Welcome to
MDS 3.0 Training 2024
Session #1

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Disclaimer:

This presentation is not a substitute for reading and reviewing the

Long-Term Care Resident Assessment Instrument 3.0 User's Manual

Version 1.18.11, October 2023

Item Sets Version 1.18.11 v6 October 2023

or

State Operations Manual Appendix PP

Revised 2/3/23

Objectives:

- Review the importance of accuracy
- Review the different RAI sections
- Technical Information
- Review Interviews and help in Appendix D
- Review Use of Dashes in the MDS
- Review Section A completion and assessment timing
- Review Related Regulations

The Importance of Accuracy

- The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis for:
  - The development of an individualized care plan
  - The Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - Quality monitoring activities, such as the quality measure reports
  - The data-driven survey and certification process
  - The quality measures used for public reporting
  - Research and policy development

Layout of the RAI Manual

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

Layout of the RAI Manual Appendices

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

MDS RAI Manual Version 1.18.11 effective October 2023

- MDS RAI Manual version 1.18.11 and MDS 3.0 v1.18.11v6 item set available:
- https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

- Final Rule: https://www.federalregister.gov/documents/2023/10/04/2023-22050/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

Find the MDS 3.0 Item Details

- SNF QRP Information webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation
- MDS 3.0 Technical Information, Data Submission Specifications: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation
- 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/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

APPENDIX D: INTERVIEWING TO INCREASE RESIDENT VOICE IN MDS ASSESSMENTS

- All residents capable of any communication should be asked what they consider most important to them and their care.
- Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident.
- In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident's cognitive status.
  - Most residents, even those with moderate to severe cognitive impairment, can answer some simple questions about these topics.

Helpful Interview Tips

• Explain the purpose of the questions to the resident.

You can tell the resident that these questions are designed to be asked of everyone to make sure that nothing is missed.

End by explaining that *their* answers will help the care team develop a care plan that is appropriate for the resident.

• Say and show the item responses. It is helpful to many older adults to both hear and read the response options.

Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.

Interviews (continued)

- Use the resident's preferred language or method of communication.
- All residents capable of any communication should be asked about what is important in their care.
- DO NOT complete the staff interview if the resident interview should have been attempted and was not.

Interviews (continued)

- Basic approaches to make the interviews effective:
  - Introduce yourself and find a quiet, private area
  - Be sure the resident can hear you
  - Is an interpreter needed?
  - Sit where the resident can see you clearly
  - Break the question apart if necessary
  - Clarify

Ending the Interview

- If the resident becomes agitated or overly emotional and does not want to continue, respond to *their* needs.
  - This is more important than finishing the interview at that moment.

- When a resident is unable to communicate information about *their* preferences, a family member, close friend, or other representative must be used to complete preference questions.
  - In this case, it is important to emphasize that this person should try to answer based on what the resident would prefer.

Interviews

- Interview status should not be based on B0700, Makes Self Understood, rather, B0700 should be evaluated after all interviews have been attempted and coded.
- B0700 cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews as the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make self understood during the entire 7-day look-back.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

Interview Items

- A1005 Ethnicity
- A1010 Race
- A1110 Language
- A1250 Transportation
- Section B- Items for Hearing, Speech Clarity, Makes Self Understood, Vision
- B1300 Health Literacy
- C0200 Brief Interview for Mental Status
- D0150 Resident Mood Interview
- Section F Interview for Preferences for Customary Routine and Activities

More Interview Items

- GG0100-GG0110 Prior Functional Abilities
- J0300-J0600 Pain Assessment Interview
- J1100 Shortness of Breath
- J1300 Current Tobacco Use
- J1700 Fall History
- K0300-K0400 Weight Loss or Gain
- O0250-O0300 Influenza and Pneumococcal Vaccines
- Section Q- Participation in Assessment and Goal Setting

Use of Dashes

- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS iQIES system.
- A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
- Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
- There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
- QMs cannot be calculated, for example, when the use of a dash (-) indicates the SNF was unable to perform a pressure ulcer assessment. Left blank, it also means no assessment was done for that item.
- Coding Conventions RAI Page 3-4

Section A: Identification Information

- Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

Section A:
Identification Information

Remember:

The CMS Database matching process includes:

- First Name
- Last Name
- Social Security Number
- Gender
- Date of Birth
- Please communicate regarding any changes to the resident's demographic information

Section A – Identification Information

A0050. Type of Record

Enter Code ☐

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**

☐☐☐☐☐☐☐☐☐☐

B. **CMS Certification Number (CCN):**

☐☐☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number:**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310: OBRA Required Assessments

- Certified beds (Title 18 and/or Title 19): OBRA schedule is required and transmitted regardless of the payer source.
- Licensed only beds are *not* transmitted.
- If you accidently transmit a record for a licensed only bed, you need to call me. A manual Correction/Deletion Request Form will need to be completed.

