advantage Plans) may require Health Insurance Prospective Payment System (HIPPS) codes or other MDS data for billing purposes. However, facilities must not code assessments done for these purposes as PPS assessments in A0310B and A0310H or submit these assessments to iQIES. It is important to note that, in most cases, when the OBRA and PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. (Refer to Sections 2.10 and 2.11 for combining OBRA and PPS assessments).

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.3	2-3–2-4	• **Swing bed facility~~ies residents~~:** SNF~~wing beds of non-critical access hospitals that provide Part A skilled nursing facility~~-level services of non-critical access hospital (non-CAH) swing bed (SB) facilities were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed ~~providers~~facilities must assess the clinical condition of Medicare beneficiaries by completing ~~the~~certain MDS assessments for each Medicare resident receiving Medicare Part A SNF level of care in order to be reimbursed under the SNF PPS Patient Driven Payment Model. CMS began collect~~s~~ing MDS data for quality monitoring purposes of ~~swing bed~~non-CAH SB facilities effective October 1, 2010. Therefore, ~~swing bed~~SB providers must complete these assessments: Swing Bed PPS ~~assessment~~ (SP) and Swing Bed Discharge (SD) ~~in addition to the~~ assessments, and Entry Tracking and Death in Facility record~~s~~. Swing bed ~~providers~~facilities may also choose to complete an Interim Payment Assessment (IPA) at any time during the resident's stay in the facility. Swing bed providers must adhere to the same assessment requirements including, but not limited to, completion date, encoding requirements, submission time frame, and RN signature. Swing bed facilities must use the instructions in this manual when completing MDS assessments.
2	2.3	2-4	• Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures~~.html~~.
2	2.1–2.5	2-1–2-16	Page length changed due to revised content.

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.3	2-5	• **Adding Certified Beds:** — If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. — Medicare and Medicaid residents should not be placed in ~~a~~one of these additional beds until the facility has been notified that the beds has~~ve~~ been certified.
2	2.3	2-5	• **Change in Ownership:** There are two types of change in ownership transactions: — 1) Assumption of Assets and Liabilities: The~~is~~ is the mo~~re~~st common situation and requires the new owner to assume the assets and liabilities of the prior owner and retain the current CMS Certification Number (CCN) ~~number~~. In this case:
2	2.3	2-5	— 2) No Assumption of Assets or Liabilities: There are ~~also~~ situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases: o The beds are no longer certified. o There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, ~~provider~~CMS Certification N~~n~~umber (CCN), etc. o The previous owner would complete an OBRA Discharge assessment - return not anticipated, thus code A0310F = 10, A2000 = date of ownership change, and A210~~0~~5 = 02 or 03 for those residents who will remain in the facility. Refer to Chapter 3, Section A for additional guidance regarding A1805.

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.3	2-6	○ The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F = 01, A1600 = date of ownership change, A1700 = 1 (admission), and A1800~~5~~ = 02 or 03. Refer to Chapter 3, Section A for additional guidance regarding A1805. ○ Staff who worked for the previous owner ~~**cannot** use their previous QIES user IDs to submit assessments for the new owner as this is now a new facility. They **must** register for new user IDs for the new facility.~~**must** update their iQIES role to submit data for the CCN associated with the new owner.
2	2.3	2-6	— When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their ~~Regional Office~~CMS Location (formerly known as Regional Office), State ~~a~~Agency, and Medicare Administrative Contractor (MAC) for guidance. — When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their ~~Regional Office~~CMS Location, State ~~a~~Agency, and MAC for guidance.

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.5	2-9	**Assessment Reference Date (ARD)** refers to the ~~last day of~~specific endpoint for the observation (or "look-back") periods in the MDS assessment process. ~~that covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period~~. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7-day look-back period. If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding.
2	2.5	2-12	Examples of when there is **no** Interrupted Stay: • If a resident is discharged from Part A, **remains in the facility, and does not resume Part A within the 3-day interruption window**, it is **not** an interrupted stay. Therefore, a Part A PPS Discharge and a 5-Day assessment are both required (as long as resumption of Part A occurs within the 30-day window allowed by Medicare). • If a resident is discharged from Part A, **leaves the facility, and does not resume Part A within the 3-day interruption window**, it is not an interrupted stay and the Part A PPS Discharge and OBRA Discharge are both required and ~~may~~must be combined if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000) (see Part A PPS Discharge assessment in Section 2.5). Any return to the facility in this instance would be considered a new entry—that means that an Entry Tracking record, OBRA admission and/or 5-Day assessment would be required.

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.5	2-13	— **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record. — ~~**Optional State Assessment (OSA).** This is the set of items that may be required by a State Medicaid agency to calculate the RUG III or RUG IV HIPPS code. This is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. This is a standalone assessment.~~ — **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in iQIES.
2	2.5	2-14	**Leave of Absence (LOA)**, which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a: • Temporary home visit of at least one night; or • Therapeutic leave of at least one night; or • Hospital observation stay less than 24 hours and the hospital does not admit the resident. Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable. Upon return of the resident to the facility, providers should make appropriate documentation in the medical record regarding any changes in the resident's status. If ~~there are changes noted, they should be documented in the medical record~~significant changes in status are noted after an LOA, a Significant Change in Status Assessment (SCSA) may be necessary (see Section 2.6).

