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Chapter	Section	Page(s) in version 1.18.11	Change
3	—	—	Updated language throughout to be gender neutral.
3	—	—	Updated screen captures of all items.
3	A0050, A0410, A2000	A-1, A-2, A-11, A-12, A-41	Changed all instances of "QIES" and "the QIES ASAP system" to "iQIES".
3	—	A-1	**Intent:** The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident, potential care needs including access to transportation, and the home in which ~~he or she~~they resides~~, and the reasons for assessment~~.
3	A0050	A-1	• **Code 2, Modify existing record:** if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the Internet Quality Improvement and Evaluation System (iQIES)~~ Assessment Submission and Processing (ASAP) system~~.
3	A0200	A-3	**Coding Instructions** • **Code 1, nursing home (SNF/NF):** if a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF). • **Code 2, swing bed:** if a non-critical access hospital with swing bed approval.
3	A0200	A-3	**DEFINITION** **SWING BED** A rural non-critical access hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

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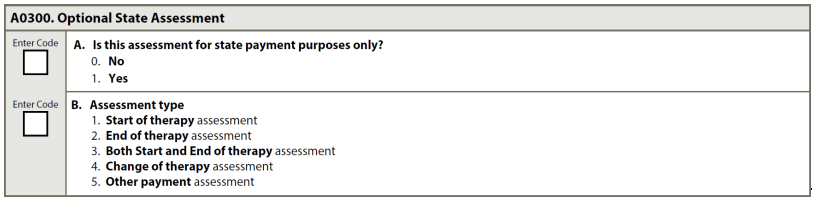
Chapter	Section	Page(s) in version 1.18.11	Change
3	A0300	A-4	~~A0300: Optional State Assessment~~  **A0300. Optional State Assessment** Enter Code ☐ **A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes** Enter Code ☐ **B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment
3	A0300	A-4	~~**Item Rationale**~~ • ~~Allows for collection of data required for state payment reimbursement.~~ ~~**Coding Instructions for A0300,**~~ **~~Optional State Assessment~~** • ~~Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.~~ • ~~If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.~~ ~~**Coding Instructions for A0300A,**~~ **~~Is this assessment for state payment purposes only?~~** • ~~Enter the value indicating whether your state requires this assessment for payment.~~ ~~**0.** No~~ ~~**1.** Yes~~

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A0300	A-4	~~**Coding Tips and Special Populations**~~ • ~~This assessment is optional, as it is not federally required; however, it may be required by your state.~~ • ~~For questions regarding completion of this assessment, please contact your State agency.~~ • ~~This must be a standalone assessment (i.e., cannot be combined with any other type of assessment).~~ • ~~The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes.~~ • ~~If your state does not require this record for state payment purposes, enter a value of "0" (No). If your state requires this record for state payment purposes, enter a value of "1" (Yes) and proceed to item A0300B, Assessment Type.~~
3	A0300	A-4	~~**Coding Instructions for A0300B, Assessment Type**~~ ~~Enter the number corresponding to the reason for completing this state assessment.~~ ~~**1.** Start of therapy assessment~~ ~~**2.** End of therapy assessment~~ ~~**3.** Both Start and End of therapy assessment~~ ~~**4.** Change of therapy assessment~~ ~~**5.** Other payment assessment~~
3	A0310	A-4	~~*For Comprehensive, Quarterly, and PPS Assessments, Entry and OBRA Discharge Records, and Part A PPS Discharge Assessment.*~~*For all Federally required assessments and records as well as all PPS assessments.*

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A0310	A-5	**Coding Instructions for A0310, Type of Assessment** *Enter the code corresponding to the reason or reasons for completing this assessment.* If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B), all requirements for both types of assessments must be met. See Chapter 2 ~~on assessment schedules~~, Section 2.10, Combining PPS Assessments and OBRA Assessments, for details of these requirements. Assessments completed for other reasons (e.g., to facilitate billing for Medicare Advantage Plans) are not coded in A0310 and are not submitted to iQIES.
3	A0310	A-7	**DEFINITION** **Part A PPS Discharge Assessment** A discharge assessment developed to inform current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; ~~or may~~and must be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).
3	A0310	A-9	• If a resident is discharged from SNF care, remains in the ~~SNF~~facility, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption.

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3	A0310	A-10	• If a resident leaves the SNF and does not return to resume Part A-covered services in the same SNF within the interruption window, an interrupted stay did not occur. In this situation, both the Part A PPS and OBRA Discharge assessments are 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)). If the resident returns to the same SNF, this would be considered a new Part A stay. An Entry Tracking record and 5-Day would be required on return. An OBRA Admission would be required if the resident was discharged return not anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.
3	A0310	A-10	• 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).
3	A0500	A-12	**Steps for Assessment** 1. Ask resident, family, significant other, and/or guardian~~, or~~ /legally authorized representative.
3	A1005	A-15	A1000~~0~~5: ~~Race/~~Ethnicity 

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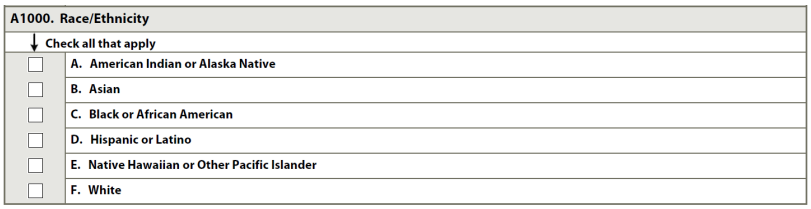
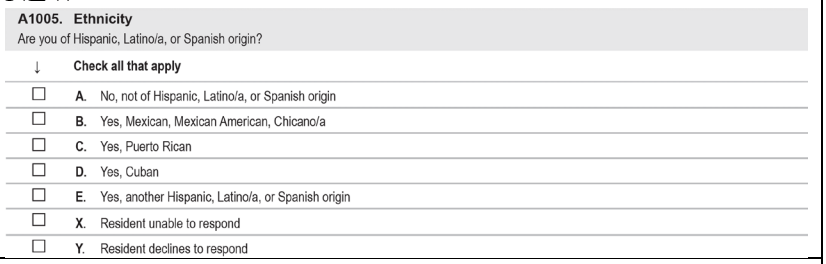
Chapter	Section	Page(s) in version 1.18.11	Change
3	A1005	A-15	Replaced screenshot. OLD  NEW 
3	A1005–A2400	A-16–A-62	Page length changed due to revised content.
3	A1005	A-16	**Item Rationale** • The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity. • The ethnicity data element uses a one-question multi-response format based on whether or not the resident is of Hispanic, Latino/a, or Spanish origin. Collection of ethnic data provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1005	A-16	• This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report ~~racial and~~ ethnic categories. Response choices A1005B through A1005E roll up to the Hispanic or Latino/a category of the OMB standard (see Definition Ethnicity). The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. • ~~Provides demographic race/ethnicity specific health trend information.~~ • Collection of ethnicity data is an important step in improving quality of care and health outcomes. • Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute-care settings. • These categories are NOT used to determine eligibility for participation in any Federal program. • For the source of these categories and definitions, see "Racial and Ethnic Categories and Definitions for NIH Diversity Programs and for Other Reporting Purposes, Notice Number: NOT-OD-15-089" available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-089.html. Additional information on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status is available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53.

