

## CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Prospective Payment System (PPS) assessments in nursing homes and the mandated PPS assessments in non-critical access hospitals with a swing bed agreement.

### 2.1 Introduction to the Requirements for the RAI

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919(f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.

The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.

MDS assessments are also required *to be completed and submitted to the iQIES system* for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). *Other payors (e.g., Medicare Advantage Plans) may require Health Insurance Prospective Payment System (HIPPS) codes or other MDS data for billing purposes. However, facilities must not code assessments done for these purposes as PPS assessments in A0310B and A0310H or submit these assessments to iQIES.*

It is important to note that, *in most cases*, when the OBRA and PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. (Refer to Sections 2.10 and 2.11 for combining OBRA and PPS assessments).

## 2.2 CMS Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by CMS. The Federal requirement also mandates facilities to encode and electronically transmit MDS 3.0 data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items.

- CMS' specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.
- CMS' specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
- All comprehensive RAIs specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including Care Area Triggers (CATs) and the CAA Summary (Section V)).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer-generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer-generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the RAI specified by CMS).

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c04.pdf>. For more information about your State's assessment requirements, contact your State RAI Coordinator (see Appendix B).

## 2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice residents:** When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.
- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
  - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("–") (See Chapter 3 for more information).
  - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs and must initiate a plan of care to meet those needs upon admission.
  - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g., pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed facilities:** SNF-level services *of non-critical access hospital (non-CAH) swing bed (SB) facilities* were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed *facilities* must assess the clinical condition of *Medicare* beneficiaries by completing *certain* MDS assessments for each Medicare resident receiving *Medicare* Part A SNF level of care in order to be reimbursed under the SNF PPS *Patient Driven Payment Model*. CMS *began* collecting MDS data for quality monitoring purposes of *non-CAH SB* facilities effective October 1, 2010. Therefore, *SB* providers must complete these assessments: Swing Bed PPS (SP) and Swing Bed Discharge (SD) *assessments, and* Entry Tracking and Death in Facility records. Swing bed *facilities* may also choose to complete an Interim Payment Assessment (IPA) at any time during the resident's stay in the facility. Swing bed providers must adhere to the same assessment requirements including, but not limited to, completion date, encoding

requirements, submission time frame, and RN signature. Swing bed facilities must use the instructions in this manual when completing MDS assessments.

**Skilled Nursing Facility Quality Reporting Program:** The IMPACT Act of 2014 established the SNF QRP. Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that SNFs are to collect and report on standardized resident assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year. Data collected for the SNF QRP is submitted through the Internet Quality Improvement Evaluation System (iQIES) as it currently is for other MDS assessments.

- Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures>.

**The RAI process must be used** with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.\*
  - Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into iQIES. Therefore, these assessments cannot be submitted to iQIES.
  - Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to iQIES.
    - For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, OBRA Discharge, etc., the facility may

receive a sequencing warning message, but should still submit the required assessment.

- **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments.
- \*NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.
- **Adding Certified Beds:**
  - If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - Medicare and Medicaid residents should not be placed in *one of these additional* beds until the facility has been notified that the beds *have* been certified.
- **Change in Ownership:** There are two types of change in ownership transactions:
  - *1) Assumption of Assets and Liabilities:* This is the most common situation and requires the new owner to assume the assets and liabilities of the prior owner and retain the current *CMS Certification Number (CCN)*. In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - Staff with iQIES user IDs continue to use the same iQIES user IDs.
    - **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 5-Day PPS assessment was combined with the OBRA Admission assessment, the next PPS assessment could be an Interim Payment Assessment (IPA), if the provider chooses to complete one, and would also be submitted under the existing provider number.
  - *2) No Assumption of Assets or Liabilities:* There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - The beds are no longer certified.
    - There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, *CMS Certification Number (CCN)*, etc.
    - The previous owner would complete an OBRA Discharge assessment - return not anticipated, thus code A0310F = 10, A2000 = date of ownership change, and A2105 = 02 *or* 03 for those residents who will remain in the facility. *Refer to Chapter 3, Section A for additional guidance regarding A1805.*

- The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F = 01, A1600 = date of ownership change, A1700 = 1 (admission), and A1805 = 02 *or 03. Refer to Chapter 3, Section A for additional guidance regarding A1805.*
- Staff who worked for the previous owner **must update their iQIES role to submit data for the CCN associated with the new owner.**
- Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.
- **Resident Transfers:**
  - When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.
  - When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within 14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-Day assessment.
  - The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.
  - When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their *CMS Location (formerly known as Regional Office)*, State *Agency*, and Medicare Administrative Contractor (MAC) for guidance.
  - When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their *CMS Location*, State *Agency*, and MAC for guidance.
  - More information on emergency preparedness can be found at:  
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html>.



## 2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
  - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The 15-month requirement for maintenance of the RAI data must be adhered to.
  - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
  - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the active clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State Agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated

CAA(s) completion (items V0200B-C), correction completion (items X1100A-E), and assessment completion (items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.

- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident.
- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a handwritten **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion date for all assessments and correction requests. This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility tracking records and MDS Correction Requests (including signed attestation).
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

## 2.5 Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

**Admission** refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1<sup>st</sup> day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR
- when the resident has been in this facility previously and was discharged return not anticipated; OR



- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

**Assessment Combination** refers to the use of one assessment to satisfy both OBRA and PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. Sections 2.10 and 2.11 provide more detailed information on combining PPS and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and OBRA Discharge assessment.

**Assessment Completion** refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (item Z0500) completion attestation.

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for PPS assessments.

