CMS
CENTERS for MEDICARE & MEDICAID SERVICES

r
Minimum Data Set (MDS) 3.0
Instructor Guide

Section A
Identification Information

Objectives

- State the intent of Section A Identification Information.

- Describe the information required to complete Section A.

- Code Section A correctly and accurately.

Methodology

This lesson uses lecture and scenario-based examples.

Training Resources

· Instructor Guide

· Slides 1 to 72

Instructor Preparation

· Review the Instructor Guide.

· Review learning objectives for the lesson.

· Rehearse with slide presentation.

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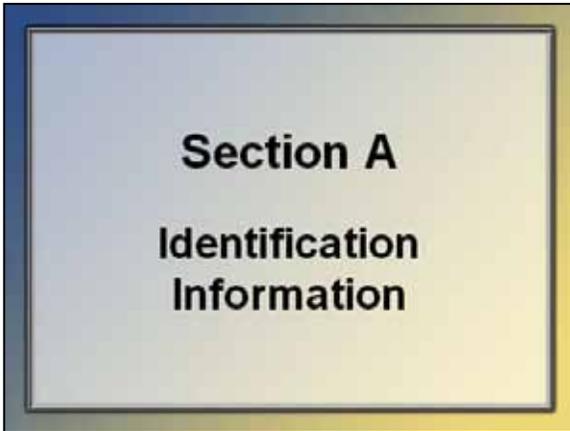
Slide 1

I. Introduction/ Objectives

   A. This lesson covers the first section of the MDS 3.0, Section A Identification Information.

   B. This section requires information that supports the administration and documentation of the entire MDS assessment.
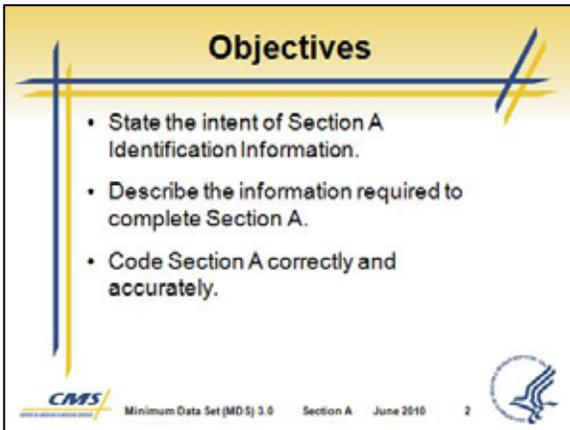

Slide 2

   C. Objectives

      ▪ State the intent of Section A Identification Information.

      ▪ Describe the information required to complete Section A.

      ▪ Code Section A correctly and accurately.

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 3

D. Intent of Section A

1. Section A documents a variety of data about the provider, the assessment being conducted, and the resident.

2. The intent of this section is to obtain key information to uniquely identify:

   a. Each resident

   b. Facility where the resident resides

   c. Type of provider (nursing home or swing bed)

   d. Reason(s) for assessment

Slide 4

**II. Items A0100 Facility Provider Numbers & A0200 Type of Provider**

A. Items A0100 and A0200 document data about the provider, including various provider numbers and the type of provider giving care to the resident.

Slide 5

B. A0100 Facility Provider Numbers

1. Items A0100 A through C document applicable Facility Provider Numbers.

   a. National Provider Identifier (NPI)

   b. CMS Certification Number (CCN)

      · This number was formerly referred to as the Medicare/Medicaid Provider Number.

   c. State Provider Number

SLIDES	INSTRUCTIONAL GUIDANCE
	2. These numbers allow the identification of the nursing home submitting the assessment.
	3. The NPI and CCN are required.
	4. The State Provider Number is optional.
	5. A0100 Coding Instructions
	· Enter the identification numbers in the spaces provided.
	· Enter one number per space.
	· Left-justify (start with the leftmost space).
	· Leave any extra spaces blank.

Instructor Notes

Notes

National Provider Identifier (NPI)

A unique federal number that identifies providers of health care services. The NPI applies to the nursing home for all of its residents.

Notes

Instructor Notes

Instructor Notes

Notes

CMS Certification Number (CCN)

Replaces the term "Medicare/ Medicaid Provider Number" in survey, certification, and assessment-related activities.

Notes

Instructor Notes

Instructor Notes

Notes

State Provider Number

Medicaid Provider Number established by a state.

Notes

Instructor Notes

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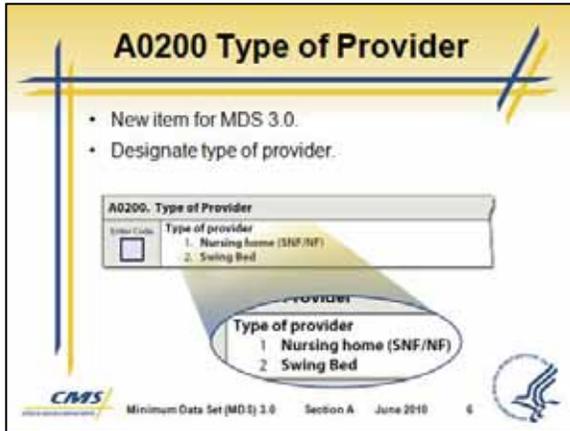
Slide 6

6. Item A0200 Type of Provider

   a. This is a new item for MDS 3.0 that allows designation of the type of provider.

   b. Nursing homes that are Medicare and/ or Medicaid certified must complete the MDS to meet OBRA requirements.

   c. SNFs and swing bed providers must complete for SNF PPS.

   d. Nursing homes and swing bed providers must complete item sets for every entry into the facility and for the appropriate type of discharge reporting.

   e. A0200 Coding Instructions

      ▪ Code the proper provider type.

      ▪ **Code 1. Nursing home (SNF/ NF)**

        If a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF)

      ▪ **Code 2. Swing Bed**

        If a hospital with swing bed approval

Instructor Notes

Swing Bed

A rural hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

Instructor Notes

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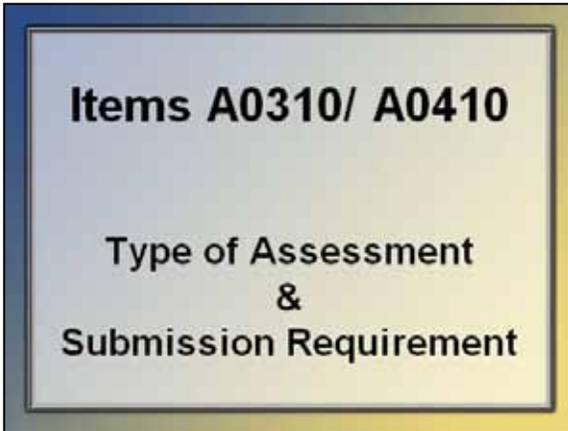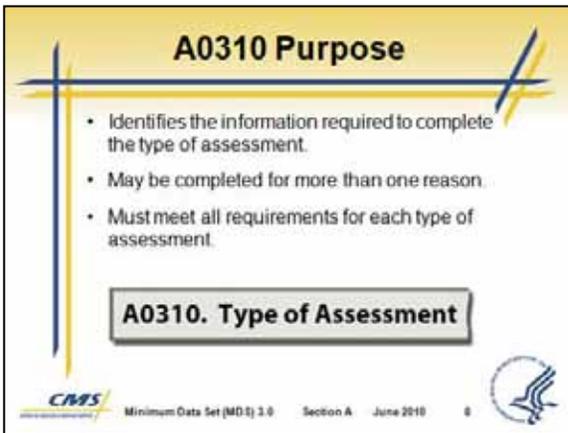
Slide 7

III. Items A0310 and A0410 Type of Assessment and Submission Requirement

   A. Items A0310 and A0410 document the type of assessment being conducted.


Slide 8

   B. A0310 Purpose

     1. This item documents the reason for completing the assessment.

       a. This allows identification of needed assessment content (what information is required to complete the type of assessment).

       b. One assessment may be completed for several reasons, such as combining the OBRA Admission and the PPS 5-day.

       c. When one assessment is completed for more than one reason, all requirements for each type of assessment must be met.