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3	A1005	A-16	
			DEFINITIONS~~S~~ **~~RACE~~/ETHNICITY** **~~AMERICAN INDIAN OR ALASKA NATIVE~~** ~~A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.~~ **~~ASIAN~~** ~~A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.~~ **~~BLACK OR AFRICAN AMERICAN~~** ~~A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American."~~ **HISPANIC OR LATINO/A** A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term "Spanish Origin" can be used in addition to Hispanic or Latino/a. **~~NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER~~** ~~A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.~~ **~~WHITE~~** ~~A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.~~

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1005	A-17	**Steps for Assessment: Interview Instructions** 1. Ask the resident to select the category or categories that most closely correspond to ~~his or her race/~~their ethnicity from the list in A100~~0~~5. • Individuals may be more comfortable if this ~~and the preceding~~ question ~~are~~is introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005). 2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative. 3. Ethnic c~~C~~ategory definitions are provided to resident or family only if requested by them in order to answer the item. 4. Respondents should be offered the option of selecting one or more ~~racial~~ethnic designations. 5. Only use medical record documentation to code A1005, Ethnicity if the resident is unable to respond and no family member, ~~or~~ significant other, and/or guardian/legally authorized representative ~~is available, observer identification or~~provides a response for this item, ~~use medical record documentation may be used~~. 6. If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1005	A-17	**Coding Instructions** *Check all that apply.* • ~~Enter the race or~~If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident~~, family or significant other uses to identify him or her~~. • **Code X, Resident unable to respond:** if the resident is unable to respond. — In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, including X. Resident unable to respond. — If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.
3	A1005	A-18	• **Code Y, Resident declines to respond:** if the resident declines to respond. — When the resident declines to respond, code only Y. Resident declines to respond. — When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1005	A-18	**Examples** 1. Resident R is admitted following an acute cerebral vascular accident (CVA) with mental status changes and is unable to respond to questions regarding their ethnicity. Their spouse informs the nurse that Resident R is Cuban. **Coding:** A1005 would be coded as D. Yes, Cuban and X. Resident unable to respond. **Rationale:** If Resident R is unable to respond but their family, significant other, or legally authorized representative provided the response, code both that response and X. Resident unable to respond.
3	A1005	A-18	2. Resident K is admitted following a total hip arthroplasty and declines to respond when asked their ethnicity. **Coding:** A1005, Ethnicity would be coded as Y. Resident declines to respond. **Rationale:** If a resident declines to respond to this item, code only Y. Resident declines to respond. Do not use other resources (family, significant other, or legally authorized representative or medical record documentation) to complete A1005, Ethnicity when a resident declines to respond.

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3	A1010	A-19	A1010. Race 

A1010. Race
What is your race?

↓	Check all that apply
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-20	**Item Rationale** • The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to social determinants of health, including race. • Collection of A1010. Race provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards. • This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial categories (see Definitions: Race). Response choices A1010D through A1010J roll up to the Asian category of the OMB standard. Response choices A1010K through A1010N roll up to the Native Hawaiian or Other Pacific Islander category of the OMB standard. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. • Collection of race data is an important step in improving quality of care and health outcomes. • Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute-care settings. • These categories are NOT used to determine eligibility for participation in any Federal program.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-20	
			DEFINITION **RACE** **AMERICAN INDIAN OR ALASKAN NATIVE** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **ASIAN** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam. **BLACK OR AFRICAN AMERICAN** A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black” or “African American.” **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. **WHITE** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-20–A-21	**Steps for Assessment: Interview Instructions** 1. Ask the resident to select the category or categories that most closely correspond to the resident's race from the list in A1010, Race. • Individuals may be more comfortable if this question is introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their racial background. We would like you to tell us your racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005). 2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative. 3. Racial category definitions are provided only if requested in order to answer the item. 4. Respondents should be offered the option of selecting one or more racial designations. 5. Only use medical record documentation to code A1010, Race if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item. 6. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-21	**Coding Instructions** Check all that apply. • If the resident provides a response, check the box(es) indicating the race category or categories identified by the resident. • **Code X, Resident unable to respond:** if the resident is unable to respond. — In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, check all boxes that apply, including X. Resident unable to respond. — If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code as X. Resident unable to respond.
3	A1010	A-21	• **Code Y, Resident declines to respond:** if the resident declines to respond. — When the resident declines to respond, code only Y. Resident declines to respond. — When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records). • **Code Z, None of the above:** if the resident reports or it is determined from other resources (family, significant other, or legally authorized representative or medical records) that none of the listed races apply.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-22	**Examples** 1. Resident W has severe dementia with agitation. During the Admission assessment, they are unable to provide their race. Their child informs the nurse that Resident W is Korean and African American. **Coding:** A1010, Race would be coded as B. Black or African American, H. Korean, and X. Resident unable to respond. **Rationale:** If Resident W is unable to respond but their family, significant other, or legally authorized representative provided the response, code those responses and X. Resident unable to respond.
3	A1010	A-22	2. Resident Q declines to provide their race during the admission assessment stating "I'd rather not answer." **Coding:** A1010, Race would be coded as Y. Resident declines to respond. **Rationale:** If a resident declines to respond to this item, then code only Y. Resident declines to respond. Do not make attempts to code A1010, Race when a resident declines to respond based on other resources (family, significant other, or legally authorized representative or medical records).

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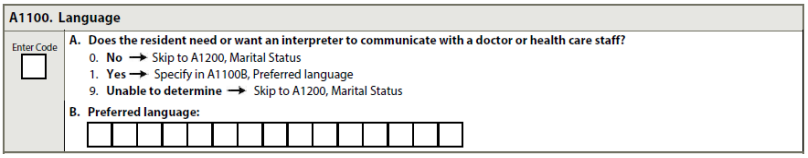
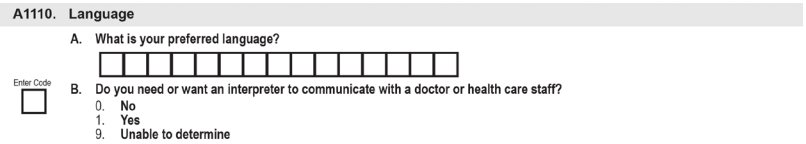
Chapter	Section	Page(s) in version 1.18.11	Change
3	A1010	A-22	3. Resident V, who is admitted to the SNF following a recent CVA resulting in confusion, is unable to answer when asked their race. Their family member reports that none of the listed races apply. **Coding:** A1010, Race would be coded as X. Resident unable to respond and Z. None of the above. **Rationale:** If a resident is unable to respond, family, significant other, or legally authorized representative input may be used to code A1010, Race and the assessor should code both the information determined via family, significant other, or legally authorized representative input or medical records (in this case, Z. None of the above) and X. Resident unable to respond.
3	A1110	A-23	A11~~0~~10: Language 
3	A1110	A-23	Replaced screenshot. OLD  A1100. Language Enter Code A. Does the resident need or want an interpreter to communicate with a doctor or health care staff? 0. No → Skip to A1200, Marital Status 1. Yes → Specify in A1100B, Preferred language 9. Unable to determine → Skip to A1200, Marital Status B. Preferred language: NEW  A1110. Language A. What is your preferred language? Enter Code B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine
3	A1110	A-23	**Health-related Quality of Life** • Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can ~~result in~~lead to social isolation, depression, resident safety issues, and unmet needs. • Language barriers can interfere with accurate assessment.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1110	A-23	**Planning for Care** • When a resident needs or wants ~~an~~ interpreter services, the nursing home ~~should~~must ensure that an interpreter is available. • An alternate method of communication also should be made available to help ~~to~~ ensure that basic needs can be expressed at all times~~, such as a~~ (e.g., communication board with pictures on it for the resident to point to ~~(~~,if able). • Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1110	A-23	**Steps for Assessment** 1. Ask for the resident's preferred language. 2. Ask the resident if ~~he or she~~they needs~~s~~ or wants~~s~~ an interpreter to communicate with a doctor or health care staff. 3. If the resident—even with the assistance of an interpreter—is unable to respond, a family member~~ or~~, significant other, and/or guardian/legally authorized representative should be asked. 4. If neither the resident nor a family member, significant other, nor guardian/legally authorized representative source is ~~available, review record~~able to provide a response for ~~evidence of a need for an interpreter~~this item, medical documentation may be used. ~~5. If an interpreter is wanted or needed, ask for preferred language.~~ 5. It is acceptable for a family member~~ or~~, significant other, and/or legally authorized representative to be the interpreter if the resident is comfortable with it and if the family member~~ or~~, significant other, and/or guardian/legally authorized representative will translate exactly what the resident says without providing ~~his or her~~their interpretation. [Note, steps have been renumbered with the additional of a new first step.]