**Assessment Reference Date (ARD)** refers to the *specific endpoint for* the observation (or “look-back”) periods *in the MDS assessment process*. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7-day look-back period. If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 a.m. on June 25<sup>th</sup> and ending on July 1<sup>st</sup> at 11:59 p.m. should be included for MDS 3.0 coding.

**Assessment Scheduling** refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

**Assessment Submission** refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

**Assessment Timing** refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the PPS assessment timing schedule is provided in Section 2.8.

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary Team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.
- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have an SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.

**Assessment Transmission** refers to the electronic transmission of submission files to iQIES. Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

**Comprehensive** MDS assessments include both the completion of the MDS as well as completion of the CAA process and care planning. Comprehensive MDSs include Admission, Annual, SCSA, and SCPA.

**Death in Facility** refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required.

**Discharge** refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Section 2.6 provides detailed instructions regarding return anticipated and return not anticipated types, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.
- Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed.
- Resident's Medicare Part A stay ends, but the resident remains in the facility.

**Discharge Assessment** refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information.

**Entry** is a term used for both an admission and a reentry and requires completion of an Entry tracking record.

**Entry and Discharge Reporting** MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.

**Interdisciplinary Team (IDT<sup>1</sup>)** is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident.

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<sup>1</sup> 42 CFR 483.21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).

**Interrupted Stay** is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

**Interruption Window** is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Examples of when there **is** an Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and no Part A PPS Discharge or OBRA Discharge is completed, nor is a 5-Day or Entry Tracking record required when Part A resumes.
- If a resident is discharged from Part A, **leaves the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required.

Examples of when there is **no** Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and does not resume Part A within the 3-day interruption window**, it is **not** an interrupted stay. Therefore, a Part A PPS Discharge and a 5-Day assessment are both required (as long as resumption of Part A occurs within the 30-day window allowed by Medicare).
- If a resident is discharged from Part A, **leaves the facility, and does not resume Part A within the 3-day interruption window**, it is not an interrupted stay and the Part A PPS Discharge and OBRA Discharge are both required and *must* be combined *if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)* (see Part A PPS Discharge assessment in Section 2.5). Any return to the facility in this instance would be considered a new entry—that means that an Entry Tracking record, OBRA admission and/or 5-Day assessment would be required.

**Item Set** refers to the MDS items that are active on a particular assessment type or tracking form. There are 9 different item subsets for nursing homes and 5 for swing bed providers as follows:

- Nursing Home
  - **Comprehensive (NC)<sup>2</sup> Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, SCSA, and SCPA). This item set is used whether the OBRA Comprehensive assessment is standalone or combined with any other assessment (PPS assessment and/or Discharge assessment).
  - **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly assessment [SCQA]). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.
  - **PPS (NP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
  - **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
  - **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in iQIES.
- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Discharge (SD) Item Set.** This is the set of items active on a standalone Swing Bed Discharge assessment (either return anticipated or not anticipated).
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

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<sup>2</sup> The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

- **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in iQIES.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the Type of Provider, item A0200 (indicating nursing home or swing bed), and the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2.14 of this chapter provides manual lookup tables for determining the item set when automated software is unavailable.

**Item Set Codes** are those values that correspond to the OBRA-required and PPS assessments represented in items A0310A, A0310B, A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

**Leave of Absence (LOA)**, which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the resident.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return *of the resident to the facility*, providers should make appropriate documentation in the medical record regarding any changes in the resident's *status*. If *significant changes in status are noted after an LOA, a Significant Change in Status Assessment (SCSA) may be necessary (see Section 2.6)*.

**Non-Comprehensive** MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly assessments and SCQAs.

**Observation (Look-Back, Assessment) Period** is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look-back period will be captured. In other words, if it did not occur during the look-back period, it is not coded on the MDS.



**OBRA-Required Tracking Records and Assessments** are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

#### Tracking records

- Entry
- Death in facility

#### Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

**PPS Assessments** provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. These assessments are coded on the MDS 3.0 in items A0310B (PPS Assessment) and A0310H (Is this a Part A PPS Discharge Assessment?). They include:

- 5-Day assessment
- Interim Payment Assessment (IPA)
- Part A PPS Discharge Assessment

**Reentry** refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

**Respite** refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and an OBRA Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

## 2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in items A0310A and A0310F (Entry/discharge reporting). PPS reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

## RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14 <sup>th</sup> calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days <b>AND</b> ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14 <sup>th</sup> calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

## RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14 <sup>th</sup> calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

## RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day <i>and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)</i>
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day <i>and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)</i>

(continued)

## RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment



## Comprehensive Assessments

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:

- Admission Assessment
- Annual Assessment
- Significant Change in Status Assessment
- Significant Correction to Prior Comprehensive Assessment

Each of these assessment types will be discussed in detail in this section. They are **not** required for residents in swing bed facilities.

### *Assessment Management Requirements and Tips for Comprehensive Assessments:*

- The ARD (item A2300) is the last day of the observation/look-back period, and day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.<sup>3</sup> In closing the record, the nursing home should note why the RAI was not completed.

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<sup>3</sup> The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.<sup>4</sup> In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- The nursing home may combine a comprehensive assessment with a Discharge assessment.
- In the process of completing any OBRA comprehensive assessment except an Admission and an SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into iQIES, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a 5-Day assessment or SNF Part A PPS Discharge assessment (see Sections 2.10 and 2.11 for details) or any Discharge assessment type.

OBRA-required comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (item A0310A).