Instructor Notes
For detailed information on the requirements for scheduling and timing of assessments, see Chapter 2 of the RAI Manual for assessment schedules.
Instructor Notes

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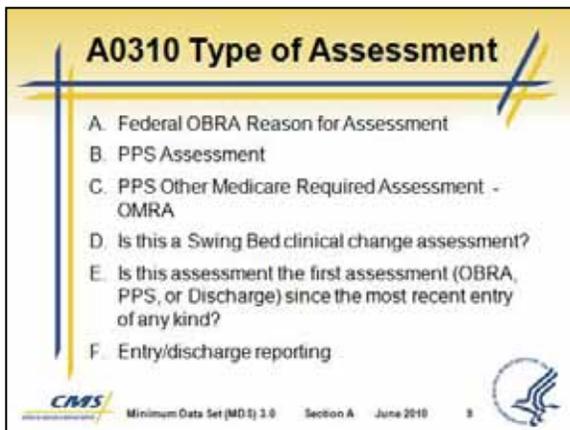
Slide 9
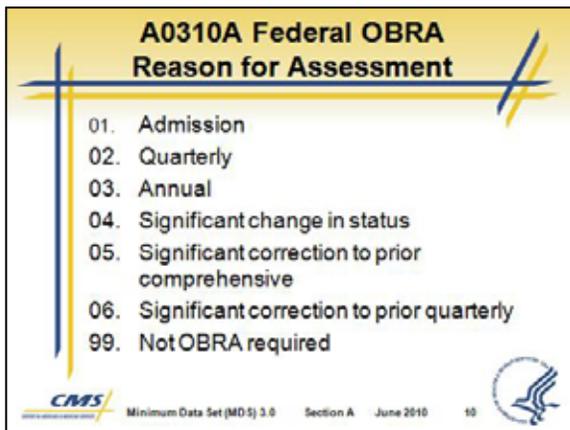
C. A0310 Types of Assessment

   1. A0310 items A through F cover a variety of reasons for conducting an MDS assessment.

      A. Federal OBRA Reason for Assessment

      B. PPS Assessment

      C. PPS Other Medicare Required Assessment - OMRA

      D. Is this a Swing Bed clinical change assessment?

      E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent entry of any kind?

      F. Entry/ discharge reporting

Slide 10

D. A0310A Federal OBRA Reason for Assessment

   1. Use option A0310A to indicate the type of OBRA assessment being conducted.

      · Admission

      · Quarterly

      · Annual

      · Significant change in status

      · Significant correction to prior comprehensive

      · Significant correction to prior quarterly

      · Not OBRA required

   2. Enter the complete, two-digit code.

   3. This includes the leading zero digit (such as 01).

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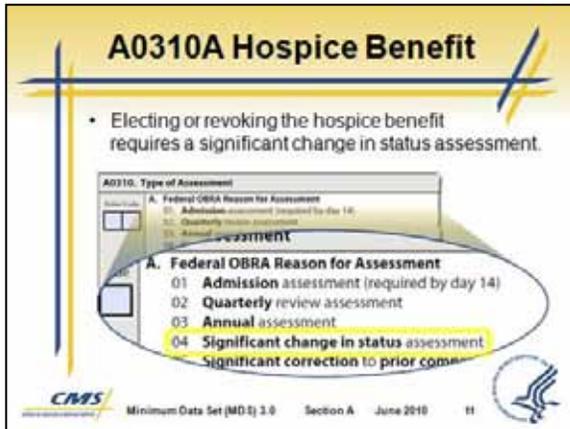
4. An option to indicate that this assessment does not meet these requirements is provided (code **99**).

E. A0310A Hospice Benefit

Slide 11

1. If a nursing home resident elects or revokes the Medicare hospice benefit, the nursing home is required to complete a significant change in status assessment.

2. The hospice benefit does not need to be Medicare to require a significant change in status assessment.

3. A significant change in status assessment is to be completed **every** time the hospice benefit is elected.

4. This is true even if a recent MDS was done and the only change is the election of the hospice benefit.

5. This is to ensure coordination and communication between nursing home and hospice staff at this vital time in a resident's care.
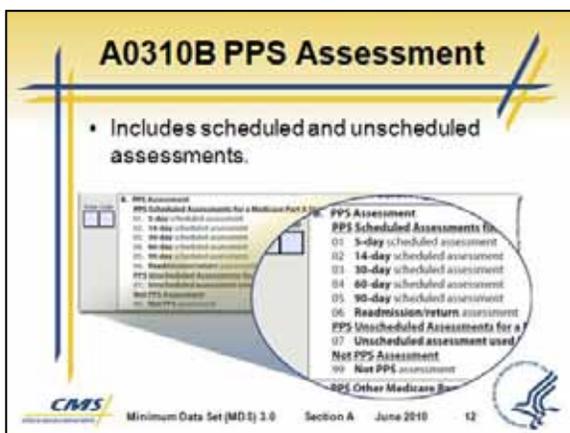
F. A0310B PPS Assessment

Slide 12

1. Use option A0310B to indicate the type of PPS assessment being conducted.

2. PPS assessments are broken down into scheduled and unscheduled assessments.

3. Enter the complete, two-digit code.

4. This includes entering the leading zero digit (such as 01).

5. An option to indicate that this assessment does not meet these requirements is provided (code **99**).

SLIDES	INSTRUCTIONAL GUIDANCE

Instructor Notes

Prospective Payment System (PPS)

PPS is a method of reimbursement in which Medicare payment is made based on the classification system for that service (e.g., resource utilization groups, RUGs for nursing home services).

Instructor Notes

A0310C PPS Other Medicare Required Assessment - OMRA

- Indicates whether the assessment is related to therapy services.
- Complete this item for all assessments.