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1110	A-24	**Coding Instructions for A1110A** • ~~**Code 0, no:** if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status.~~ • ~~**Code 1, yes:** if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.~~ • ~~**Code 9, unable to determine:** if no source can identify whether the resident wants or needs an interpreter. Skip to A1200, Marital Status.~~ • Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/or guardian/legally authorized representative and/or reviewing the medical record. • If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (—) in the first box. A dash indicates "no information." CMS expects dash use to be a rare occurrence.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1110	A-24	**Coding Instructions for A1110B** • **Code 0, No:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates there is no need or want of an interpreter to communicate with a doctor or health care staff. • **Code 1, Yes:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated. • **Code 9, Unable to determine:** if the resident is unable or declines to respond or any available source (family, significant other, guardian/legally authorized representative or medical records) cannot or does not identify the need or want of an interpreter.
3	A1110	A-24	~~**Coding Instructions for A1100B**~~ • ~~Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.~~
3	A1200	A-25	**Steps for Assessment** 1. Ask the resident about ~~his or her~~their marital status. 2. If the resident is unable to respond, ask a family member or other significant other. 3. If neither ~~source~~the family member nor significant other can report, review the medical record for information.

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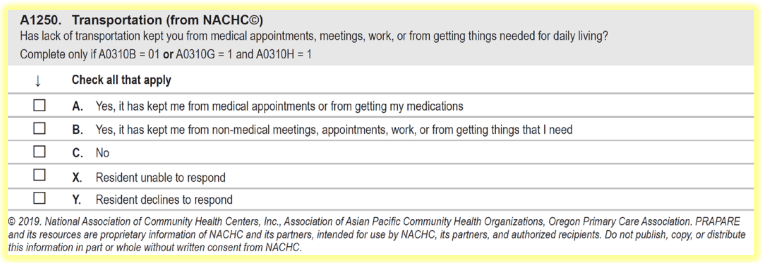
Chapter	Section	Page(s) in version 1.18.11	Change
3	A1250	A-26	**A1250. Transportation**  **A1250. Transportation (from NACHC©)** Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1 ↓ **Check all that apply** ☐ **A.** Yes, it has kept me from medical appointments or from getting my medications ☐ **B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need ☐ **C.** No ☐ **X.** Resident unable to respond ☐ **Y.** Resident declines to respond *© 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC.*
3	A1250	A-26	**Item Rationale** **Health-related Quality of Life** • Access to transportation for ongoing health care and medication access needs is essential for effective care management. • Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources. **Planning for Care** • Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1250	A-26	**Steps for Assessment: Interview Instructions** 1. Ask the resident: • "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?" • "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?" 2. Respondents should be offered the option of selecting more than one "yes" designation, if applicable. 3. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative. 4. Only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative may provide a response for this item, use medical record documentation. 5. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1250	A-27	**Coding Instructions** • **Code A, Yes, it has kept me from medical appointments or from getting my medications:** if the resident indicates that lack of transportation has kept the resident from medical appointments or from getting medications. • **Code B, Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need:** if the resident indicates that lack of transportation has kept the resident from non-medical meetings, appointments, work, or from getting things that the resident needs. • **Code C, No:** if the resident indicates that a lack of transportation has not kept the resident from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the resident needs. • **Code X, Resident unable to respond:** if the resident is unable to respond. — In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, check all boxes that apply, including X. Resident unable to respond. — If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1250 as only X. Resident unable to respond.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1250	A-27	• **Code Y, Resident declines to respond:** if the resident declines to respond. — When the resident declines to respond, code only Y. Resident declines to respond. — When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).
3	A1250	A-28	**Example** 1. Resident E is admitted with Multiple Sclerosis. They are confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No family, significant other, or legally authorized representative with related information is available, but their medical record indicates that their spouse uses their car to transport Resident E wherever they need to go. **Coding:** A1250 would be coded as C. No and X. Resident unable to respond. **Rationale:** If neither Resident E nor their family, significant other, or legally authorized representative was able to provide a response but the medical record documentation can provide the necessary information, code both the information in the medical record and X. Resident unable to respond.
3	A1500	A-30	Please see ~~https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html~~ https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html for CMS information on PASRR.

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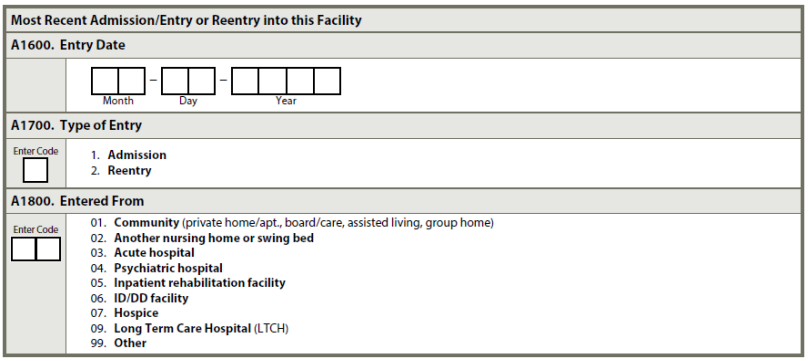
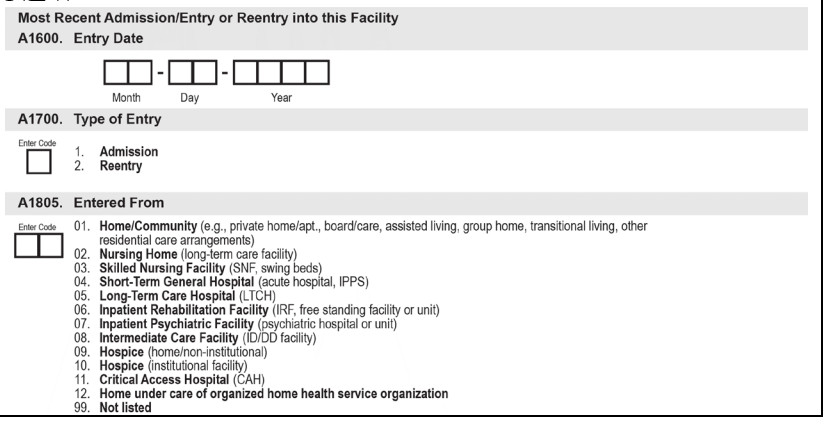
Chapter	Section	Page(s) in version 1.18.11	Change
3	A1600–A1805	A-34	A1600–A1800~~5~~: Most Recent Admission/Entry or Reentry into this Facility
3	A1600–A1805	A-34	Replaced screenshot. OLD  **Most Recent Admission/Entry or Reentry into this Facility** **A1600. Entry Date** Month – Day – Year **A1700. Type of Entry** Enter Code 1. **Admission** 2. **Reentry** **A1800. Entered From** Enter Code 01. **Community** (private home/apt., board/care, assisted living, group home) 02. **Another nursing home or swing bed** 03. **Acute hospital** 04. **Psychiatric hospital** 05. **Inpatient rehabilitation facility** 06. **ID/DD facility** 07. **Hospice** 09. **Long Term Care Hospital** (LTCH) 99. **Other** NEW  **Most Recent Admission/Entry or Reentry into this Facility** **A1600. Entry Date** Month – Day – Year **A1700. Type of Entry** Enter Code 1. **Admission** 2. **Reentry** **A1805. Entered From** Enter Code 01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. **Nursing Home** (long-term care facility) 03. **Skilled Nursing Facility** (SNF, swing beds) 04. **Short-Term General Hospital** (acute hospital, IPPS) 05. **Long-Term Care Hospital** (LTCH) 06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit) 07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit) 08. **Intermediate Care Facility** (ID/DD facility) 09. **Hospice** (home/non-institutional) 10. **Hospice** (institutional facility) 11. **Critical Access Hospital** (CAH) 12. **Home under care of organized home health service organization** 99. **Not listed**