### **01. Admission Assessment (A0310A = 01)**

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:

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<sup>4</sup> The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

### *Assessment Management Requirements and Tips for Admission Assessments:*

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day "1" of admission.
- The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than day 14.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry tracking record **each time** the resident returns to the facility and an OBRA Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

## **02. Annual Assessment (A0310A = 03)**

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

### *Assessment Management Requirements and Tips for Annual Assessments:*

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

### **03. Significant Change in Status Assessment (SCSA) (A0310A = 04)**

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

A “**significant change**” is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered “self-limiting”;
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

*A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.*

*A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.*

### *Assessment Management Requirements and Tips for Significant Change in Status Assessments:*

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.
- An SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from *their* baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
  - The resident's condition is not expected to return to baseline within two weeks.
  - For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from an SCSA during the intervening period, the staff must complete an SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- An SCSA may **not** be completed prior to an OBRA Admission assessment.
- An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving *their* highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O01 *10K1*. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
- An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice

election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O01 *10K1*. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.
- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

### *Guidelines for Determining a Significant Change in a Resident's Status:*

*Note: this is not an exhaustive list*

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.

### *Some Guidelines to Assist in Deciding If a Change Is Significant or Not:*

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA. This time frame may vary depending on clinical judgment and resident needs. For



example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.
- **If there is only one change**, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT must make the decision as to whether or not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion.
- An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- An SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.
- **Decline in two or more of the following:**
  - Resident's decision-making ability has changed;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9<sup>©</sup>), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
  - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;
  - Any decline in an ADL physical functioning area (*e.g., self-care or mobility*) (at least 1) where a resident is newly coded as *partial/moderate* assistance, *substantial/maximal assistance*, *dependent*, *resident refused*, or *the activity was not attempted* since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
  - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.
- **Improvement in two or more of the following:**
  - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, *setup or clean-up assistance, or supervision or touching* assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - Resident's decision making improves;
  - Resident's incontinence pattern improves.

### Examples (SCSA):

1. *Resident* T no longer responds to verbal requests to alter *their* screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. *They are* also starting to resist *their* daily care, pushing staff away from *themselves* as the *staff members* attempt to assist with *their* ADLs. This is a significant change, and an SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. *Resident* T's behavioral symptoms could have many causes, and an SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of *Resident* T's disruptive behavior.
2. *Resident* T required *supervision* with ADLs. *They* fractured *their* hip and upon return to the facility require *maximal* assistance with all ADLs. Rehab has started and staff is hopeful *they* will return to *their* prior level of function in 4–6 weeks.
3. *Resident* G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission *they were* very frail, had trouble thinking, *were* confused, and had many behavioral complications. The course of treatment led to steady improvement and *they are* now stable. *They are* no longer confused or exhibiting inappropriate behaviors. The resident, *their* family, and staff agree that *they have* made remarkable progress. An SCSA is required at this time. The resident is not the person *they were* at admission - *their* initial problems have resolved and *they* will be remaining in the facility. An SCSA will permit the interdisciplinary team to review *their* needs and plan a new course of care for the future.

### Guidelines for When a Change in Resident Status Is Not Significant:

*Note: this is not an exhaustive list*

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a

psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require an SCSA).

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate an SCSA).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

### *Guidelines for Determining the Need for an SCSA for Residents with Terminal Conditions:*

*Note: this is not an exhaustive list*

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

### *Examples (SCSA):*

1. *Resident* M has been in this nursing home for two and one-half years. *They have* been a favorite of staff and other residents, and *their child* has been an active volunteer on the unit. *Resident* M is now in the end stage of *their* course of chronic dementia, diagnosed as probable Alzheimer's. *They* experience recurrent pneumonias and swallowing difficulties, *their* prognosis is guarded, and family members are fully aware of *their* status. *They are* on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of *their child* in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, *Resident* M's care is of a high quality, and as *their* physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.

2. *Resident* K came into the nursing home with identifiable problems and has steadily responded to treatment. *Their* condition has improved over time and has recently hit a plateau. *They* will be discharged within 5 days. The initial RAI helped to set goals and start *their* care. The course of care provided to *Resident* K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if *Resident* K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if *they are* not discharged, an SCSA is required by the end of the allotted 14-day period.
3. *Resident* P, too, has responded to care. Unlike *Resident* K, however, *they* continue to improve. *Their* discharge date has not been specified. *They are* benefiting from *their* care and full restoration of *their* functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an SCSA at this time. However, if *their* condition *were* to stabilize and *their* discharge was not imminent, an SCSA would be in order.

*Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:*

- If an SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.<sup>5</sup>
- PASRR is not a requirement of the resident assessment process but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at <http://www.cms.gov/>.
- The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

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<sup>5</sup> The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

*Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:*

*Note: this is not an exhaustive list*

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident's plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with an SCSA.)

*Example (PASRR & SCSA):*

1. *Resident* L has a diagnosis of serious mental illness, but *their* primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and *they* become ambulatory, even if other conditions exist for which *Resident* L receives medical care, *they* should be referred for a PASRR evaluation to determine whether a change in *their* placement or services is needed.

*Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:*

*Note: this is not an exhaustive list*

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

#### 04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A = 05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

*A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.*

#### *Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:*

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCPA is appropriate when:
  - the erroneous comprehensive assessment has been completed and transmitted/submitted into iQIES; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).



## Non-Comprehensive Assessments and Entry and Discharge Reporting

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:

- Quarterly Assessment
- Significant Correction to Prior Quarterly Assessment
- Discharge Assessment – Return not Anticipated
- Discharge Assessment – Return Anticipated

The Quarterly assessments, OBRA Discharge assessments and SCQAs are not required for Swing Bed residents. However, Swing Bed providers are required to complete the Swing Bed Discharge item set (SD).