Enter Code [ ] C. PPS Other Medicare Required Assessment - OMRA
0. No
1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment

CMS   Minimum Data Set (MDS) 3.0   Section A   June 2010   13
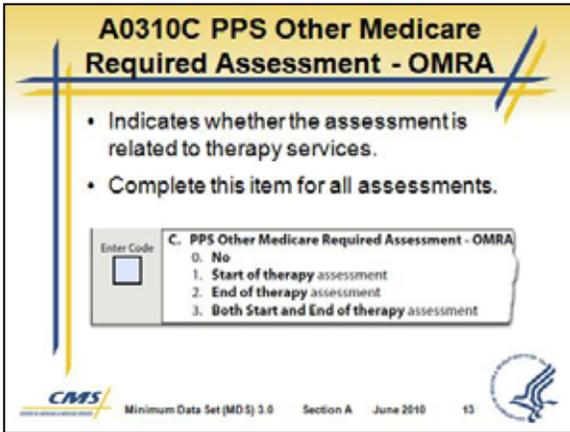
Slide 13

G. A0310C PPS Other Medicare Required Assessment – OMRA

  1. Indicates whether the assessment is related to the start or end of therapy services.

  2. This item should be completed for all assessments.

A0310C OMRA Coding Instructions

- **Code 0.** Not an OMRA assessment.
- **Code 1.** ARD is 5 - 7 days after first day of therapy services.
- **Code 2.** ARD is 1-3 days after last day of therapy services.
- **Code 3.** ARD meets both therapy criteria.
- Except when used as a short stay assessment.

CMS   Minimum Data Set (MDS) 3.0   Section A   June 2010   14
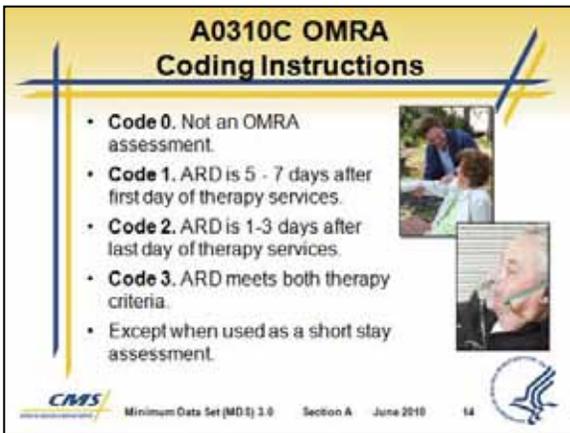
Slide 14

  3. A0310C OMRA Coding Instructions

    a. A0310C PPS Other Medicare Required Assessment – OMRA requires a one-digit code.

    · **Code 0. No**

      If this assessment is not an OMRA

    b. Additional codes indicate whether the assessment is conducted due to therapy services.

    c. Determining the correct code depends on the Assessment Reference Date (ARD).

SLIDES	INSTRUCTIONAL GUIDANCE
	· **Code 1. Start of therapy assessment**
	With an ARD that is 5 - 7 days after the first day therapy services are provided (except when the assessment is used as a short stay assessment -- see Chapter 6 of the RAI Manual)
	The start of therapy is the day of evaluation.
	· **Code 2. End of therapy assessment**
	With an ARD that is 1 to 3 days after the last day therapy services were provided
	The last day of therapy is the last day resident physically received therapy.
	· **Code 3. Both Start and End of therapy assessment**
	With an ARD that is both 5 - 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment -- see Chapter 6 of the RAI Manual)

Slide 15

H. A0310D Is this a Swing Bed clinical change assessment?

1. This item should be completed only if A0200 Type of Provider is coded **2. Swing Bed**.

2. Coding A0200 as **2** designates a swing bed provider.

3. Enter the correct one-digit code.

SLIDES	INSTRUCTIONAL GUIDANCE
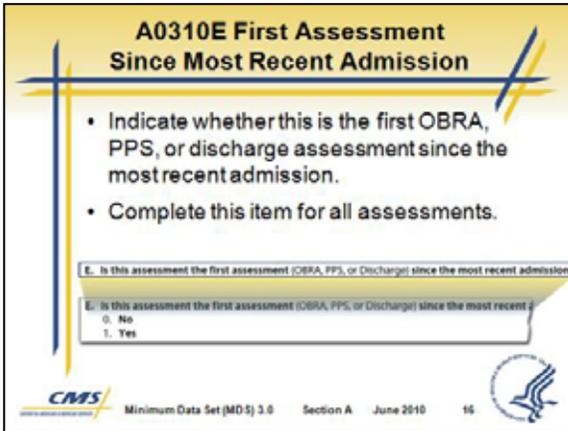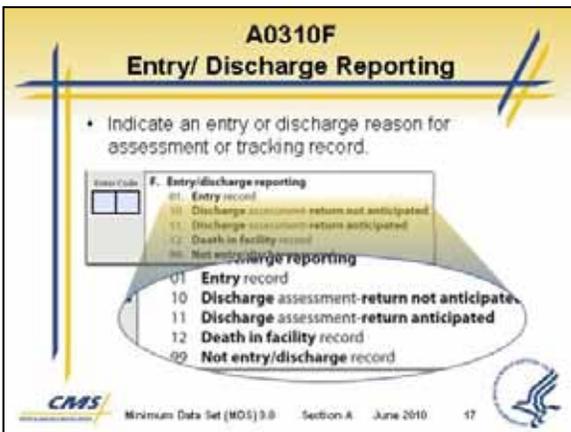
· **Code 0. No**

If this assessment is not a swing bed clinical change assessment

· **Code 1. Yes**

If this assessment is a swing bed clinical change assessment

Slide 16

I. A0310E Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?

1. Complete this item for all assessments.

· Code **0. No**

If this assessment is not the first assessment since the most recent entry of any kind (admission or reentry)

· Code **1. Yes**

If this assessment is the first assessment since the most recent entry of any kind (admission or reentry)

2. Code A0310E as **0. No** for any tracking record (entry or death in the facility).

Slide 17

J. A0310F Entry/ Discharge Reporting

1. Indicates whether this assessment or tracking record is conducted for entry or discharge purposes.

2. Discharge options include residents who are anticipated to return and not anticipated to return to the provider facility.

3. Complete this item for every assessment.

SLIDES	INSTRUCTIONAL GUIDANCE
	4. Enter the code corresponding to the entry/ discharge reason for completing this assessment or tracking record.
	· **Code 01. Entry record (tracking record)**
	· **Code 10. Discharge assessment-return not anticipated**
	· **Code 11. Discharge assessment-return anticipated**
	· **Code 12. Death in facility record (tracking record)**
	· **Code 99. No entry/ discharge**
	5. Enter the complete, two-digit code.
	6. This includes the leading zero digit (such as 01).
	7. An option to indicate that this assessment does not meet these requirements is provided (code **99**).

Slide 18

K. A0410 Submission Requirement

1. Item A0410 designates the submission requirement for the assessment.

2. There must be a federal and/ or state authority to submit MDS data to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System.