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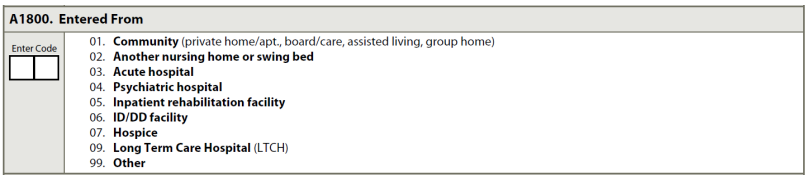
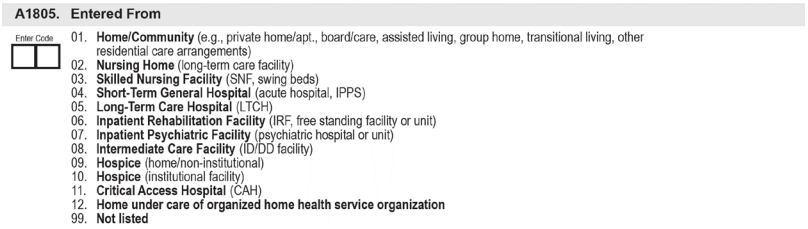
Chapter	Section	Page(s) in version 1.18.11	Change
3	A1600	A-35	**Coding Instructions** • Enter the most recent date of admission/entry or reentry to this facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010. • In the case of an interrupted stay, the return date (i.e., date of continuation of Medicare Part A stay in the same SNF) is entered in A1600 using the format above.
3	A1805	A-36	A1805: Entered From
3	A1805	A-36	Replaced screenshot. OLD  NEW 

Track Changes
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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1805	A-36	**Item Rationale** • ~~Understanding~~Knowing the setting ~~that~~ the individual was in immediately prior to facility admission/entry or reentry informs the delivery of services and care planning that the resident receives during their stay and may also inform discharge planning ~~and discussions~~. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings. • Demographic information.
3	A1805	A-36	**Steps for Assessment** 1. Review transfer and admission records. 2. Ask the resident and/or family member ~~or~~, significant others~~,~~ and/or guardian/legally authorized representative.

Chapter	Section	Page(s) in version 1.18.11	Change
3	A1805	A-36	**Coding Instructions** *Enter the ~~2~~two-digit code that ~~corresponds to~~best describes the ~~location or program~~setting the resident was ~~admitted from for~~in immediately preceding this admission/entry or reentry.* • **Code 01, Home/C~~c~~ommunity ~~(private home/apt, board/care, assisted living, group home)~~:** if the resident was admitted from a private home, apartment, board and care, assisted living facility ~~or~~, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. • **Code 02, ~~another n~~Nursing ~~h~~Home ~~or swing bed~~(long-term care facility):** if the resident was admitted from an institution ~~(or a distinct part of an institution)~~ that is primarily engaged in providing ~~skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.~~medical and non-medical care to people who have a chronic illness or disability.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1805	A-37	• **Code 03, ~~acute hospital:~~** ~~if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.~~**Skilled Nursing Facility (SNF, swing bed):** if the resident was admitted from a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes residents admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements. • **Code 04, ~~psychiatric hospital:~~** ~~if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.~~**Short-Term General Hospital (acute hospital/IPPS):** if the resident was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accepts a predetermined rate as payment in full.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1805	A-37	• **Code 05, Long-Term Care Hospital (LTCH):** if the resident was admitted from a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit. • **Code 05~~5~~6, i~~I~~npatient r~~R~~ehabilitation f~~F~~acility (IRF, free standing facility or unit):** if the resident was admitted from a~~n institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled, or sick persons. Includes IRFs that are units within acute care hospitals.~~ rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents admitted from a rehabilitation unit of a critical access hospital.
3	A1805	A-37	• **Code 07, Inpatient Psychiatric Facility (psychiatric hospital or unit):** if the resident was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. This category also includes residents admitted from a psychiatric unit of a critical access hospital. • **Code 0~~6~~8, Intermediate Care Facility (ID/DD ~~facility~~):** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals ~~who have~~with intellectual disabilities (ID) or developmental disabilities (DD). • **Code 09, Hospice (home/non-institutional):** if the resident was admitted from a community-based program for terminally ill persons.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1805	A-37	• **Code 07~~1~~0, ~~h~~Hospice (institutional facility):** if the resident was admitted from an inpatient program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. ~~Includes community-based or inpatient hospice programs.~~ • ~~**Code 09, long term care hospital (LTCH):** if the resident was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.~~
3	A1805	A-37	• **Code 11, Critical Access Hospital (CAH):** if the resident was admitted from a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge. • **Code 12, Home under care of organized home health service organization:** if the resident was admitted from home under care of an organized home health service organization. This includes only skilled services provided by a home health agency.
3	A1805	A-38	• **Code 99, ~~other~~Not listed:** if the resident was admitted from none of the above.
3	A1805	A-38	**Coding Tips and Special Populations** • If an individual was enrolled in a home-based hospice program enter **07~~9~~, Hospice**, instead of **01, Home/Community**.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1900	A-38	**Examples** 1. ~~Mrs.~~Resident H was admitted to the facility from an acute care hospital on 09/14/20~~13~~20 for rehabilitation after a hip replacement. In completing ~~her~~their Admission assessment, the facility entered 09/14/20~~13~~20 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0~~3~~4, ~~acute hospital~~Short-Term General Hospital (acute hospital, IPPS) in item A180~~0~~5, Entered From; and entered 09/14/20~~13~~20 in item A1900, Admission Date.
3	A1900	A-38	2. The facility received communication from an acute care hospital discharge planner stating that ~~Mrs.~~Resident H, a former resident of the facility who was discharged home return not anticipated on 11/02/20~~13~~20 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/20~~14~~21 and wished to return to the facility for rehabilitation after hospital discharge. ~~Mrs.~~Resident H returned to the facility on 2/15/20~~14~~21. Although ~~Mrs.~~Resident H was a resident of the facility in September of 20~~13~~20, ~~she was~~they were discharged home return not anticipated; therefore, the facility rightly considered ~~Mrs.~~Resident H as a new admission. In completing ~~her~~their Admission assessment, the facility entered 02/15/20~~14~~21 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0~~3~~4, ~~acute hospital~~Short-Term General Hospital (acute hospital, IPPS) in item A180~~0~~5, Entered From; and entered 02/15/20~~14~~21 in item A1900, Admission Date.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1900	A-39	3. ~~Mr.~~Resident K was admitted to the facility on 10/05/20~~13~~20 and was discharged to the hospital, return anticipated, on 10/20/20~~13~~20. ~~He~~They returned to the facility on 10/26/20~~13~~20. Since ~~Mr.~~Resident K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, ~~Mr.~~Resident K was considered as continuing in ~~his~~their current stay. Therefore, when the facility completed ~~his~~Resident K's Entry Tracking Record on return from the hospital, they entered 10/26/20~~13~~20 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 0~~3~~4, ~~acute hospital~~Short-Term General Hospital (acute hospital, IPPS) in item A180~~0~~5; and entered 10/05/20~~13~~20 in item A1900, Admission Date. Approximately a month after ~~his~~their return, ~~Mr.~~Resident K was again sent to the hospital, return anticipated on 11/05/20~~13~~20. ~~He~~They returned to the facility on 11/22/20~~13~~20. Again, since ~~Mr.~~Resident K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, ~~Mr.~~Resident K was considered as continuing in ~~his~~their current stay. Therefore, when the facility completed ~~his~~Resident K's Entry Tracking Record, they entered 11/22/20~~13~~20 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 0~~3~~4, ~~acute hospital~~Short-Term General Hospital (acute hospital, IPPS) in item A180~~0~~5; and entered 10/05/20~~13~~20 in item A1900, Admission Date.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1900	A-39	4. ~~Ms.~~Resident S was admitted to the facility on 8/26/20~~14~~21 for rehabilitation after a total knee replacement. Three days after admission, ~~Ms.~~Resident S spiked a fever and ~~her~~their surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent ~~Ms.~~Resident S to the emergency room and completed ~~her~~their OBRA Discharge assessment as return anticipated. The hospital called the facility to inform them ~~Ms.~~Resident S was admitted. A week into ~~her~~their hospitalization, ~~Ms.~~Resident S developed a blood clot in ~~her~~their affected leg, further complicating ~~her~~their recovery. The facility was contacted to readmit ~~Ms.~~Resident S for rehabilitative services following discharge from the hospital on 10/10/20~~14~~21. Even though ~~Ms.~~Resident S was a former patient in the facility's rehabilitation unit and was discharged return anticipated, ~~she~~they did not return within 30 days of discharge to the hospital. Therefore, ~~Ms.~~Resident S is considered a new admission to the facility. On ~~her~~their return, when the facility completed ~~Ms.~~Resident S's Admission assessment, they entered 10/10/20~~14~~21 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 0~~3~~4, ~~acute hospital~~Short-Term General Hospital (acute hospital, IPPS) in item A180~~0~~5, Entered From; and entered 10/10/20~~14~~21 in item A1900, Admission Date.
3	A1900	A-40	• Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A180~~0~~5 (Entered From). It is also tied to the concepts of a "stay" and an "episode." A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident's time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A1900	A-40	• When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A180~~0~~5 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A180~~0~~5 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began ~~his or her~~their first stay in the episode).
3	A2000	A-41	A2000: ~~OBRA~~ Discharge Date