OBRA Required Assessments

- Coding Instructions for A0310A, Federal OBRA Reason for Assessment
- Document the reason for completing the assessment. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment.
  - 01. Admission assessment (required by day 14)
  - 02. Quarterly review assessment
  - 03. Annual assessment
  - 04. Significant change in status assessment
  - 05. Significant correction to prior comprehensive assessment
  - 06. Significant correction to prior quarterly assessment
  - 99. None of the above

Significant Change in Status Assessment

A SCSA is appropriate when:

— It is determined there has been a significant change (improvement or decline) in a resident's condition from his/her baseline has occurred

and

— The resident's condition is not expected to return to baseline within two weeks.

Hospice Services

- Electing Hospice or palliative care from an outside agency requires a SCSA to coordinate care and care plans.
- In-house palliative care services are not indicated on the MDS, a SCSA is not required but the resident should be evaluated for a SCSA, and the care plans need to be updated to reflect palliative care.
- CMS does not differentiate between levels of Hospice services, only that they are received.
- O0110K indicates Hospice services for terminally ill persons. If a resident is receiving outside palliative services through a Hospice provider and is terminally ill, it should be counted here.
- J1400 should be marked when a resident has a life expectancy of 6 months or less and/or is receiving Hospice services marked at O0100K.
- Residents with non-terminal conditions receiving palliation services from a Hospice provider should not be marked.

Hospice then Discharges to Hospital

Example: A resident receiving hospice services was sent out and admitted to the hospital. The facility completed a Discharge return-anticipated and transmitted it.

If, upon return to the facility, the resident re-enrolls in hospice services, then a SCSA is required, *whether or not it is the same hospice provider.* This is to ensure a coordinated plan of care between the hospice and nursing home is in place.

- RAI Panel 1/23/2018

A0310B
PPS Assessments

- A0310B: PPS Scheduled Assessments include:
  - 01. 5-day scheduled assessment
- PPS Unscheduled Assessment include:
  - 08. IPA- Interim payment Assessment

- A0310H: PPS Part A Discharge

Interim Payment Assessment (IPA)

- Optional
- Sets payment for remainder of the stay beginning on the ARD
- Too many IPAs may appear to CMS as you trying to manipulate the system
- Should have a plan to help determine when an IPA should be completed

IPA (continued)

- Look back period is 7 days unless otherwise indicated.
  - D0150 with a 14 day look back
  - GG0130 and GG0170 with 3 day look back
  - K0300 with 6 month look back
  - O0110 with a 14 day look back
- Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

IPA (continued)

- The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior).
- It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.
- The IPA does not affect the variable per diem schedule.

PPS 5-day
Factors Impacting Scheduling

- *Resident Expires Before or On the Eighth Day of SNF Stay*
- *Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay*
- *Resident Is Admitted to an Acute Care Facility and Returns*
- *Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility*
- *Resident Takes a Leave of Absence from the SNF*
- *Resident Discharged from Part A Skilled Services and from the Facility and Returns to SNF Part A Skilled Level Services*
- *Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility*
- *Delay in Requiring and Receiving Skilled Services*

RAI starting on page 2-52

Section A – Identification Information

A0310. Type of Assessment

Enter Code ☐☐

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

01. **5-day** scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

08. **IPA** - Interim Payment Assessment

Not PPS Assessment

99. **None of the above**

Enter Code ☐

E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**

0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting

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

A0310F/A0310G/A0310G1/A0310H: Entry/Discharge Reporting Required for all residents