3. Facilities must be certain they are submitting MDS assessments under the appropriate authority.

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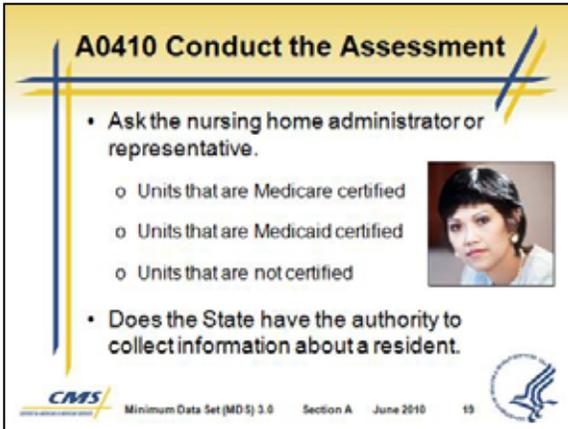
Slide 19

4. A0410 Conduct the Assessment

a. Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, if any, and which units are Medicaid certified, if any.

b. Identify all units in the nursing home that are not certified, if any.

c. If some units are not either Medicare or Medicaid certified, ask whether the State has any authority to collect MDS information for residents on these units.
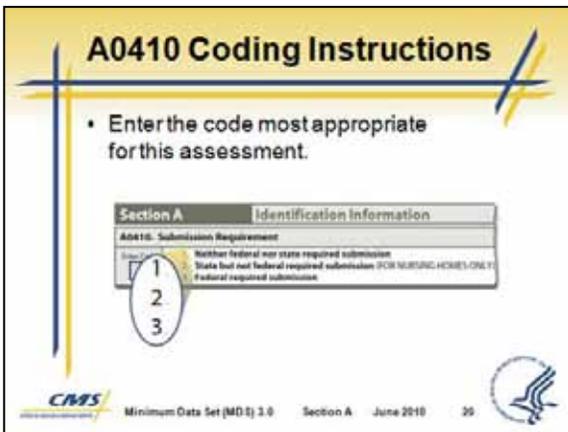
Slide 20

5. A0410 Coding Instructions

a. Code the type of submission requirement most appropriate for this assessment.

· **Code 1. Neither federal nor state required submission**

· **Code 2. State but not federal required submission**

· **Code 3. Federal required submission**

Detailed coding information provided below.

SLIDES	INSTRUCTIONAL GUIDANCE

A0410 Submission Requirement Detailed Coding Instructions

· **Code 1. Neither Federal nor State Required Submission**

If the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for residents on this unit. If the record is submitted, it will be rejected and all information from that record will be purged

· **Code 2. State but not Federal Required Submission**

If the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or other requirements, to collect MDS information for these residents

· **Code 3. Federal Required Submission**

If the MDS record is for a resident on a Medicare and/ or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit

Items A0500 – A2400
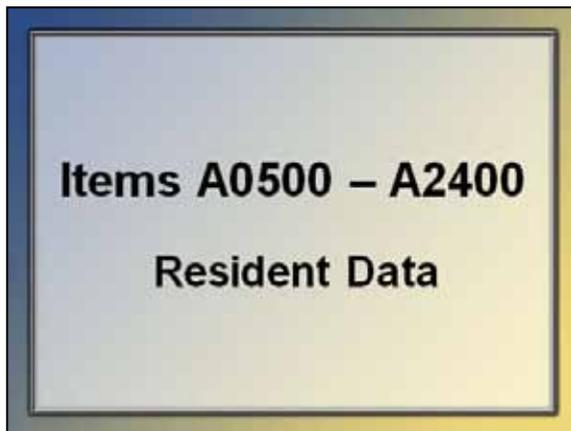
Resident Data

**IV. Items A0500 through A2400 Resident Data**

   A. The remaining items in Section A document information about the resident.

Slide 21

SLIDES	INSTRUCTIONAL GUIDANCE
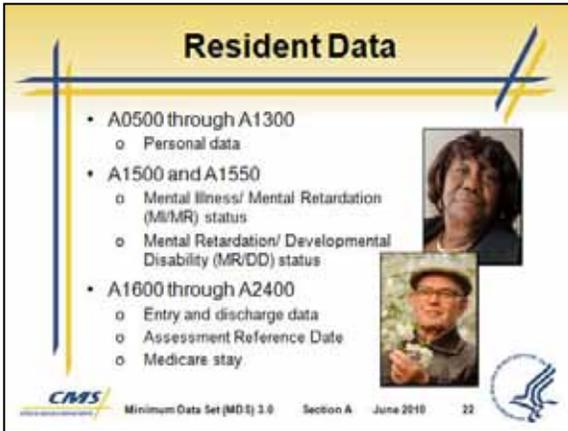
Slide 22

B. Resident Data

   1. Section A requires a range of information describing the resident.

      a. Sections A0500 through A1300 document personal data about the resident.

      b. Sections A1500 and A1550 document Mental Illness/ Mental Retardation (MI/ MR) and Mental Retardation / Development Disability (MR/ DD) status.

      c. Sections A1600 through A2400 document:

         · Entry and discharge data

         · Assessment Reference Date (ARD)

         · Medicare stay data

Instructor Notes   Notes

MI/ MR and MR/ DD

MI/ MR – Mental Illness and Mental Retardation

MR/ DD – Mental Retardation or Developmental Disabilities

Notes   **Instructor Notes**
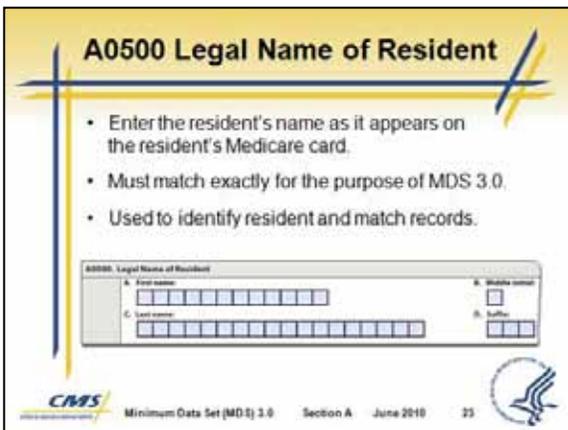
Slide 23

   2. A0500 Legal Name of Resident

      a. Enter the resident's name as it appears on the resident's Medicare card.

      b. If the resident is not enrolled in the Medicare program, use the residents name as it appears on a Medicaid card or other government issued document.

         · Drivers license

         · Birth certificate

SLIDES	INSTRUCTIONAL GUIDANCE
	· Passport
	· Social Security card
	c. Ask resident, family member, significant other, guardian, or other legal representative.
	d. The resident's name must match exactly for the purpose of the MDS 3.0.
	e. Allows identification of the resident and matching of records for the resident.
	f. Write in printed letters if completing the MDS on paper.
	g. A0500B Middle Initial
	· Leave blank if resident does not have a middle name.
	· If the resident has two or more middle names, use the initial of the first middle name.

Slide 24

3. A0600 Social Security and Medicare Numbers

    a. Enter the resident's Social Security Number (SSN).

    b. Leave this item blank if no SSN is available, such as for:

       · Recent immigrant

       · Child

    c. Enter the resident's Medicare number exactly as it appears on the resident's documents.

    d. Make sure the resident name on the MDS matches the name on the Medicare card.