Tracking records include a select number of MDS items and are required for **all** residents in the nursing home and swing bed facility. They include:

- Entry Tracking Record
- Death in Facility Tracking Record

### *Assessment Management Requirements and Tips for Non-Comprehensive Assessments:*

- The ARD is considered the last day of the observation/look-back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA.

For example:

- Resident A has a Quarterly assessment with an ARD of March 20<sup>th</sup>. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23<sup>rd</sup> and returns on March 25<sup>th</sup>. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3<sup>rd</sup> (which is day 14 after the ARD).
- Resident B also has a Quarterly assessment with an ARD of March 20<sup>th</sup>. *They* go to the hospital on March 20<sup>th</sup> and returns March 30<sup>th</sup>. While there is no significant

change the facility decides to start a new assessment and sets the ARD for April 2<sup>nd</sup> and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.<sup>6</sup> In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.<sup>6</sup> When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and an SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into iQIES and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a 5-Day assessment or SNF Part A PPS Discharge Assessment (see Sections 2.10 and 2.11 for details).

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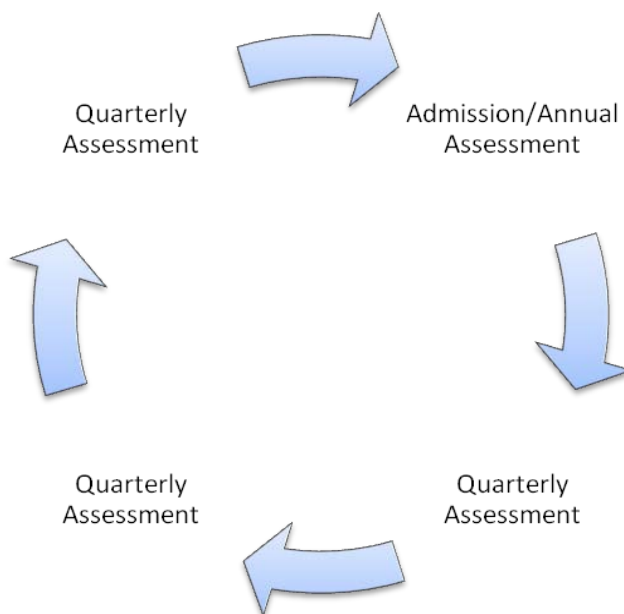
<sup>6</sup> The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

## 05. Quarterly Assessment (A0310A = 02)

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

### *Assessment Management Requirements and Tips:*

- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period. Assuming the resident does not have an SCSA or SCPA completed and was not discharged from the nursing home, a typical 12-month OBRA schedule would look like this:



- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions.
- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, SCQA, or Annual assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).

## 06. Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A = 06)

The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (item A2300) and completion dates (item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

*A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.*

### Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCQA is appropriate when:
  - the erroneous Quarterly assessment has been completed (MDS completion date, item Z0500B) and transmitted/submitted into iQIES; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be less than or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

## Tracking Records and Discharge Assessments (A0310F)

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry and discharge reporting is required for residents in Swing Beds or those in respite care.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit OBRA Discharge assessments and Entry tracking records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

OBRA-required Tracking Records and Discharge Assessments include the following types (item A0310F):

## 07. Entry Tracking Record (Item A0310F = 01)

There are two types of entries – admission and reentry.

### Admission (Item A1700 = 1)

- Entry tracking record is coded an Admission every time a resident:
  - is admitted for the first time to this facility; or
  - is readmitted after a discharge return not anticipated; or
  - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

#### Example (Admission):

1. *Resident* S. was admitted to the nursing home on February 5, 2011 following a stroke. *They* regained most of *their* function and returned to *their* home on March 29, 2011. *They were* discharged return not anticipated. Five months later, *Resident* S. underwent surgery for a total knee replacement. *They* returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

A0310F = 01  
A1600 = 08-27-2011  
A1700 = 1

### Reentry (Item A1700 = 2)

- Entry tracking record is coded Reentry every time a person:
  - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

#### Example (Reentry):

1. *Resident* W. was admitted to the nursing home on April 11, 2011. Four weeks later *they* became very short of breath during lunch. The nurse assessed *them* and noted *their* lung sounds were not clear. *Their* breathing became very labored. *They were* discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, *Resident* W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

A0310F = 01  
A1600 = 05-18-2011  
A1700 = 2

### *Assessment Management Requirements and Tips for Entry Tracking Records:*

- The Entry tracking record is the first item set completed for all residents.
- Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility), including upon return if a resident in a Medicare Part A stay is discharged from the facility and does not resume Part A within the same facility within the 3-day interruption window (see Interrupted Stay in Section 2.5, Assessment Types and Definitions above).
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14<sup>th</sup> calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a standalone tracking record.
- May **not** be combined with an assessment.

### **08. Death in Facility Tracking Record (A0310F = 12)**

- Must be completed when the resident dies in the facility or when on LOA.
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any type of assessment.

#### *Example (Death in Facility):*

1. *Resident* W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. *They* passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

A0310F = 12  
A2000 = 11-13-2011  
A2105 = 13

### **OBRA Discharge Assessments (A0310F)**

OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.

## 09. Discharge Assessment–Return Not Anticipated (A0310F = 10)

- Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
- Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident returns, the Entry tracking record will be coded A1700 = 1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the provider must determine whether the interrupted stay policy applies. Refer to Section 2.9 for instructions on the PPS assessments.