- A0310F
  - 01. Entry tracking record
  - 10. Discharge assessment- return not anticipated
  - 11. Discharge assessment- return anticipated
  - 12. Death in facility tracking
  - 99. None of the above
- A0310G Type of Discharge
  - 1. Planned, 2. Unplanned
- A0310G1 Is this a SNF Part A Interrupted Stay?
  - 0. No, 1. Yes
- A0310H Is this a SNF Part A PPS Discharge Assessment?
  - 0. No, 1. Yes

RAI pages 2-17 through 2-19

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	14th 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 **AND** 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	14th 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)

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	14th 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)

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 *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)*
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 *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)*

Section A (continued) Interrupted Stay

- A0310G1: Is this a SNF Part A Interrupted Stay? Yes or No
- DEFINITIONS:
  - 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 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. If both 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.

A0310H SNF PPS Part A Discharge (End of Stay) Assessment

- A Part A PPS Discharge assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility

- 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)
- Needs to be completed even if in the facility for a short period of time

RAI page 2-47

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.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or *is* combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

A0310F: Entry/Discharge Reporting

Entry Record

Completed within 7 days every time a person is **admitted or readmitted** into a nursing home (or swing bed facility)

Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)

Submit before the next assessment

Required in addition to the initial Admission assessment or other OBRA or PPS assessments

Cannot be combined with an assessment

Needs to be completed even if in the facility for a short period of time

Discharge Assessment and Record

Not associated with the bed hold status or opening and closing of the medical record

A0410

- A0410 Unit Certification or Licensure Designation

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State

2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State

3. Unit is Medicare and/or Medicaid certified

    Should always be ‘3’ unless it should not be transmitted then ‘1’ would be coded

Section A – Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge - Complete only if A0310F = 10 or 11

1. **Planned**
2. **Unplanned**

Enter Code ☐

G1. Is this a SNF Part A Interrupted Stay?

0. **No**
1. **Yes**

Enter Code ☐

H. Is this a SNF Part A PPS Discharge Assessment?

0. **No**
1. **Yes**

A0410. Unit Certification or Licensure Designation

Enter Code ☐

1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

Section A – Identification Information

A0500. Legal Name of Resident

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number: ___ - ___ - ____

B. Medicare Number:

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code

1. Male
2. Female

A0900. Birth Date

__ - __ - ____

Month Day Year

Section A (continued)

- A0500: Legal Name of Resident: First and Last Names: needs to be what Medicare has on file, match the Medicare/Medicaid card, the common working file.
- A0500 D: Suffix: *Please use!*
- A0600A Social Security Number
- A0700 Medicaid Number
- A0800 Gender: What it says on the Medicare card.
- A0900 Date of Birth
- Used in the CMS Database Matching Process!

- A2400 Medicare Stay: This is for traditional Medicare ONLY

A1005 Ethnicity

Section A	Identification Information

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

Check all that apply

☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

A1005 Ethnicity Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- Code X, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply*, including* X. Resident unable to respond.

If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

- Code Y, Resident declines to respond:

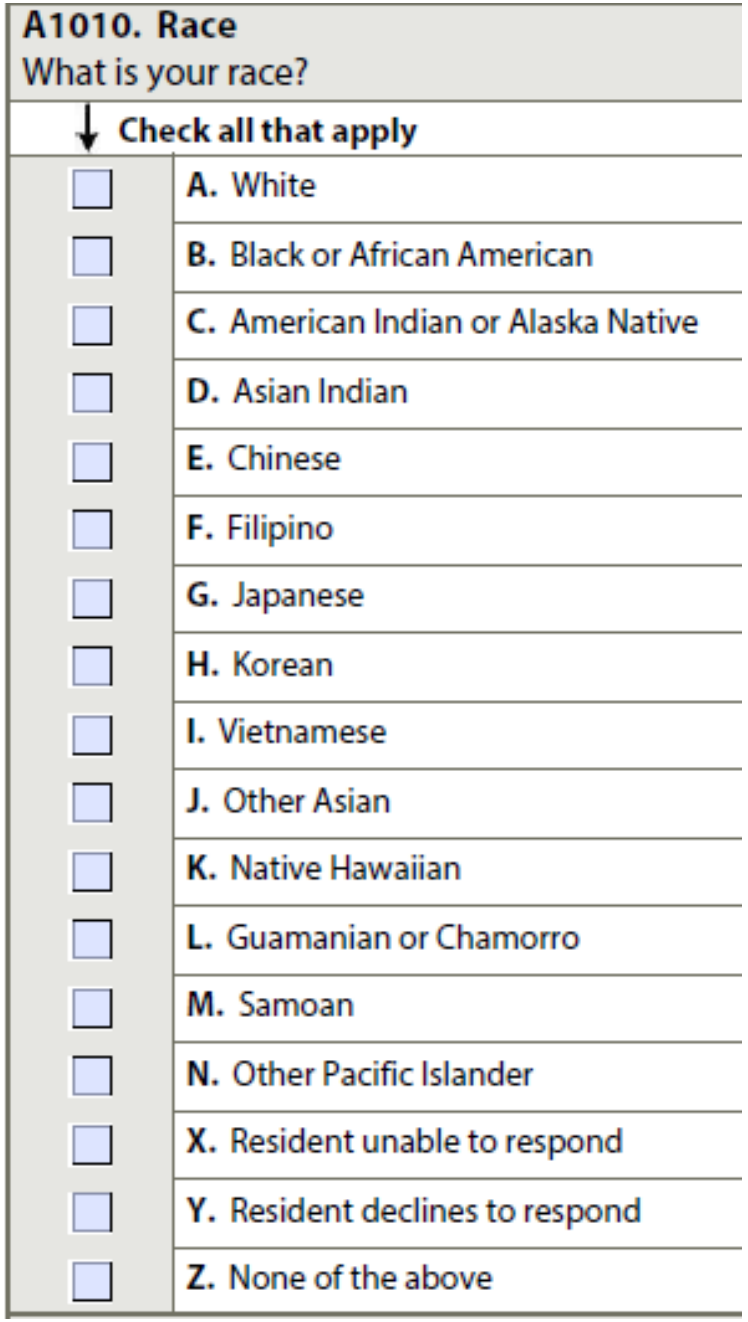
When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

RAI page A-17&18

A1010 Race

- Race and Ethnicity will become Standardized Patient Assessment Data Elements (SPADEs) for SNF QRP starting 10/1/23.
- To aid in completing a culturally competent and trauma-informed comprehensive care plan.



A1010. Race
What is your race?

↓ **Check all that apply**

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

A1010 Race Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- **Code X**, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply*, including* X. Resident unable to respond.

If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1010 as X. Resident unable to respond.

- **Code Y**, Resident declines to respond:

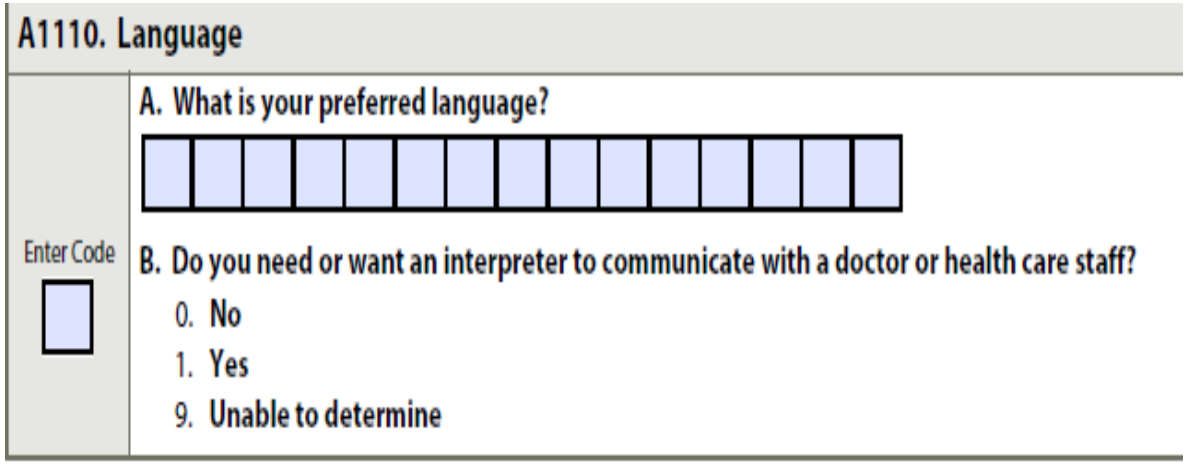
When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

- **Code Z**, None of the above: if the resident reports or it is determined from other resources that none of the listed races apply.