SLIDES	INSTRUCTIONAL GUIDANCE
	e. If the resident does not have a Medicare number, a comparable Railroad Retirement Board (RRB) number may be substituted.
	Refer to example in the graphic.
	f. If a Medicare or RRB number is unavailable, the item may be left blank.
	g. For PPS Assessments, either the SSN (A0600A) or Medicare / RRB number (A0600B) must be present, so both may NOT be blank.
	h. **Do not** use an HMO number or other insurance number.
	i. Coding Instructions
	· Enter the numbers one digit or letter per space.
	· Left justify (start with the leftmost space).

Instructor Notes

Medicare Number (or Comparable Railroad Insurance Number)

An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance Identified may be different from the resident's social security number (SSN) and may contain both letters and numbers. For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.

Instructor Notes

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 25

4. A0700 Medicaid Number

   a. Assists in correct resident identification.

   b. Record this number if the resident is a Medicaid recipient.

   c. Check the resident's Medicaid card, admission or transfer records, or medical record.

   d. Confirm that the resident's name on the MDS matches the resident's name on the Medicaid card.

   e. It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment for Federal purposes.

   f. A correction to a prior assessment may be a state requirement.

Slide 26

   g. A0700 Coding Instructions

      · Enter one digit per space starting with the leftmost space.

      · Enter a "+" sign if a Medicaid number is pending.

      · Include the Medicaid number on the next assessment.

      · If this number is not applicable because the resident is not a Medicaid recipient, enter "N" in the leftmost space.

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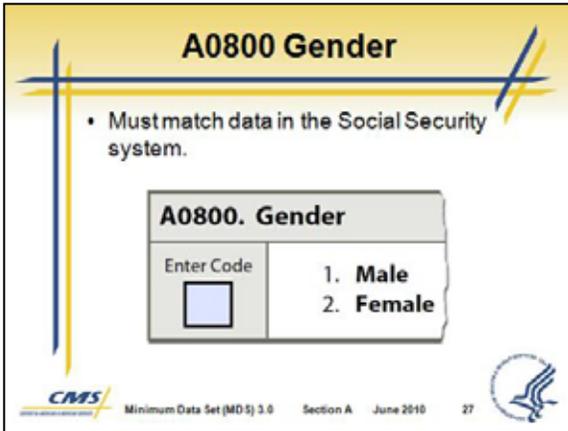
Slide 27	5. A0800 Gender
	
	   a. Assists in correct identification and provides demographic gender-specific health trend information.
	
	   b. Resident gender in the MDS must match the data in the Social Security system.
	
	   c. This does not reflect any lifestyle choices expressed by the resident.
	
	   d. A0800 Coding Instructions
	
	      · **Code 1. Male**
	
	      · **Code 2. Female**

Slide 28	6. A0900 Birth Date
	
	   a. Assists in correct identification.
	
	   b. Allows determination of age.
	
	   c. A0900 Coding Instructions
	
	      · Enter the birth date in the spaces in month, day, year format.
	
	      · Enter a two-digit month, two-digit day, and four-digit year.
	
	      · Use a leading zero to complete a single-digit month or day.
	
	Refer to example for month in the graphic.
	
	      · For example, January is entered as 01 and the year as the full year (in this example, 1918).
	
	      · If the complete birth date is known, do not leave any spaces]]]]] blank.

SLIDES	INSTRUCTIONAL GUIDANCE

· If any component of the birth date is unknown, leave those spaces blank.

· For example, enter the year and month but leave the day blank if the day is unknown.

Slide 29

7. A0100 Race Ethnicity

  a. Provides demographic health trend information.

  b. The categories in this item follow the common uniform language approved by the Office of Management and Budget (OMB).

  c. These categories are NOT used to determine eligibility for participation in any federal program.

Slide 30

  d. A1000 Conduct the Assessment

· Ask the resident to select the category or categories that most closely correspond to his or her race/ ethnicity from the list in A1000.

· Use suggested language to explain why this information is needed.

See suggested language below.

· If the resident is unable to respond, ask a family member or significant other.

· Category definitions are provided to resident or family only if requested by them in order to answer the item.

SLIDES	INSTRUCTIONAL GUIDANCE
	· Observer identification or medical record documentation may be used only if the resident is unable to respond and no family member or significant other is available.

Instructor Notes

Suggested Language for Race/ Ethnicity Question

Individuals may be more comfortable if this and the preceding question are introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005)

Instructor Notes
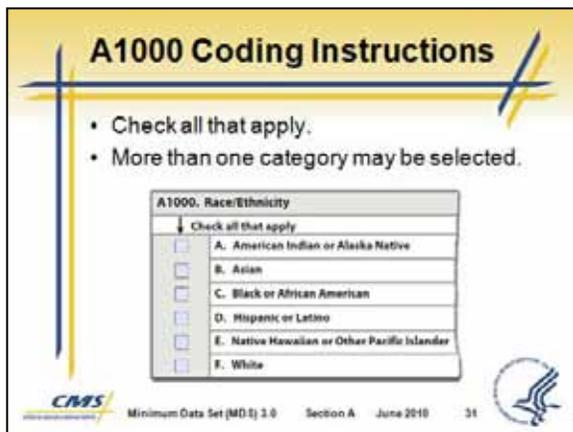
Slide 31

e. A1000 Coding Instructions

· Check all categories that apply.

· More than one category may be selected to reflect the resident's race and ethnic background.

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 32

8. A1100 Language.

   a. Inability to make needs known and to engage in social interaction because of a language barrier:

      · Can be very frustrating.

      · Can result in isolation, depression, and unmet needs.

   b. Language barriers can interfere with assessment.

   c. This item identifies residents who may need interpreter services.

      · To enable the resident to complete the interview items in the MDS assessment.

      · To participate in the consent process.

Slide 33

   d. A1100 Conduct the Assessment

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

      · Consult family member or significant other.

      · Review the medical record if the resident is unable to respond and if family is not available.

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

SLIDES	INSTRUCTIONAL GUIDANCE

· It is acceptable for a family member or significant other to be the interpreter **if**:

- Resident is comfortable with it

- Family member or significant other will translate exactly what the resident says without providing his or her interpretation
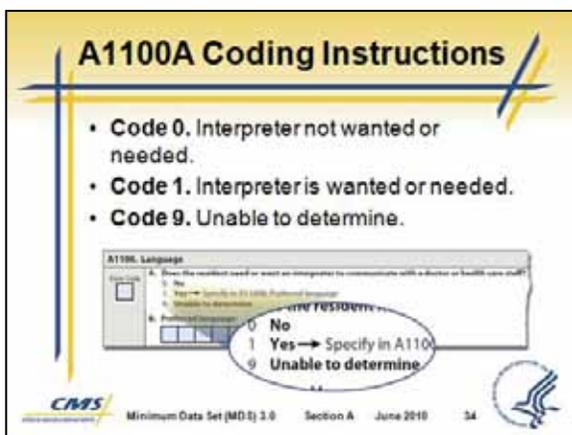
Slide 34

e. A1100A Coding Instructions

· Item A1100A answers the question "*Does the resident need or want an interpreter to communicate with a doctor or health care staff?*"

· **Code 0. No**

· **Code 1. Yes**

· **Code 9. Unable to determine**

Detailed coding instructions provided below.