### *Examples (Discharge-return not anticipated):*

1. *Resident* S. was admitted to the nursing home on February 5, 2011 following a stroke. *They* regained most of *their* function and *were* discharged return not anticipated to *their* home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:

A0310F = 10  
A2000 = 03-29-2011  
A2105 = 01

2. *Resident* K. was transferred from a Medicare-certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

A0310F = 10  
A2000 = 12-12-2013  
A2105 = 02

## 10. OBRA Discharge Assessment–Return Anticipated (A0310F = 11)

- Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
- For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that *they* will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
- Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days).



- Must be submitted within 14 days after the MDS completion date (item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns to the nursing home, the IDT must determine if criteria are met for an SCSA (only when the OBRA Admission assessment was completed prior to discharge).
  - If criteria are met, complete an SCSA.
  - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If an interrupted stay occurs, an SCSA should be completed if clinically indicated.
- If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

*Example (Discharge-return anticipated):*

1. *Resident* C. was admitted to the nursing home on May 22, 2011. *They* tripped while at a restaurant with *their child*. *They were* discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows:

A0310F = 11  
 A2000 = 05-31-2011  
 A2105 = 04

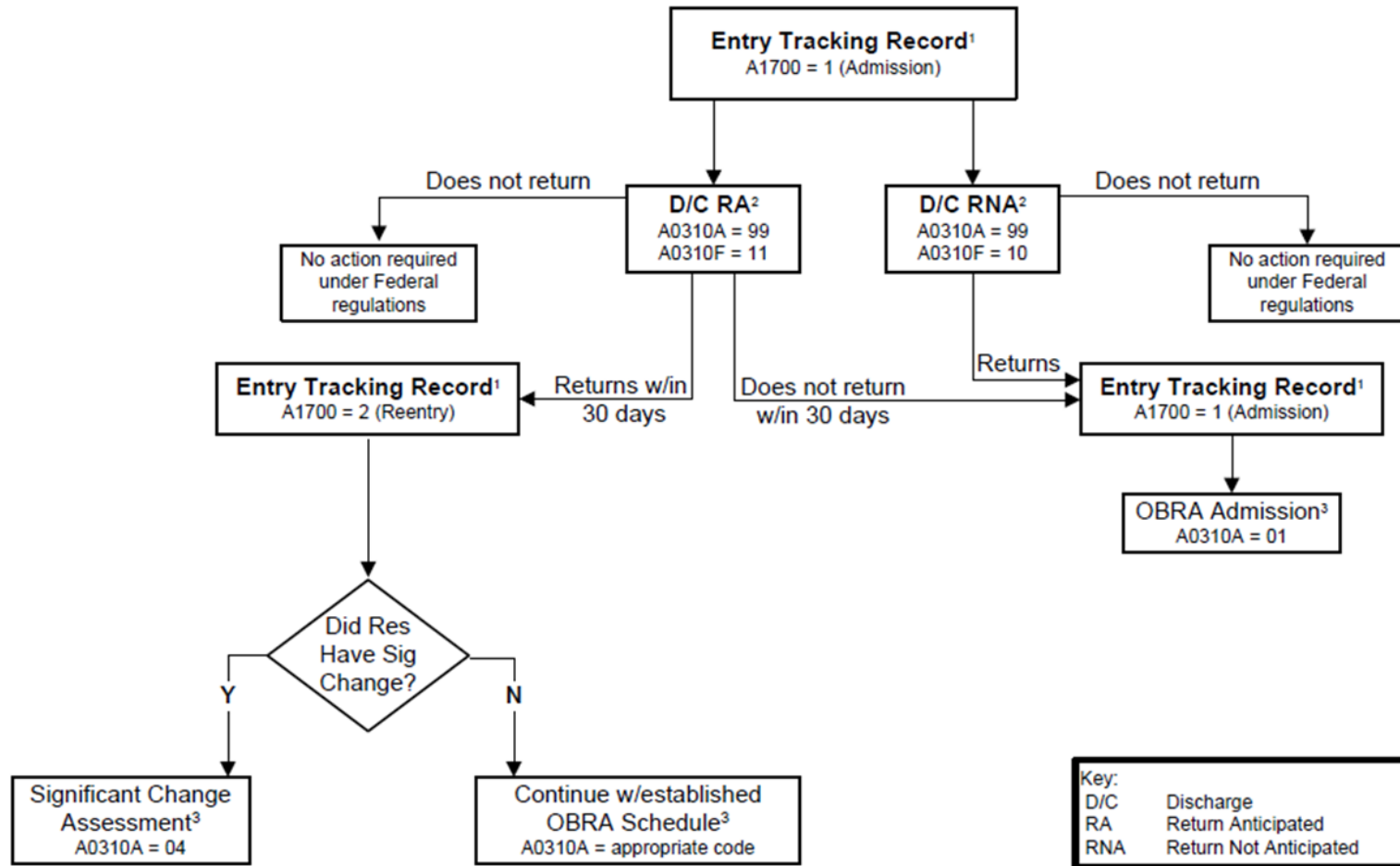
### Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge in Section 2.5, Assessment Types and Definitions).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed if a resident in a Medicare Part A stay is discharged from the facility regardless of whether the resident resumes Part A within the 3-day interruption window (see Interrupted Stay, Section 2.5, Assessment Types and Definitions above).
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.

- May be combined with any *OBRA or* 5-Day and must be combined with a *Part A PPS* Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000).
- For an OBRA Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met.
- For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
  - An unplanned discharge includes, for example:
    - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
    - Resident unexpectedly leaving the facility against medical advice; or
    - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

The following chart details the sequencing and coding of Tracking records and OBRA Discharge assessments.