RAI page A-21

A1110 Language


A1110. Language

Enter Code

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.

2. If the resident is unable to respond, a family member or significant other should be asked.

3. If neither source is available, review record for evidence of a need for an interpreter.

4. If an interpreter is wanted or needed, ask for preferred language.

5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Section A1250 Transportation

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ **Check all that apply**

- ☐ **A.** Yes, it has kept me from medical appointments or from getting my medications
- ☐ **B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ **C.** No
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

Only completed for

PPS 5-day

or

Planned + PPS discharge

*Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

A1250 Transportation- Steps for Assessment

1. *Ask the resident:*

- *"In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"*
- *"In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"*

2. *Respondents should be offered the option of selecting more than one "yes" designation, if applicable.*

3. *If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.*

4. *Only if the resident is unable to respond and a representative is not available, the facility may use medical record documentation.*

5. *If the resident declines to respond, do not code based on other resources*

RAI page A-26

Section A – Identification Information

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	**Check all that apply**
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

Interview question

A1300. Optional Resident Items

A. Medical record number:

☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number:

☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Lifetime occupation(s) - put "/" between two occupations:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Interview question

PASRR

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01, 03, 04, or 05

Enter Code ☐

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions

Complete only if A0310A = 01, 03, 04, or 05

↓	Check all that apply
☐	A. Serious mental illness
☐	B. Intellectual Disability
☐	C. Other related conditions

PASRR

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

- ☐ **A. Down syndrome**
- ☐ **B. Autism**
- ☐ **C. Epilepsy**
- ☐ **D. Other organic condition related to ID/DD**

ID/DD Without Organic Condition

- ☐ **E. ID/DD with no organic condition**

No ID/DD

- ☐ **Z. None of the above**

A1500 –Preadmission Screening and Resident Review (PASRR)

- PASRR is a preadmission screening process.
- A positive screen indicates the resident has a mental illness, intellectual disability, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Reports on the results of the PASRR process.
- Only completed on the OBRA comprehensive MDS assessments.

PASRR Help Desk 888-245-0179, 919-813-5603
https://www.ncmust.com/doclib/PASRR_Numbers.pdf

- *https://www.medicaid.gov/medicaid/long-term-services-supports/institutionallong-term-care/preadmission-screening-and-resident-review/index.html*

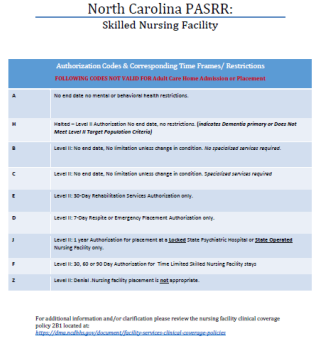
A1500: PASRR

- NCMUST (919) 816-3015, (888) 245-0179 or (919) 318-5550,
  Fax (919) 224-1072
- Not everyone with MI has a Level II PASRR determination.
- Everyone with ID/DD should have a Level II PASRR determination.
- All known Level II PASRR residents need to have a referral completed for any significant change in status identified. Do not wait until the SCSA assessment has been completed to make this referral.
- Level I residents who experience a psychiatric episode, have a new psychiatric diagnosis or have been placed on antipsychotic medications should have a Level II PASRR referral made (RAI page 2-30 through 2-31).

Halted PASRR

Halted – Level II Authorization No end date, no restrictions.

(*indicates Dementia primary or Does Not Meet Level II Target Population Criteria)*