SLIDES	INSTRUCTIONAL GUIDANCE

Instructor Notes

A1100A Detailed Coding Instructions

· **Code 0. No**

If the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff.

· **Code 1. Yes**

If the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff.

Specify preferred language. Proceed to 1100B and enter the resident's preferred language.

· **Code 9. Unable to determine**

If no source can identify whether the resident wants or needs an interpreter.

Instructor Notes

Slide 35

f. A1100B Coding Instructions

· Specify a language only if an interpreter is needed or wanted.

· Otherwise, a language does not need to be provided.

· Organized systems of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

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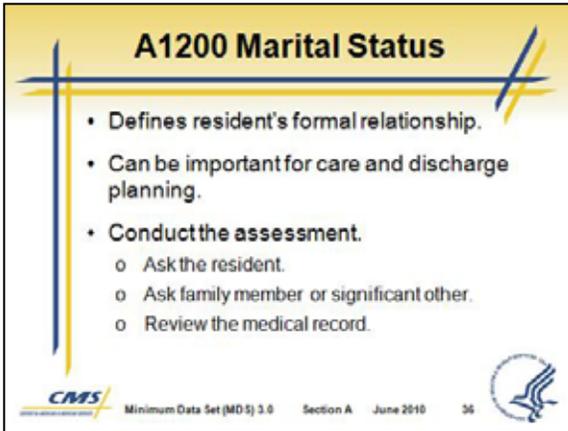
Slide 36

9. A1200 Marital Status

   a. Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.

   b. Also provides demographic information.

   c. A1200 Conduct the Assessment

      · Ask the resident about his or her marital status.

      · Consult family member or significant other if the resident cannot respond.

      · Review the medical record if the resident is unable to respond and if family is not available.
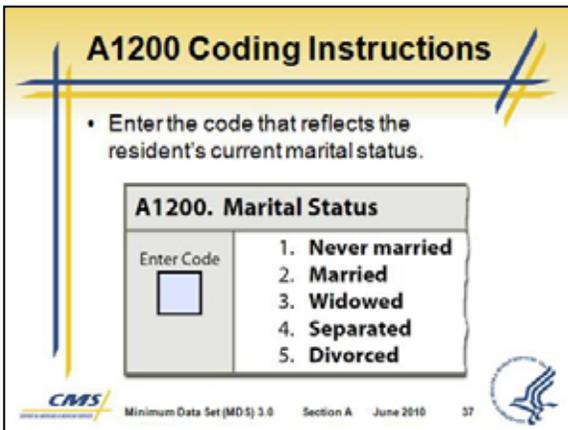
Slide 37

   d. A1200 Coding Instructions

      · Enter the code for the option that best describes the current marital status of the resident.

      · **Code 1. Never married**

      · **Code 2. Married**

      · **Code 3. Widowed**

      · **Code 4. Separated**

   · **Code 5. Divorced**

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 38

10. A1300 Optional Resident Items

   a. This item has been added to the MDS 3.0 to document information that may be helpful to the facility in tracking resident data and improving resident interaction and care.

   b. This item is optional for Federal purposes. The information is not needed for CMS program function.

   c. However, your State may require some or all of these items. Check with your State RAI coordinator.

   d. Write in information in the spaces beginning with the leftmost space.

   e. Medical Record Number

      · Enter the resident's medical record number if the nursing home chooses to exercise this option.

      · Use the number from the nursing home medical record, admission office or Health Information Management Department.

   f. Room Number

      · Enter the resident's room number if the nursing home chooses to exercise this option.

      · The unit can be identified by the room number.

SLIDES	INSTRUCTIONAL GUIDANCE

	g. Preferred Name
	
	   · Enter the resident's preferred name.
	
	   · This field captures a preferred nickname, middle name, or title that the resident prefers staff use.
	
	   · For example, a physician may appreciate being referred to as "Doctor."
	
	h. Lifetime Occupation
	
	   · Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the nursing home.
	
	   · When two occupations are identified, place a slash (/) between each occupation.
	
	   · The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker."
	
	i. For a resident who is a child or a mentally retarded/ developmentally delayed adult resident who has never had an occupation, record as "none.
	
	j. Knowing a lifetime occupation(s) is helpful for conversation and care planning purposes.

SLIDES	INSTRUCTIONAL GUIDANCE

SLIDES

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INSTRUCTIONAL GUIDANCE

11. A1500 PASRR Overview

    a. New item in MDS 3.0.

    b. A PASRR is the state Preadmission Screening and Resident Review (PASRR) process.

    c. PASRR applies only to the Medicaid unit of a facility.

    d. A positive screen indicates that the resident mental has a mental illness, mental retardation, or a related condition.

    e. Individuals with serious mental illness and/ or mental retardation (MI/ MR) or a related condition may require certain care and services provided by facility, and/ or specialized services provided by state.

    f. This item is simply a statement of fact: does the resident have a positive Level II PASRR evaluation or not.

    g. Does not call for judgment about an individual's mental illness, mental retardation or related condition.

    h. A1500 only reports on the results of the PASRR process.

Instructor Notes

Level I PASRR

All applicants to Medicaid-certified NFs (regardless of payer source) receive a Level I PASRR screen to identify possible MI/ MR.

These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state.

Individuals who do or may have MI/ MR are referred for a Level II PASRR evaluation.

Instructor Notes

SLIDES	INSTRUCTIONAL GUIDANCE

Instructor Notes

Level II PASRR

The Level II PASRR evaluation and determinations are to confirm whether the applicant has MI/ MR for PASRR purposes, to assess the applicant's need for NF services, and to determine whether the applicant requires specialized MI/ MR services.

The State Mental Health Authority must use an independent evaluation (that meets minimum Federal criteria) in making the NF and specialized services determinations for MI. The State Mental Retardation Authority has responsibility for both the evaluation and the determination functions for MR. The State Mental Health or Mental Retardation Authority may delegate these responsibilities to another state agency (e.g., State Department on Aging) or a contractor.

Determinations made by the State Mental Health or Mental Retardation Authority as to whether NF level of services and specialized services are needed must be based on an individualized Level II evaluation, except for certain categories of persons obviously likely to require nursing facility services, or for whom specialized services are not normally needed.

States may elect in their Medicaid State plan to utilize these "categorical determinations" as defined in Federal regulations. Categorical determinations may be based on existing sources of data rather than an individualized Level II evaluation.