## Entry, OBRA Discharge, and Reentry Algorithms



<sup>1</sup>A0310A = 99    A0310B = 99    A0310E = 0    A0310F = 01

<sup>2</sup>A0310B – E = appropriate code

<sup>3</sup>A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

## 2.7 The Care Area Assessment (CAA) Process and Care Plan Completion

Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.

### CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (item V0200B2) must be either later than or the same date as the MDS completion date (item Z0500B). In no event should either date be later than the established time frames as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/problems. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14<sup>th</sup> calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

## Care Plan Completion

- Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (item V0200C2) must be either later than or the same date as the CAA completion date (item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (item Z0500B) must be earlier than or the same date as the care plan completion date. In no event should either date be later than the established time frames as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

## 2.8 Skilled Nursing Facility Prospective Payment System Assessment Schedule

SNFs must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF PPS. In addition to the PPS assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the PPS assessments, such as completion and submission time frames.

### Assessment Window

The PPS 5-Day assessment has defined days within which the Assessment Reference Date (ARD) must be set. The ARD must be a day within the prescribed window of Days 1 through 8

of the Part A stay and must be set on the MDS form itself or in the facility software before this window has passed.

The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes and for purposes of the variable per diem adjustment, as discussed in Chapter 6, Section 6.7. In most cases, the first day of Medicare Part A coverage is the date of admission. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date. See Chapter 6, Section 6.7, for more detailed information.

## Scheduled PPS Assessment

The PPS-required standard assessment is the 5-Day assessment, which has a predetermined time period for setting the ARD. The SNF provider must set the ARD on days 1–8 to assure compliance with the SNF PPS PDPM requirements.

## Unscheduled PPS Assessments

There are situations when a SNF provider may complete an assessment after the 5-Day assessment. This assessment is an unscheduled assessment called the Interim Payment Assessment (IPA). When deemed appropriate by the provider, this assessment may be completed to capture changes in the resident's status and condition.

## Tracking Records and Discharge Assessments Reporting

Tracking records and Discharge assessments reporting are required on **all** residents in the SNF and swing bed facilities. Tracking records and standalone Discharge assessments do not impact payment.

### Part A PPS Discharge Assessment (A0310H)

The Part A PPS Discharge assessment contains data elements used to calculate current and future SNF QRP quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which Post-Acute Care (PAC) providers (which includes SNFs) are required to submit standardized resident assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that resident assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting.

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

*situations in which the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) equals the day of discharge as listed in A2000.*

### Part A PPS Discharge Assessment (A0310H = 1):

- For the Part A PPS Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- 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 *must* be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) **must** be equal to the Discharge Date (A2000). The Part A PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met (please see Section 2.10 Combining PPS Assessments and OBRA Assessments).
- *If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.*
- *The Part A PPS Discharge assessment must* be completed (item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- *The Part A PPS Discharge assessment must* be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits do not resume within 3 days, the PPS schedule starts again with a 5-Day assessment. If the Medicare Part A stay does resume within the 3-day interruption window, then this is an interrupted stay (see below).
- If the resident leaves the facility for an interrupted stay, no Part A PPS Discharge Assessment is required when the resident leaves the building at the outset of the interrupted stay; however, an OBRA Discharge record is required if the discharge criteria are met (see Section 2.5). If the resident returns to the facility within the interruption window, as defined above, an Entry tracking form is required; however, no new 5-Day assessment is required.

The following chart summarizes the PPS assessments, tracking records, and discharge assessments:



### PPS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	<ul style="list-style-type: none"> <li>See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier.</li> <li>CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSPA or SCPA.</li> </ul>
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	<ul style="list-style-type: none"> <li>Optional assessment.</li> <li>Does not reset variable per diem adjustment schedule.</li> <li>May not be combined with another assessment.</li> </ul>
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	<ul style="list-style-type: none"> <li>Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or <i>is</i> combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).</li> </ul>

## 2.9 MDS PPS Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in items A0310A and A0310B respectively. If the assessment is being used for reimbursement under the SNF PPS, the PPS Reason for Assessment must be coded in item A0310B. The OBRA Reason for Assessment is described earlier in this section while the PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and PPS requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and PPS assessments is discussed below and in more detail in Sections 2.10 and 2.11.

### PPS Assessments for a Medicare Part A Stay

#### 01. 5-Day Assessment

- ARD (item A2300) must be set for Days 1 through 8 of the Part A SNF covered stay.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for entire PPS stay (except in cases when an IPA is completed).
- Must be submitted electronically and accepted into iQIES within 14 days after completion (item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).

- Is the first PPS-required assessment to be completed when the resident is first admitted for a SNF Part A stay.
- Is the first PPS-required assessment to be completed when the resident is re-admitted to the facility for a Part A stay following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment–return anticipated.
- A 5-Day assessment is not required at the time when a resident returns to a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption (facility discharge, resident no longer skilled, payer change, etc.).
- If a resident changes payers from Medicare Advantage to Medicare Part A, the SNF must complete a 5-Day assessment with the ARD set for one of days 1 through 8 of the Medicare Part A stay, with the resident's first day covered by Medicare Part A serving as Day 1, unless it is a case of an interrupted stay.

## 02. Interim Payment Assessment

- Optional assessment.
- ARD (item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day assessment.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for remainder of the PPS stay, beginning on the ARD.
- Must be submitted electronically and accepted into iQIES within 14 days after completion (item Z0500B) (completion + 14 days).
- The ARD for an IPA may not precede that of the 5-Day assessment.
- May not be combined with any other assessments (PPS or OBRA).

## 03. Part A PPS Discharge Assessment

- See definition provided in Section 2.8, Part A PPS Discharge Assessment (A0310H = 1).