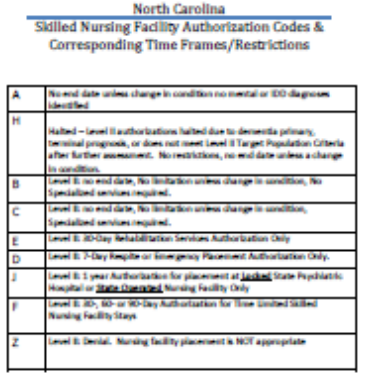


North Carolina PASRR:
Skilled Nursing Facility

Authorization Codes & Corresponding Time Frames/ Restrictions FOLLOWING CODES NOT VALID FOR Adult Care Home Admission or Placement	
A	no end date no mental or behavioral health restrictions.
H	Halted – Level II Authorization No end date, no restrictions. *(Indicates Dementia primary or Does Not Meet Level II Target Population Criteria)*
B	Level II: No end date, No limitation unless change in condition. *No specialized services required.*
C	Level II: No end date, No limitation unless change in condition. *Specialized services required*
E	Level II: 30-Day Rehabilitation Services Authorization only.
D	Level II: 7-Day Respite or Emergency Placement Authorization only.
J	Level II: 1 year Authorization for placement at a Locked State Psychiatric Hospital or State Operated Nursing Facility only.
F	Level II: 30, 60 or 90 Day Authorization for Time Limited Skilled Nursing Facility stays
Z	Level II: Denial. Nursing facility placement is not appropriate.

For additional information and/or clarification please review the nursing facility clinical coverage policy 2B1 located at:
https://dma.ncdhhs.gov/document/facility-services-clinical-coverage-policies

Halted – Level II authorizations halted due to dementia primary, terminal prognosis, or does not meet Level II Target Population Criteria after further assessment. No restrictions, no end date unless a change in condition. 1/19/24



North Carolina
Skilled Nursing Facility Authorization Codes & Corresponding Time Frames/Restrictions

A	No end date unless change in condition no mental or IDD diagnoses identified
H	Halted – Level II authorizations halted due to dementia primary, terminal prognosis, or does not meet Level II Target Population Criteria after further assessment. No restrictions, no end date unless a change in condition.
B	Level II: no end date, No limitation unless change in condition, No Specialized services required.
C	Level II: no end date, No limitation unless change in condition, Specialized services required.
E	Level II: 30-Day Rehabilitation Services Authorization Only
D	Level II: 7-Day Respite or Emergency Placement Authorization Only.
J	Level II: 1 year Authorization for placement at Locked State Psychiatric Hospital or State Operated Nursing Facility Only
F	Level II: 30-, 60- or 90-Day Authorization for Time Limited Skilled Nursing Facility Stays
Z	Level II: Denial. Nursing facility placement is NOT appropriate

PASRR Level II for Referral

- ***§483.20(e)(2) Refer all level II residents and all residents with newly evident or possible serious mental disorder (MI), intellectual disability (ID), or a related condition for level II resident review upon a significant change in status assessment***
- ***F644, F645, F646***

Admission Discharge

A1805. Entered From

Enter Code ☐☐

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

A1900. Admission Date (Date this episode of care in this facility began)

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A1805
Entered From

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month – Day – Year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1805. Entered From

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

A1900. Admission Date (Date this episode of care in this facility began)

Month – Day – Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A2105
Discharge Status

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

- A2121 Completed only on SNF Part A PPS DC and A2105= 02-12
- A2122 Completed only if A2121= Yes
- A2123 Completed only on SNF Part A PPS DC
- SNF QRP will begin collecting data on Transfer of Health (TOH) Information to the provider and to the resident. Documentation supports the MDS.
- *Need a process for documentation and communication of the reconciled medication list.
- How does this get coded if staying in the facility?

In the case of a standalone Medicare Part A PPS Discharge assessment with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes.

In the case of a standalone Medicare Part A PPS Discharge assessment and the resident is moving to a different unit and/or IDT, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

RAI pages A-45 and A-46

A2124 Route of Current Reconciled Medication List Transmission to Resident
Only completed if A2123=1 (Yes)

Section A	Identification Information

A2124. Route of Current Reconciled Medication List Transmission to Resident

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123 At the time of DC, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

1.= Yes- Current reconciled medication list provided to the resident, family and/or caregiver.