Instructor Notes
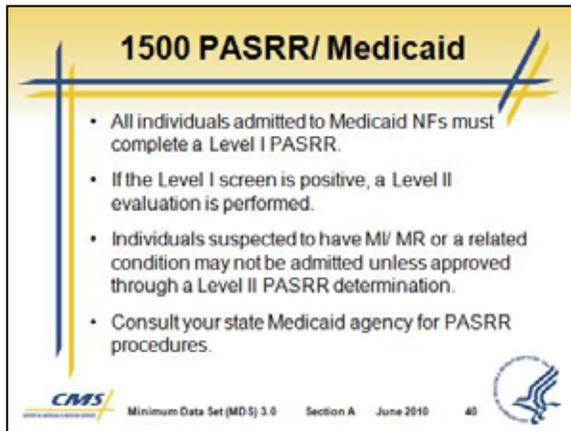
Slide 40

12. A1500 PASRR/ Medicaid

   i. All individuals admitted to Medicaid NFs must have a Level I PASRR completed to screen for possible mental illness, mental retardation, or related conditions regardless of method of payment.

   j. Note that the requirement is based on the certification of the part of the nursing home the resident will occupy.

   k. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted or transferred to a Medicaid certified part of the building.

SLIDES	INSTRUCTIONAL GUIDANCE
	l. If the Level I screen is positive, a Level II evaluation is performed.

m. Individuals who have or are suspected to have MI/ MR or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination.

n. Each State Medicaid agency might have specific processes and guidelines for referral, and which types of significant changes should be referred.

o. Therefore, facilities should become acquainted with their own State requirements.

p. For more information about PASRR, contact your state Medicaid agency for the State's plan.

  · This includes information on the role of state MI/ MR agencies.

  · States may have training available.

13. A1500 PASRR Reporting

A1500 PASRR Reporting

- Required for an Admission MDS only.
- If completing a significant change in status MDS for a resident on a Level II PASRR, provider is required to notify:
  o State mental health authority
  o Mental retardation or developmental disability authority

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q. Complete this item for an Admission MDS only.

  · A0310A = **01**.

1. If a significant change in status MDS assessment is completed for a resident on a Level II PASRR, the provider is required to notify:

  · State mental health authority

SLIDES	INSTRUCTIONAL GUIDANCE
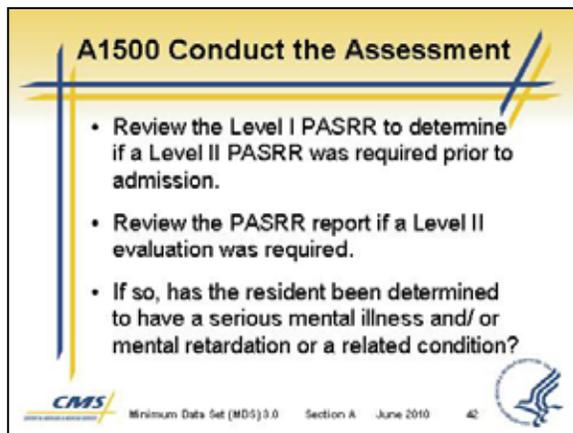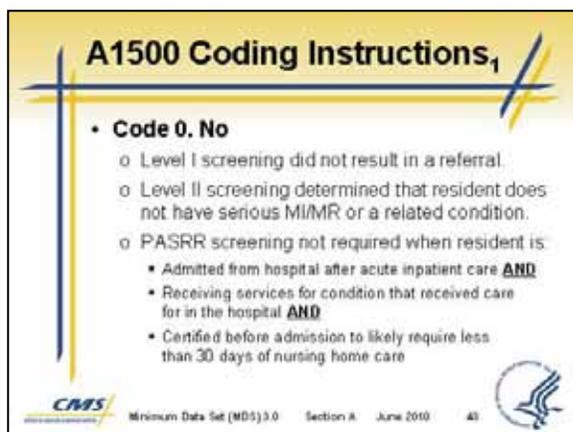
| | · Mental retardation and developmental disability authority |
| | · Depending on which operates in their State |

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r. A1500 Conduct the Assessment

· Need to determine if the resident has been evaluated by a Level II PASRR.

· Review the Level I PASRR screening form to determine if a Level II PASRR was required.

· Review the report provided by the State if a Level II screening was required.

· If the resident has been evaluated by a Level II PASRR, has the resident been determined to have a serious mental illness and/ or mental retardation or a related condition?

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s. A1500 Coding Instructions

· **Code 0. No**

- PASRR Level I screening did not result in a referral for Level II screening.

- Level II screening determined that the resident does not have a serious mental illness and/ or mental retardation-related condition.

SLIDES	INSTRUCTIONAL GUIDANCE

- PASRR screening is not required because:

   i. Resident was admitted from a hospital after requiring acute inpatient care.

AND

   ii. Is receiving services for the condition for which he or she received care in the hospital.

AND

   iii. Attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

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· **Code 1. Yes**

If PASRR Level II screening determined that the resident has a serious mental illness and/ or mental retardation-related condition

· **Code 9 Not a Medicaid certified unit**

If bed is not in a Medicaid-certified nursing home

The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.

· This requirement is based on the certification of the part of the nursing home the resident will occupy.

SLIDES	INSTRUCTIONAL GUIDANCE
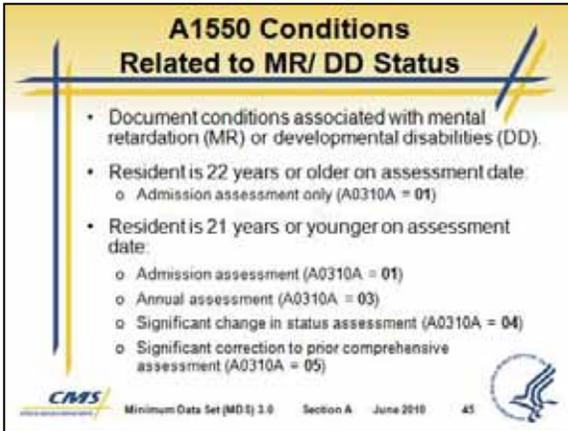
Slide 45

14. A1550 Conditions Related to MR/ DD Status

   a. Document conditions associated with mental retardation or developmental disabilities (MR/ DD).

   b. If the resident is 22 years or older on the assessment date, this item is required at the Admission assessment only. (A0310A = **01**)

   c. If the resident is 21 years or younger on the assessment date, this item is required for:

      · Admission assessment (A0310A = **01**)

      · Annual assessment A0310A = **03**)

      · Significant change in status assessment (A0310A = **04**)

      · Significant correction to prior comprehensive assessment (A0310A = **05**)
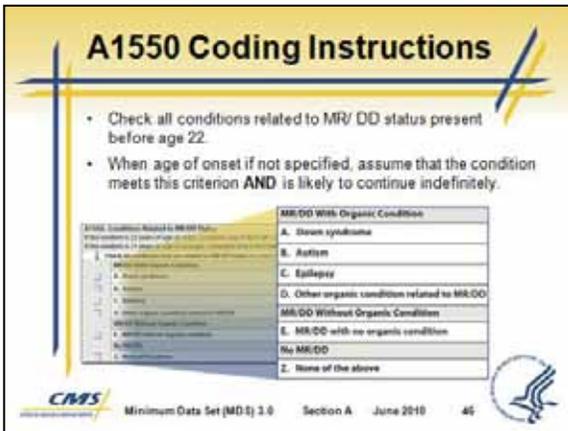
Slide 46

   d. Item A1550 Coding Instructions

      · Check all conditions related to MR/ DD status present before age 22.