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2000	A-41	**Coding Tips and Special Populations** • A Part A PPS Discharge assessment (NPE Item Set) is required under the SNF QRP when the resident's Medicare Part A stay ends, but the resident does not leave the facility. • ~~If a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), then both an OBRA Discharge assessment and a Part A PPS Discharge assessment are required; but these two assessments may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).~~ • The PPS Discharge assessment is completed whenever a Medicare Part A stay ends. The PPS Discharge assessment must be combined with the OBRA Discharge assessment when the Medicare Part A stay ends on or one day prior to the day of discharge from the facility. When the OBRA and Part A discharge assessments are combined, the ARD (A2300) must be equal to the day of discharge from the facility (A2000). • The PPS Discharge assessment is also completed when the resident's Medicare Part A stay ends, but the resident remains in the facility. When this occurs, the ARD (A2300) of the PPS Discharge assessment must be the last Medicare Part A covered day. The 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).
3	A2105	A-42	A21005: ~~OBRA~~ Discharge Status

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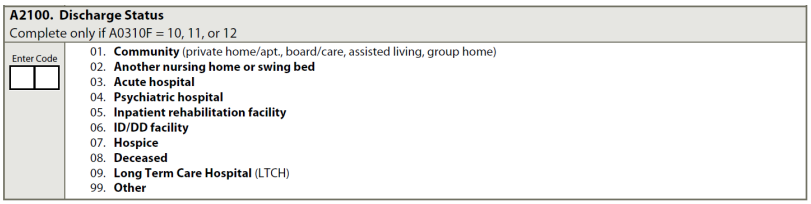
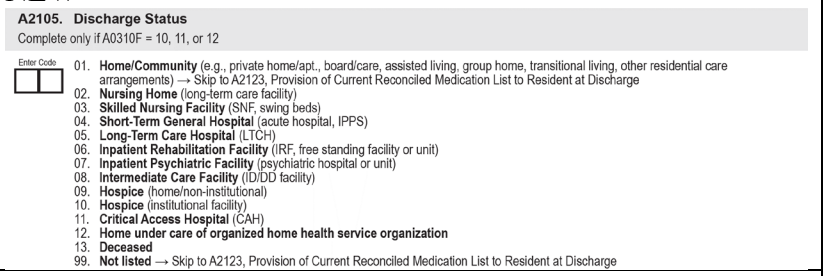
Chapter	Section	Page(s) in version 1.18.11	Change
3	A2105	A-42	Replaced screenshot. OLD  **A2100. Discharge Status** Complete only if A0310F = 10, 11, or 12 Enter Code 01. **Community** (private home/apt., board/care, assisted living, group home) 02. **Another nursing home or swing bed** 03. **Acute hospital** 04. **Psychiatric hospital** 05. **Inpatient rehabilitation facility** 06. **ID/DD facility** 07. **Hospice** 08. **Deceased** 09. **Long Term Care Hospital** (LTCH) 99. **Other** NEW  **A2105. Discharge Status** Complete only if A0310F = 10, 11, or 12 Enter Code 01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge 02. **Nursing Home** (long-term care facility) 03. **Skilled Nursing Facility** (SNF, swing beds) 04. **Short-Term General Hospital** (acute hospital, IPPS) 05. **Long-Term Care Hospital** (LTCH) 06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit) 07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit) 08. **Intermediate Care Facility** (ID/DD facility) 09. **Hospice** (home/non-institutional) 10. **Hospice** (institutional facility) 11. **Critical Access Hospital** (CAH) 12. **Home under care of organized home health service organization** 13. **Deceased** 99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
3	A2105	A-42	**Item Rationale** • This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings. • Demographic and outcome information.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2105	A-42	**Coding Instructions** *Select the ~~2~~two-digit code that corresponds to the resident's discharge status.* • **Code 01, Home/~~c~~Community ~~(private home/apt., board/care, assisted living, group home)~~:** if the resident was discharged to ~~location is~~ a private home, apartment, board and care, assisted living facility, ~~or~~ group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. • **Code 02, ~~another n~~Nursing ~~h~~Home ~~or swing bed~~(long-term care facility):** if the resident was discharged to ~~location is~~ an institution ~~(or a distinct part of an institution)~~ that is primarily engaged in providing ~~skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.~~medical and non-medical care to people who have a chronic illness or disability.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2105	A-43	• **Code 03, ~~acute hospital:~~** ~~if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.~~**Skilled Nursing Facility (SNF, swing beds):** if the resident was discharged to a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes patients admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements. • **Code 04, ~~psychiatric hospital:~~** ~~if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.~~**Short-Term General Hospital (acute hospital/IPPS):** if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2105	A-43	• **Code 05, Long-Term Care Hospital (LTCH):** if the resident was discharged to a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit. • **Code 05~~5~~6, ~~i~~Inpatient ~~r~~Rehabilitation ~~f~~Facility (IRF, free standing facility or unit):** if the resident was discharged to a ~~location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.~~ rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents discharged to a rehabilitation unit of a critical access hospital.
3	A2105	A-43	• **Code 07, Inpatient Psychiatric Facility (psychiatric hospital or unit):** if the resident was discharged to an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents. This category also includes residents discharged to a psychiatric unit of a critical access hospital. • **Code 0~~6~~8, Intermediate Care Facility (ID/DD ~~facility~~):** if the resident was discharged to ~~location is~~ an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual disabilities (ID) or developmental disabilities (DD).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2105	A-43	• **Code 09, Hospice (home/non-institutional):** if the resident was discharged to a community-based program for terminally ill persons. • **Code 0~~7~~10, ~~h~~Hospice (institutional facility):** if the resident was discharged to an inpatient ~~location is a~~ program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. ~~Includes community-based (e.g., home) or inpatient hospice programs.~~
3	A2105	A-43–A-44	• **Code 11, Critical Access Hospital (CAH):** if the resident was discharged to a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge. • **Code 12, Home under care of organized home health service organization:** if the resident was discharged home under care of an organized home health service organization. This includes only skilled services provided by a home health agency. • **Code ~~0~~813, deceased:** if resident is deceased. • ~~**Code 09, long term care hospital (LTCH):** if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.~~ • **Code 99, ~~other~~Not listed:** if the resident was discharged to ~~location is~~ none of the above.