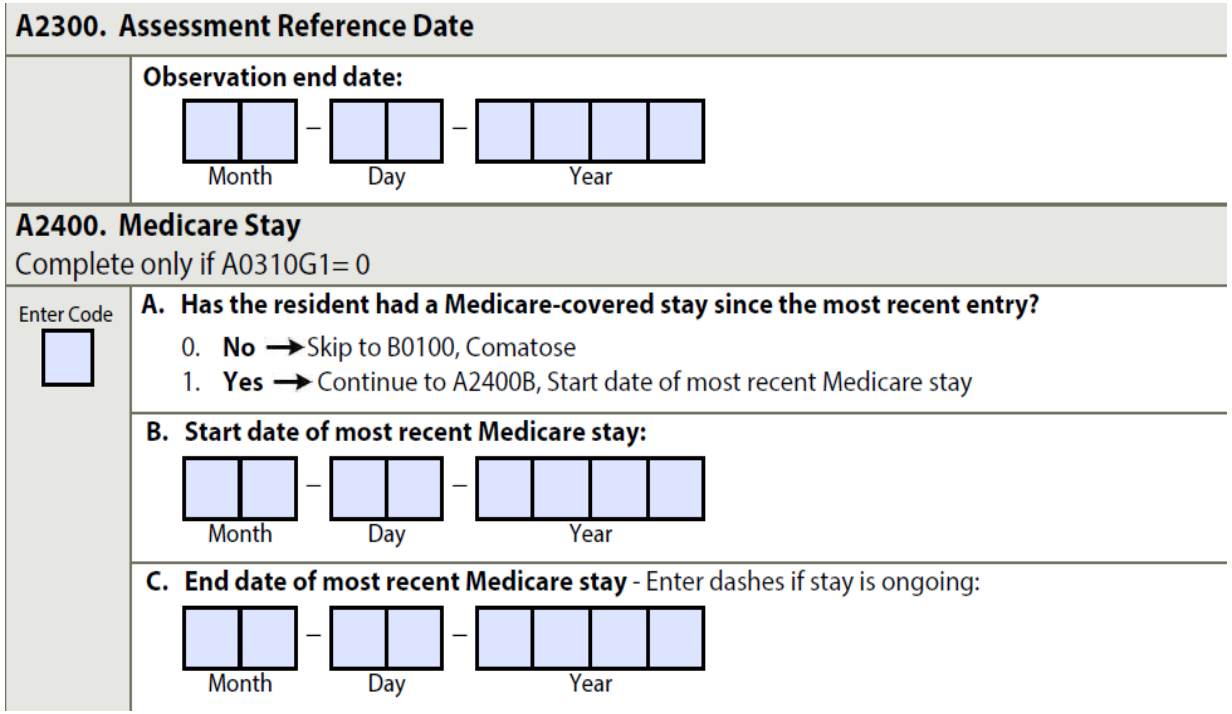
Completed only on SNF Part A PPS DC

Assessment Reference Date

- **Assessment Reference Date (ARD)** refers to the *specific endpoint for* the observation (or "look-back") period*s 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 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding. RAI page 2-9

Section A

- A2200 Previous Assessment Reference Date for Significant Correction
- A2300 Assessment Reference Date
- A2400 Medicare Stay



A2300. Assessment Reference Date

Observation end date:

Month – Day – Year

A2400. Medicare Stay

Complete only if A0310G1= 0

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

Month – Day – Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

Month – Day – Year

Med A stay

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A2400. Medicare Stay

Complete only if A0310G1 = 0

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

---

B. Start date of most recent Medicare stay:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 2/3/23: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- Resident Assessment
  - Regulations F635-F646
- Comprehensive Resident Centered Care Plans
  - Regulations F655-F661

CFR 483.20 Resident Assessments

- F636 Comprehensive Assessments & Timing
- F637 Comprehensive Assessment After Significant Change
- F638 Quarterly Assessment At Least Every 3 Months
- F640 Encoding/Transmitting Resident Assessment
- F641 Accuracy of Assessments
- F642 Coordination/Certification of Assessment
- F644 Coordination of PASARR and Assessments
- F645 PASARR Screening for MD & ID
- F646 MD/ID Significant Change Notification

Regulation F636
Comprehensive Assessments & Timing

- *Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*
- *Comprehensive Assessments: Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's <u>needs, strengths, goals, life history and preferences</u>, using the resident assessment instrument (RAI) specified by CMS.*

Regulation F636
Comprehensive Assessments & Timing (continued)

- The assessment must include at least the following:
- (i) Identification and demographic information.
- (ii) Customary routine.
- (iii) Cognitive patterns.
- (iv) Communication.
- (v) Vision.
- (vi) Mood and behavior patterns.
- (vii) Psychological well-being.

Regulation F636
Comprehensive Assessments & Timing (cont.)

- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnosis and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin Conditions.
- (xiii) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures.

Regulation F636
Comprehensive Assessments & Timing (cont.)

- (xvi) Discharge planning.
- (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
- (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
- Not less than once every 12 months.

F636 Intent

- *INTENT: To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.*

F636 Guidance

- The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.
- The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, the resident's representative, family members, or outside consultants.

F636 Guidance (continued)

- At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.
- The facility must use the RAI process to develop a comprehensive care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

F637 Comprehensive Assessment After Significant Change

- Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition.
- A "significant change" means a major decline or improvement in the resident's status that:
  - will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions
  - that has an impact on more than one area of the resident's health status
  - requires interdisciplinary review or revision of the care plan, or both.

F637 SCSA

A Significant Change in Status MDS is required when:

- A resident enrolls in a hospice program; or
- A resident changes hospice providers and remains in the facility; or
- A resident receiving hospice services discontinues those services; or
- A resident experiences a consistent pattern of changes, with either **two or more** areas of decline or **two or more** areas of improvement, from baseline (as indicated by comparison of the resident's current status to the most recent CMS-required MDS).

F638 Quarterly Assessment at Least Every 3 Months

- **A facility must assess a resident using the quarterly review instrument (RAI Manual) specified by the State and approved by CMS not less frequently than once every 3 months.**
- **"Quarterly Review Assessment"** is an OBRA required, non-comprehensive assessment 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 Minimum Data Set (MDS) items appear on the Quarterly assessment.

F640
Encoding/Transmitting Resident Assessment

- **INTENT**
- To ensure that facilities have provided resident specific information for payment and quality measure purposes.
- To enable a facility to better monitor each resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data.

F640 Definitions, in part

- **"Accurate"** means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at F641, and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).
- **"Capable of transmitting"** means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission.
- **"Complete"** means that all items required according to the record type, and in accordance with CMS' record specifications and State required edits are in effect at the time the record is completed.
- **"Discharge subset of items"** refers to the MDS Discharge assessment.
- **"Encoding"** means entering information into the facility MDS software in the computer.
- **"Transmitted"** means electronically transmitting to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record.

F640 Guidance

- Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the QIES ASAP System.
- For the subset of items required upon a resident's entry, transfer, discharge and death refer to Chapter 2 of the Long-Term Care Resident Assessment Instrument User's Manual for further information about these records.
  - For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- Submission must be according to State and Federal time frames. Electronically submit MDS information to the QIES ASAP system within 14 days:
- **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
- **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Regulation F641
Accuracy of Assessments

- *Accuracy of Assessments. The assessment must accurately reflect the resident's status.*

- *INTENT: To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.*

F641 Guidance

- Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

F642
Coordination/Certification of Assessment

- Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
- Certification. A registered nurse must sign and certify that the assessment is completed.
- Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- Penalty for Falsification.

F642 Guidance

- **Patterns of MDS Assessment and Submissions**
- MDS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures.
- All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).
- A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher Resource Utilization Group (RUG) scores, un-triggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures….

F644 Coordination of PASRR and Assessments

- **A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:**
- **§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.**
- **§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.**

F644 Related Conditions

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

- It is attributable to— Cerebral palsy or epilepsy; or any other condition, other than a mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
- It is manifested before the person reaches age 22.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity:
- Self-care, Understanding and use of language, Learning, Mobility, Self-direction, Capacity for independent living.

F645 PASRR Screening for MD & ID

Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. A nursing facility must not admit, on or after January 1, 1989, any new residents with:

- **Mental disorder as defined in this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,**
  - That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
  - If the individual requires such level of services, whether the individual requires specialized services; or
- **Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—**
  - That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
  - If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

F645 Intent

- To ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.

F646 MD/ID Significant Change Notification

- **A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.**

- **INTENT**
- To ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs.

Contact Information

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Thank you!

- Thank you for all the work you do to ensure the care, comfort and safety of our most vulnerable in society. This is not an easy job you do, and it must come from the heart. Weariness and frustration can easily become your best friends, but don’t let them take over! Know that you are not alone in your work. Reach out, make friends and contacts who will encourage your soul.
  Please know that you are welcome
  to call or email me anytime.
  Sincerely, Janet