## 2.10 Combining PPS Assessments and OBRA Assessments<sup>7</sup>

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

- The OBRA standards are designated by the reason selected in item A0310A, **Federal OBRA Reason for Assessment**, and item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The PPS standards are designated by the reason selected in item A0310B, **PPS Assessment** and item A0310H, **Is this a SNF Part A PPS Discharge Assessment?**
- When the OBRA and PPS assessment time frames coincide (except the IPA), one assessment may be used to satisfy both requirements. PPS and OBRA assessments (except

<sup>7</sup> OBRA assessments do not apply to Swing Bed providers; however, Swing Bed providers are required to complete the Entry Tracking record, Swing Bed PPS (SP), Swing Bed Discharge (SD) assessment, and Death in Facility Tracking record.

the IPA) may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and PPS assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 5-Day assessment. For the OBRA Admission, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For the 5-Day, the ARD must be set for days 1 through 8. However, when combining a 5-Day assessment with the OBRA Admission assessment, the use of the latter end of the OBRA Admission ARD window would cause the 5-Day assessment to be considered late. To assure the assessment meets both standards, an ARD of a day between Day 1 and 8 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/ 5-Day assessment, completion by day 14 would be required. Finally, when combining a PPS assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed.

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

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

**Item Sets by Assessment Type for Skilled Nursing Facilities**

	<b>Comprehensive Item Sets</b>	<b>Quarterly and PPS* Item Sets</b>	<b>Other Assessments and Tracking Records/Item Sets</b>
Standalone Assessment Types	<ul style="list-style-type: none"> <li>• OBRA Admission</li> <li>• Annual</li> <li>• Significant Change in Status (SCSA)</li> <li>• Significant Correction to Prior Comprehensive (SCPA)</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly</li> <li>• Significant Correction to Prior Quarterly</li> <li>• 5-Day</li> </ul>	<ul style="list-style-type: none"> <li>• Entry Tracking Record</li> <li>• OBRA Discharge assessments</li> <li>• Death in Facility Tracking Record</li> <li>• Part A PPS Discharge</li> <li>• Interim Payment Assessment (IPA)</li> </ul>
Combined Assessment Types	<ul style="list-style-type: none"> <li>• OBRA Admission and 5-Day</li> <li>• Annual and 5-Day</li> <li>• SCSA and 5-Day</li> <li>• SCPA and 5-Day</li> <li>• Any OBRA comprehensive and any Discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly and 5-Day</li> <li>• Significant Correction to Prior Quarterly and 5-Day</li> <li>• 5-Day and any Discharge</li> <li>• Significant Correction to Prior Quarterly and any Discharge</li> </ul>	<ul style="list-style-type: none"> <li>• OBRA Discharge assessment and Part A PPS Discharge Assessment</li> </ul>

\*Nursing home-based SNFs must check with their State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

### Item Sets by Assessment Type for Swing Bed Providers

	Swing Bed PPS/Item Set	Other Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	<ul style="list-style-type: none"> <li>(SP) Swing Bed PPS assessment</li> </ul>	<ul style="list-style-type: none"> <li>Entry Tracking record</li> <li>Death in Facility Tracking record</li> <li>(SD) Swing Bed Discharge</li> <li>Interim Payment Assessment (IPA)</li> </ul>
Assessment Type Combinations	<ul style="list-style-type: none"> <li>(SP) Swing Bed PPS assessment and (SD) Swing Bed Discharge</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>

Tracking records (Entry and Death in Facility) and the Interim Payment Assessment can never be combined with other assessments.

## 2.11 PPS and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. A provider may choose to combine more than two assessment types when all requirements are met. The coding of items in A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in item A0310 (see Section 2.14).

### 5-Day Assessment and OBRA Admission Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

### 5-Day Assessment and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

### 5-Day Assessment and Annual Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

***5-Day Assessment and Significant Change in Status Assessment***

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

***5-Day Assessment and Significant Correction to Prior Comprehensive Assessment***

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

***5-Day Assessment and Significant Correction to Prior Quarterly Assessment***

- See 5-Day assessment and OBRA Quarterly Assessment.

***5-Day Assessment and OBRA Discharge Assessment***

- PPS item set.
- ARD (item A2300) must be set for the day of discharge (item A2000) **and** the date of discharge must fall within the allowed window of the 5-Day as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

***5-Day Assessment and Part A PPS Discharge Assessment***

- PPS item set.
- ARD (item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the 5-Day assessment as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

## 2.12 Factors Impacting SNF PPS Assessment Scheduling<sup>8</sup>

### *Resident Expires Before or On the Eighth Day of SNF Stay*

If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in iQIES, the provider must bill the default rate for any Medicare days. The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

### *Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay*

If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (e.g., transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in iQIES, the provider must bill the default rate for any Medicare days.

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required.

When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments *must* be combined. (See Sections 2.10 and 2.11 for details on combining a PPS assessment with a Discharge assessment.)

### *Resident Is Admitted to an Acute Care Facility and Returns*

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF to resume Part A coverage, the resident requires a new 5-Day assessment, unless it is an instance of an interrupted stay. If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form. An IPA may be completed, if deemed appropriate.

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

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, a new 5-Day PPS assessment is not required, though an IPA may be completed, if deemed appropriate. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the “midnight rule.” For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of *their* Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of *their* return to the SNF, Thursday,

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<sup>8</sup> These requirements/policies also apply to swing bed providers.

becomes day 22 of *their* Part A stay. This means that this day is skipped for purposes of the variable per diem adjustment, described in Chapter 6.