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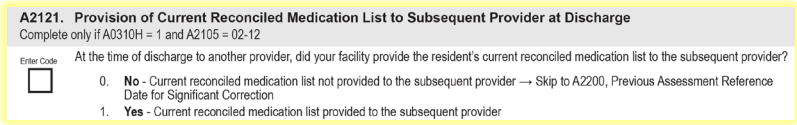
Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-44	## A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge *Complete only if A0310H = 1 and A2105 = 02-12.*  **A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge** Complete only if A0310H = 1 and A2105 = 02-12 Enter Code ☐ At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? 0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. **Yes** - Current reconciled medication list provided to the subsequent provider
3	A2121	A-44	### Item Rationale • The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care and help subsequent providers reconcile medications, and it may mitigate adverse outcomes related to medications. Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.
3	A2121	A-44	### Steps for Assessment 1. Determine whether the resident was discharged to one of the subsequent providers defined below under Coding Tips, based on discharge location item A2105. 2. If yes, determine whether, at the time of discharge, your facility provided a current reconciled medication list to the resident's subsequent provider.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-44	**Coding Instructions** • **Code 0, No:** if at discharge to a subsequent provider, your facility did not provide the resident's current reconciled medication list to the subsequent provider, or the resident was not discharged to a subsequent provider. • **Code 1, Yes:** if at discharge to a subsequent provider, your facility did provide the resident's current reconciled medication list to the subsequent provider.
3	A2121	A-45	**Coding Tips** • **Subsequent provider**—For the purposes of coding this item, a subsequent provider is based on the discharge locations in A2105 and defined as any of the following: 02. Nursing home (long-term care facility) 03. Skilled nursing facility (SNF, swing beds) 04. Short-term general hospital (acute hospital, IPPS) 05. Long-term care hospital (LTCH) 06. Inpatient rehabilitation facility (IRF, free standing facility or unit) 07. Inpatient psychiatric facility (psychiatric hospital or unit) 08. Intermediate care facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical access hospital (CAH) 12. Home under care of organized home health service organization

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-45	**DEFINITION** **MEANS OF PROVIDING A CURRENT RECONCILED MEDICATION LIST** Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR]), giving providers access to a portal).[2] [2] *A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, providers and patients can view health information such as current medications, recent doctor visits and discharge summaries. Retrieved from https://www.healthit.gov/faq/what-patient-portal April 2, 2019.*

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-45–A-46	• While the resident may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item. **Current Reconciled Medication list—**This refers to a list of the resident's current medications at the time of discharge that was reconciled by the facility prior to the resident's discharge. • Your facility should be guided by current standards of care and any applicable regulations and guidelines (e.g., Requirements of Participation) in determining what information should be included in a current reconciled medication list. • In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes. • In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) and the resident is moving to a different unit and/or interdisciplinary team (IDT), code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

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3	A2121	A-46	**Additional Considerations for Important Medication List Content** • The following information on the important content that may be included in a reconciled medication list is provided as guidance. This guidance does not dictate what information should be included in your facility's current reconciled medication list in order to code 1, Yes, that a current reconciled medication list was provided to the subsequent provider. The completeness of this reconciled medication list is left to the discretion of the providers who are coordinating this care with the resident. Examples of information that could be part of a reconciled medication list can be, but are not limited to: — **Types of medications**—Current prescribed and over-the-counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route at the time of discharge. Medications may also include total parenteral nutrition (TPN) and oxygen.
3	A2121	A-46	— The list of reconciled medications could include those that are: o active, including those that are scheduled to be discontinued after discharge; o held during the stay and planned to be continued/resumed after discharge; and o discontinued during the stay, if potentially relevant to the resident's subsequent care.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-46	— **Information included**—A reconciled medication list often includes important information about (1) the resident—including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and any special instructions (e.g., crush medications). For any held medications, it may include the reason for holding the medication and when medication should resume. This information can improve medication safety. Additional information may be applicable and important to include in the medication list, such as the resident's weight and date taken, preferred language, and ability to self-administer medication; when the last dose of the medication was administered by the discharging provider; and when the final dose should be administered (e.g., end of treatment).