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.5	2-14	**Observation (Look-Back, Assessment) Period** is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look-back period will be captured. In other words, if it did not occur during the look-back period, it is not coded on the MDS.
2	2.6	2-17–2-20	Revised RAI OBRA-required Assessment Summary column four heading as follows: 7-day Observation Period (Look-Back) Consists Of
2	2.6	2-17–2-20	Revised RAI OBRA-required Assessment Summary column five heading as follows: 14-day Observation Period (Look-Back) Consists Of
2	2.6	2-19	Revised RAI OBRA-required Assessment Summary, row one, column eleven, as follows: May be combined with any OBRA or 5-Day ~~or~~and must be combined with a Part A PPS Discharge ~~Assessment~~if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)
2	2.6	2-19	Revised RAI OBRA-required Assessment Summary, row two, column eleven, as follows: May be combined with any OBRA or 5-Day ~~or~~and must be combined with a Part A PPS Discharge ~~Assessment~~if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.6	2-21	*Assessment Management Requirements and Tips for Comprehensive Assessments:* • The ARD (item A2300) is the last day of the observation/look-back period, and day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.6	2-25–2-26	• If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O010~~0~~10K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required. • An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. • If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O010~~0~~10K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.6	2-27	• **Decline in two or more of the following:** — Resident's decision-making ability has changed; — Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); — Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; — Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as ~~Extensive~~ partial/moderate assistance, ~~Total dependence~~substantial/maximal assistance, dependent, resident refused, or the ~~A~~activity ~~did not occur~~was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning;
2	2.6	2-28	• **Improvement in two or more of the following:** — Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, ~~Supervision, or Limited~~setup or clean-up assistance, or supervision or touching assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
2	2.6	2-28	2. ~~Mrs.~~Resident T required ~~minimal assistance~~supervision with ADLs. ~~She~~They fractured ~~her~~their hip and upon return to the facility require ~~extensive~~maximal assistance with all ADLs. Rehab has started and staff is hopeful ~~she~~they will return to ~~her~~their prior level of function in 4–6 weeks.

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.6	2-33	*Assessment Management Requirements and Tips for Non-Comprehensive Assessments:* • The ARD is considered the last day of the observation/look-back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
2	2.6	2-38	1. ~~Mr.~~Resident W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. ~~He~~They passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows: A0310F = 12 A2000 = 11-13-2011 A210~~0~~5 = ~~08~~13

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.6	2-39	1. ~~Mr.~~Resident S. was admitted to the nursing home on February 5, 2011 following a stroke. ~~He~~They regained most of ~~his~~their function and ~~was~~were discharged return not anticipated to ~~his~~their home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows: A0310F = 10 A2000 = 03-29-2011 A210~~0~~5 = 01 2. ~~Mr.~~Resident K. was transferred from a Medicare-certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows: A0310F = 10 A2000 = 12-12-2013 A210~~0~~5 = 02
2	2.6	2-40	1. ~~Ms.~~Resident C. was admitted to the nursing home on May 22, 2011. ~~She~~They tripped while at a restaurant with ~~her~~their ~~daughter~~child. ~~She~~They ~~was~~were discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows: A0310F = 11 A2000 = 05-31-2011 A210~~0~~5 = 0~~3~~4
2	2.6	2-41	• May be combined with ~~a~~any 5-Day ~~or Part A PPS Discharge Assessment when requirements for all assessments are met~~and must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000).

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.8	2-45–2-46	• Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay)**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment ~~can~~must also be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required. In situations in which the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) equals the day of discharge as listed in A2000.

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2	2.8	2-46	• ~~If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.~~ • If the End Date of the Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and ~~may~~must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) **must** be equal to the Discharge Date (A2000). The Part A PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met (please see Section 2.10 Combining PPS Assessments and OBRA Assessments). • If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required. [Note: made "must" bold font for emphasis.]
2	2.8	2-46	• The Part A PPS Discharge assessment m~~M~~ust be completed (item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days). • The Part A PPS Discharge assessment m~~M~~ust be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
2	2.8	2-47	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or ~~can be~~is combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Track Changes
from Chapter 2 v1.17.1R
to Chapter 2 v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
2		2-52	When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments ~~may~~must be combined. (See Sections 2.10 and 2.11 for details on combining a PPS assessment with a Discharge assessment.)
2	2.14	2-57	There ~~are two~~is one additional item set~~s~~ not listed in the above table~~. The first item set is~~ used for inactivation request records. This is the set of items active on a request to inactivate a record in iQIES. 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 second item set is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. This is the set of items required to calculate the RUG III or RUG IV HIPPS code.~~ ~~The item set for this type of record is the "Optional State Assessment" with an ISC code of OSA and is indicated by coding A0300 = 1.~~