### ***Resident Takes a Leave of Absence from the SNF***

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-13 in this chapter, there may be payment implications. For example, if a resident leaves a SNF at 6:00 p.m. on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3).

### ***Resident Discharged from Part A Skilled Services and from the Facility and Returns to SNF Part A Skilled Level Services***

In the situation when a beneficiary is discharged from Medicare Part A and is physically discharged from the facility, but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and can be combined (see Part A PPS Discharge in Section 2.5).

On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new 5-Day and Entry Tracking record must be completed. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

However, in the case of an interrupted stay, that is, if a resident **leaves the facility and resumes Part A within the 3-day interruption window**, only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.

The beneficiary should be assessed to determine if there was a significant change in status.

### ***Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility***

In the situation when a resident's Medicare Part A stay ends, but the resident is not physically discharged from the facility, remaining in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item A1900) and must also complete a Part A PPS Discharge assessment.

If Part A benefits resume, there is no reason to change the OBRA schedule; the PPS schedule would start again with a 5-Day assessment, MDS item A0310B = 01, **unless** it is a case of an



interrupted stay—that is, if the resident is discharged from Part A, remains in the facility, and resumes Part A **within the 3-day interruption window**, no Part A PPS Discharge is completed, nor is a 5-Day required when Part A resumes.

### ***Delay in Requiring and Receiving Skilled Services***

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

### ***Non-Compliance with the PPS Assessment Schedule***

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

### ***Late PPS Assessment***

If the SNF fails to set the ARD within the defined ARD window for a 5-Day assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 of the Part A stay and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed.

### ***Missed PPS Assessment***

If the SNF fails to set the ARD of a 5-Day assessment prior to the end of the last day of the ARD window, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A.

### ***Errors on a PPS Assessment***

To correct an error on an MDS that has been submitted to iQIES, the SNF must follow the normal MDS correction procedures (see Chapter 5).

## **2.13 Expected Order of MDS Records**

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (item A1700) indicating admission, and the next record is expected to be an Admission assessment, a

5-Day assessment, a Discharge assessment, or Death in Facility tracking record. iQIES will issue a warning when an unexpected record is submitted. Examples include an assessment record after a discharge (an entry is expected) or any record after a Death in Facility tracking record.

The target date, rather than the submission date, is used to determine the order of records. The target date is the Assessment Reference Date (item A2300) for assessment records, the Entry Date (item A1600) for entry records, and the Discharge Date (item A2000) for discharge or Death in facility records. In the following table, the prior record is represented in the columns and the next (subsequent) record is represented in the rows. A “no” has been placed in a cell when the next record is not expected to follow the prior record; iQIES will issue a record order warning for record combinations that contain a “no.” A “yes” indicates that the next record is expected to follow the prior record; a record order warning will **not** be issued for these combinations. Note that there are not any iQIES record order warnings produced for Swing Bed MDS records.

## Expected Order of MDS Records

Next Record	Prior Record									
	Entry	OBRA Admission	OBRA Annual	OBRA Quarterly	5-Day	IPA	OBRA Discharge	Part A PPS Discharge	Death in facility	No prior record
Entry	no	no	no	no	no	no	yes	no	no	yes
OBRA Admission	yes	no	no	no	yes	yes	no	yes	no	no
OBRA Annual	yes	no	no	yes	yes	yes	no	yes	no	no
OBRA Quarterly, sign. change, sign correction	yes	yes	yes	yes	yes	yes	no	yes	no	no
5-Day	yes	yes	yes	yes	no	no	no	yes	no	no
IPA	yes	yes	yes	yes	yes	yes	no	no	no	no
OBRA Discharge	yes	yes	yes	yes	yes	yes	no	yes	no	no
Part A PPS Discharge	yes	yes	yes	yes	yes	yes	no	no	no	no
Death in facility	yes	yes	yes	yes	yes	yes	no	yes	no	no

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

## 2.14 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the item set code (ISC) and Description columns for that row. If the combination of items A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by iQIES.

**Nursing Home Item Set Code (ISC) Reference Table**

OBRA RFA (A0310A)	PPS RFA (A0310B)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01, 03, 04, 05	01, 99	10, 11, 99	0, 1	NC	Comprehensive
02, 06	01, 99	10, 11, 99	0, 1	NQ	Quarterly
99	01	10, 11, 99	0, 1	NP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	ND	OBRA Discharge
99	99	01, 12	0	NT	Tracking
99	99	99	1	NPE	Part A PPS Discharge

Consider examples of the use of this table. If items A0310A = 01, A0310B = 99, item A0310F = 99, and A0310H = 0 (a standalone OBRA Admission assessment), then these values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if item A0310F is changed to 10 (Admission assessment combined with a return not anticipated Discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If items A0310A = 99, A0310B = 99, item A0310F = 12, and A0310H = 0 (a Death in Facility tracking record), then these values are matched in the second to last row and the item set is a tracking record (NT). Finally, if items A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.

There *is one* additional item set not listed in the above table *used* for inactivation request records. This is the set of items active on a request to inactivate a record in iQIES. An inactivation request is indicated by A0050 = 3. The item set for this type of record is “Inactivation” with an ISC code of XX.

The next lookup table is for swing bed records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and

A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by iQIES.

**Swing Bed Item Set Code (ISC) Reference Table**

<b>OBRA RFA (A0310A)</b>	<b>PPS RFA (A0310B)</b>	<b>Entry/ Discharge (A0310F)</b>	<b>Part A Discharge (A0310H)</b>	<b>ISC</b>	<b>Description</b>
99	01	10, 11, 99	0, 1	SP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	SD	Discharge
99	99	01, 12	0	ST	Tracking

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