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3	A2121	A-47	**Examples** 1. Resident B is being discharged from the SNF to an acute care hospital in the same health care system that uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see Definitions: EHR/EMR and definition in the glossary). Resident B's current reconciled medication list at the time of discharge from the SNF is accessible to the subsequent acute care hospital staff admitting Resident B, and this is how the medication list is shared. **Coding:** A2121 would be coded 1, Yes. **Rationale:** Having access to Resident B's medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.
3	A2121	A-47	2. Resident D is not taking any prescribed or over-the-counter medications at the time of discharge. **Coding:** If the lack of any medications for a resident is clearly documented and communicated to the subsequent provider when the resident is discharged, code 1, Yes, that the medication list was transferred. If this information is not communicated to the subsequent provider, code 0, No. **Rationale:** Information confirming that the resident is not taking any medications at discharge is important for the subsequent provider.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2121	A-47	3. Resident F was transferred to an acute care hospital with a reconciled medication list that included a list of their current medications, but with less additional information than is usually provided by the SNF at discharge because of the urgency of the situation. Some of the contraindications for the medications, as well as resident weight and height and dates taken, were omitted from the medication list. **Coding:** A2121 would be coded 1, Yes. **Rationale:** As long as a current reconciled list of medications is provided to the admitting provider, this item should be coded 1, Yes.
3	A2121	A-47	4. Resident J's Medicare Part A stay ended, and they were transferred to a long-term care unit in the same nursing home. The IDT from the subacute unit staff provided and reviewed with the long-term care unit staff a reconciled medication list at the time of transfer. **Coding:** A2121 would be coded 1, Yes. **Rationale:** If a current reconciled list of medications is provided to the subsequent provider (in this case, a different unit staff in the same nursing home), this item should be coded 1, Yes.
3	A2121	A-48	5. Resident P's Medicare Part A stay ended, and they remained in the same dually certified bed in the nursing home with care provided by the same IDT. **Coding:** A2121 would be coded 1, Yes. **Rationale:** As the same IDT continued to care for Resident P and have access to the current list of reconciled medications, this item should be coded 1, Yes.

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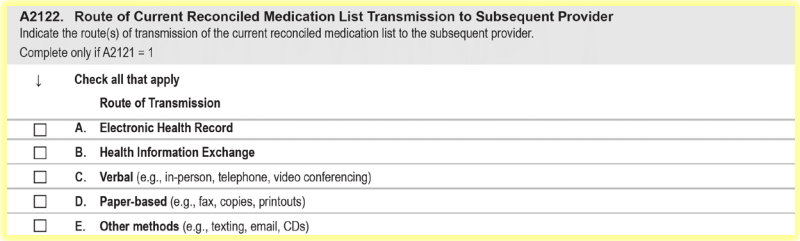
3	A2121	A-48	6. Resident G's reconciled medication list was electronically faxed to the subsequent provider, and this action is documented in their clinical record. However, the subsequent provider's records do not show documentation that the fax was successfully received. **Coding:** A2121, would be coded 1, Yes. **Rationale:** Documentation of the subsequent provider's successful receipt of the reconciled medication list is not a required component for this item.
3	A2122	A-48	## A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider  **A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider** Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider. Complete only if A2121 = 1 ↓ Check all that apply Route of Transmission ☐ A. Electronic Health Record ☐ B. Health Information Exchange ☐ C. Verbal (e.g., in-person, telephone, video conferencing) ☐ D. Paper-based (e.g., fax, copies, printouts) ☐ E. Other methods (e.g., texting, email, CDs) *The guidance below addresses coding A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider. Assessors should apply this same guidance to A2124. Route of Current Reconciled Medication List Transmission to Resident.*
3	A2122	A-48	### Item Rationale This item collects important data to monitor how medication lists are transmitted at discharge.
3	A2122	A-48	### Steps for Assessment 1. Identify all routes of transmission that were used to provide the resident's current reconciled medication list to the subsequent provider.

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3	A2122	A-49	**Coding Instructions** Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider. • **Check A2122A, Electronic Health Record:** if your facility has an EHR, sometimes referred to as an electronic medical record (EMR), and used it to transmit or provide access to the reconciled medication list to the subsequent provider. This would include situations in which both the discharging and receiving provider have direct access to a common EHR system. Checking this route does not require confirmation that the subsequent provider has accessed the common EHR system for the medication list.
3	A2122	A-49	• **Check A2122B, Health Information Exchange:** if your facility participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider. • **Check A2122C, Verbal:** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider. • **Check A2122D, Paper-Based:** if the current reconciled medication list was transmitted to the subsequent provider using a paper-based method such as a printout, fax, or eFax. • **Check A2122E, Other Methods:** if the current reconciled medication list was transmitted to the subsequent provider using another method not listed above (e.g., texting, email, CDs).

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2122	A-49	**DEFINITIONS** **EHR/EMR** An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a resident's medical history that is maintained by the provider over time.[3] **PORTAL** A portal is a secure online website that gives providers, residents, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection.[4] [3] https://www.healthit.gov/faq/what-electronic-health-record-ehr. [4] Office of the National Coordinator, What is a patient portal? Available from https://www.healthit.gov/faq/what-patient-portal, Accessed June 10, 2019.
3	A2123	A-50	A2123. Provision of Current Reconciled Medication List to Resident at Discharge *Complete only if A0310H = 1 and A2105 = 01, 99.* **A2123. Provision of Current Reconciled Medication List to Resident at Discharge** Complete only if A0310H = 1 and A2105 = 01, 99 Enter Code ☐ At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

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3	A2123	A-50	**Item Rationale** • Communication of medication information to the resident at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination and quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications. • It is recommended that a reconciled medication list that is provided to the resident, family member, guardian/legally authorized representative, or caregiver use consumer-friendly terminology and plain language to ensure that the information provided is clear and understandable.[5] [5] For examples of plain language resources for healthcare information see: https://www.plainlanguage.gov/resources/content-types/healthcare/
3	A2123	A-50	**Steps for Assessment** 1. Determine whether the resident was discharged to a home setting, 01, defined below under Coding Tips, or 99, Not Listed based on discharge location item A2105. 2. If yes, determine whether, at discharge, your facility provided the resident's medication list to the resident, family member, guardian/legally authorized representative, and/or caregiver.

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3	A2123	A-50	**Coding Instructions** • **Code 0, No:** if at discharge to a home setting (A2105 = 01) or a not listed location (A2105 = 99), your facility did not provide the resident's current reconciled medication list to the resident, family, guardian/legally authorized representative, and/or caregiver. • **Code 1, Yes:** if at discharge to a home setting (A2105 = 01) or a not listed location (A2105 = 99), your facility did provide the resident's current reconciled medication list to the resident, family, guardian/legally authorized representative, and/or caregiver.
3	A2123	A-51	**Coding Tips** • **Resident, family, significant other, guardian/legally authorized representative and/or caregiver**—The recipient of the current reconciled medication list can be the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

Chapter	Section	Page(s) in version 1.18.11	Change
3	A2123	A-51	**Examples** 1. Resident D does not take any prescribed or over-the-counter medications at the time of discharge. **Coding:** If it is clearly documented that the resident is taking no medications and this is then clearly communicated to the resident, family member, significant other, and/or caregiver when the resident is discharged, A2123 would be coded 1, Yes, that the medication list was transferred. If this information is not communicated to the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver, code 0, No. **Rationale:** Information confirming that the resident is not taking any medications at discharge is important for the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver.
3	A2123	A-51	2. Resident F is cognitively impaired and unable to manage their medications after discharge. Their medication list is provided to their sibling, who will be their primary caregiver. **Coding:** A2123 would be coded 1, Yes. **Rationale:** The medication list must be provided to the resident, family member, significant other, guardian/legally authorized representative, and/or a caregiver in order to code 1, Yes. In this example, Mr. F's sibling is a family member and a caregiver, so code 1, Yes.

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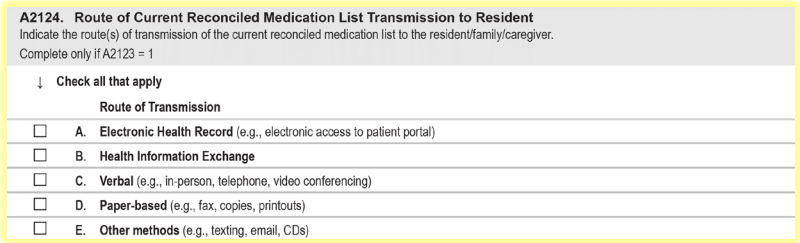
Chapter	Section	Page(s) in version 1.18.11	Change
3	A2123	A-51	3. Resident P chooses to leave the facility before their treatment is completed. They tell the charge nurse on their way out the door that their ride is waiting for them and they are going home. The charge nurse explains that they have not completed their course of treatment and are not ready to be discharged, but they insist that they are leaving now and proceed out of the facility. **Coding:** A2123 would be coded 0, No. **Rationale:** No medication list review was completed, and no medication list was provided to Resident P as they left against medical advice and did not want to keep their ride waiting.
3	A2124	A-52	## A2124. Route of Current Reconciled Medication List Transmission to Resident  **A2124. Route of Current Reconciled Medication List Transmission to Resident** Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver. Complete only if A2123 = 1 ↓ Check all that apply Route of Transmission ☐ A. **Electronic Health Record** (e.g., electronic access to patient portal) ☐ B. **Health Information Exchange** ☐ C. **Verbal** (e.g., in-person, telephone, video conferencing) ☐ D. **Paper-based** (e.g., fax, copies, printouts) ☐ E. **Other methods** (e.g., texting, email, CDs)
3	A2124	A-52	## Item Rationale This item collects important data to monitor how medication lists are transmitted at discharge.
3	A2124	A-52	## Steps for Assessment 1. Identify all routes of transmission that were used to provide the resident's current reconciled medication list to the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2124	A-52	**Coding Instructions** Please refer to the coding instructions for A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider.
3	A2124	A-52	**Coding Tips for A2122 and A2124** • The route of transmission usually is established with each subsequent provider, depending on how it is able to receive information from your facility. The route(s) may not always be documented in the resident's record. It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item. • More than one route of transmission may apply. Check all that apply.
3	A2124	A-53	**Examples** 1. A SNF is discharging and sending a resident to a hospital by ambulance. The driver obtains a printout and brings the resident's medication list to the hospital. The facility follows up with a call to the subsequent provider and discusses the resident's medications. **Coding:** Check paper-based (D) and verbal (C) for A2122. **Rationale:** Two routes for transmitting the medication list information were used—a paper copy of the list (D) and follow up verbal discussion (C). Both of these occurred at the time of discharge.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2124	A-53	2. One of a SNF's referral HHAs is preparing to admit a resident who will discharge soon. The HHA intake nurse has secure access to the SNF's EHR to obtain important care planning information from the resident's records, including the medication list. **Coding:** Check Electronic Health Record (A) for A2122. **Rationale:** The SNF provided access to the resident's medication list through its EHR. Even if there is no confirmation that the intake nurse accessed the medication list from the SNF's EHR system, code EHR (A) because it was made available by the SNF.
3	A2124	A-53	3. Resident P receives a paper copy of their medication list, receives education about their medications from the SNF nurse at discharge, and is notified that the SNF's patient portal is another means by which they can obtain their discharge medication list. **Coding:** Check Electronic Health Record (A), verbal (C), and paper-based (D) for A2124. **Rationale:** The copy of the medication list is paper-based (D). The information about Resident P's medication list was also communicated verbally by the nurse at the time of discharge (C). The resident portal uses the SNF's EHR to provide access to the medication list (A). It is not necessary to confirm that Resident P is a registered user of and accessed the patient portal in order to code EHR (A) as a route.

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3	A2124	A-54	4. A SNF participates in a regional HIE as does a local acute care hospital. When residents are discharged to this acute care hospital, the SNF's discharge medication list is included in the medications section of a transfer summary document from its EHR, which is electronically exchanged through the HIE. The acute care hospital is then able to obtain and integrate the medication information into its EHR. **Coding:** Check Electronic Health Record (A) and Health Information Exchange (B) for A2122. **Rationale:** The medication information is exchanged by the regional HIE through health IT standards. Sending the medication information in transfer summary allows the acute care hospital to integrate the medication information into its EHR. Code as EHR (A), since it was used to generate and exchange the information, and as HIE (B), since it is the means through which information exchange is possible with external providers.
3	A2124	A-54	5. A SNF has developed an interface that allows documents from its EHR to be electronically faxed to the subsequent provider. The SNF's EHR connects via a phone line to a designated receiver's secure email at the subsequent provider. **Coding:** Check paper-based (D) for A2122. **Rationale:** Faxing information is considered paper-based as faxed documents are comparable to hard-copy documents and not computable.

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Chapter	Section	Page(s) in version 1.18.11	Change
3	A2124	A-54	6. A SNF generates the current reconciled medication list electronically from the medication administration record (MAR) and treatment administration record (TAR) and electronically sends via secure email to the subsequent provider. **Coding:** Check Other Method (E) for A2122. **Rationale:** Providing the medication list through secure email is considered "Other Method" for coding this item. The source of the medication list is not the EHR, and the list is not transmitted directly to the subsequent provider's EHR, so do NOT check EHR (A).
3	A2300	A-55	## Item Rationale • Designates the end of the ~~look-back~~observation period so that all assessment items refer to the resident's status during the same period of time. As the last day of the ~~look-back~~observation period, the ARD serves as the reference point for determining the care and services captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for an MDS item with a 7-day ~~look-back~~observation period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this ~~look-back~~observation period. For an item with a 14-day ~~look-back~~observation period, the information is collected for a 14-day period ending on and including the ARD. The ~~look-back~~observation period includes observations and events through the end of the day (midnight) of the ARD.

Track Changes
from Chapter 3 Section A v1.17.1
to Chapter 3 Section A v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	A2300	A-56	
			DEFINITION **ASSESSMENT REFERENCE DATE (ARD)** The specific end-point for the ~~look-back~~observation periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, this ~~look-back~~observation period, also called the ~~observation~~look-back or assessment period, is a 7-day period ending on the ARD. ~~Look-back~~observation periods may cover the 7 days ending on this date, 14 days ending on this date, etc.

Track Changes
from Chapter 3 Section A v1.17.1
to Chapter 3 Section A v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	A2300	A-56	**Coding Tips and Special Populations** • When the resident dies or is discharged prior to the end of the ~~look-back~~observation period for a required assessment, the ARD must be adjusted to equal the discharge date. • The ~~look-back~~observation period may not be extended simply because a resident was out of the nursing home during part of the ~~look-back~~observation period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the ~~look-back~~observation period, the 2 leave days are still considered part of the ~~look-back~~observation period. • When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to ~~the physician during the leave, the visit would be counted in Item O0600, **Physician Examination** (if criteria are otherwise met)~~ their home for a holiday and the resident falls, the assessor will capture the fall in J1900: **Number of Falls Since Admission/Entry or Reentry or Prior Assessment** (OBRA or Scheduled PPS), whichever is more recent. This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.
3	A2400	A-57	**Item Rationale** • Identifies when a resident is receiving services under the scheduled PPS. • Identifies when a resident's Medicare Part A stay begins and ends. • ~~The end date is used to determine if the resident's stay qualifies for the short stay assessment.~~

Track Changes
from Chapter 3 Section A v1.17.1
to Chapter 3 Section A v1.18.11

Chapter	Section	Page(s) in version 1.18.11	Change
3	A2400	A-58	• If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and ~~may~~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).
3	A2400	A-59–A-61	Updated the year in dates for all five A2400 examples to 2021 to reflect dates after PDPM implementation. Also, item A2100 was renumbered to A2105.