      · When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

   e. Check all options that apply to this resident.

      · Select options **A**, **B**, or **C** if these conditions are present.

SLIDES	INSTRUCTIONAL GUIDANCE
	· Select option **D** of another organic condition related to MR/ DD is present.
	· Select option **E** if an MR/ DD condition is present but the resident does not have any of the specific conditions listed.
	· Select option **Z** if MR/ DD condition is not present.

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15. A1600 Entry Date

    a. Document the most recent date of entry to the facility.

    b. A1600 Coding Instructions

      · Enter the entry date.

      · Use the format month — day –year.

16. A1700 Type of Entry

    a. New item in MDS 3.0.

    b. This item captures the admission date or reentry date..

SLIDES	INSTRUCTIONAL GUIDANCE

Slide 48

c. A1700 Coding Instructions

- **Code 1. Admission**

  When **one** of the following occurs:

  - Resident has never been admitted to this facility before.

  OR

  - Resident has been in this facility previously and was discharged prior to completion of the OBRA admission assessment.

  OR

  - Resident has been in this facility previously and was discharged return not anticipated.

  OR

  - Resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.

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- **Code 2. Reentry**

  When **all three** of the following occur prior to this entry:

  - Resident was admitted to this nursing home (i.e., OBRA admission assessment was completed).

  AND
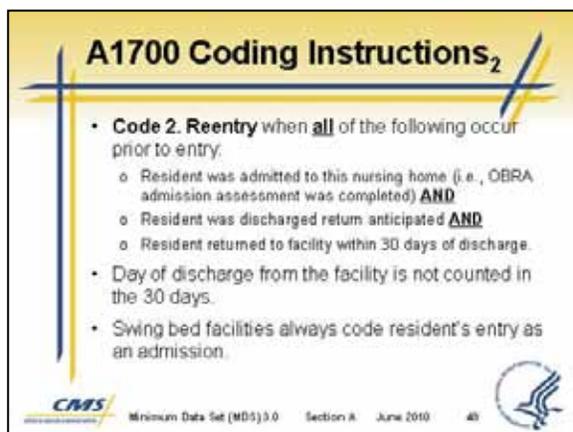
SLIDES	INSTRUCTIONAL GUIDANCE
	- Resident was discharged return anticipated.

AND

- Resident returned to facility within 30 days of discharge.

· In determining if a resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days.

· For example, a resident is discharged return anticipated on December 1 would need to return to the facility December 31 to meet the "within 30 day" requirement.

· Swing Bed facilities will always code the resident's entry as an admission, '1', since swing bed providers never complete an OBRA Admission assessment.

17. A1800 Entered From

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a. Reflects the setting the resident was in immediately prior to nursing home admission.

b. Understanding this setting informs care planning.

c. May also inform discharge planning and discussions.

| SLIDES	INSTRUCTIONAL GUIDANCE
Slide 51	d. A1800 Conduct the Assessment · Review transfer and admission records. · Ask the resident. · Ask family or significant others.
Slide 52	e. A1800 Coding Instructions · Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission. *Coding instructions provided below.* · **Code 01. Community (private home/ apt, board/ care, assisted living, group home)** · **Code 02. Another nursing home or swing bed** · **Code 03. Acute hospital** · **Code 04. Psychiatric hospital** · **Code 05. Inpatient rehabilitation facility (IRF)** · **Code 06. MR/ DD facility** · **Code 07. Hospice** · **Code 99. Other** If the resident was admitted from none of the above.
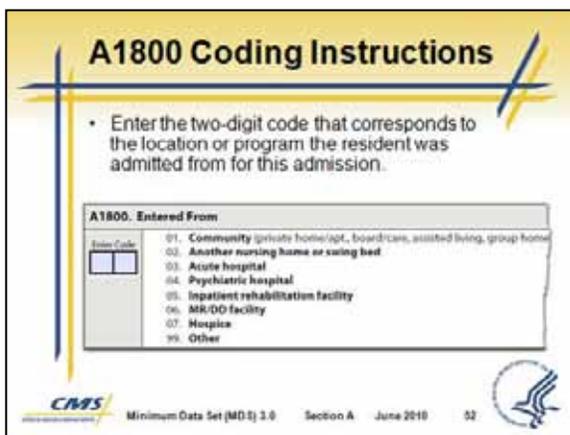
SLIDES	INSTRUCTIONAL GUIDANCE

A1800 Detailed Coding Instructions

- **Code 01. Community (private home/ apt, board/ care, assisted living, group home)**
    - If the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
    - If an individual was enrolled in a home-based hospice program enter **07, hospice**, instead of **01, community**.
- **Code 02. Another nursing home or swing bed**

    If the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons.

    Includes swing beds.

- **Code 03. Acute hospital**

    If the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

- **Code 04. Psychiatric hospital**

    If the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.

- **Code 05. Inpatient rehabilitation facility (IRF)**

    If the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled or sick persons.

    Includes IRFs that are units within acute care hospitals.

- **Code 06. MR/ DD facility**

    If the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

- **Code 07. Hospice**
    - If the resident was admitted from a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions.
    - The hospice must be licensed by the State as a hospice provider and/ or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
    - If the resident was admitted from none of the above.

Notes

SLIDES	INSTRUCTIONAL GUIDANCE

Instructor Notes

Notes

Private Home or Apartment

Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.

Notes

Instructor Notes

Instructor Notes

Notes

Board and Care/ Assisted Living Group Home

A non-institutional community residential setting that includes services of the following types: home health services, homemaker/ personal care services, or meal services.

Notes

Instructor Notes
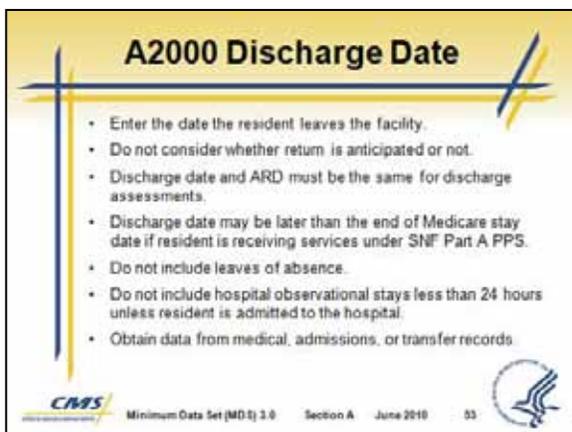
Slide 53

18. A2000 and A2100 document information concerning the resident's discharge from the facility.

   a. A2000 Discharge Date closes the case in the system.

   b. A2000 Coding Instructions

      · Enter the actual date the resident leaves the facility (whether or not return is anticipated).

      · The discharge date (A2000) and ARD (A2300) must be the same date for discharge assessments.

      · If a resident was receiving services under SNF Part A PPS, the discharge date may be later than the end of Medicare stay date (A2400C).

      · Do not include leaves of absence.

SLIDES	INSTRUCTIONAL GUIDANCE
	· Do not include hospital observational stays less than 24 hours unless admitted to the hospital.
	· Obtain data from the medical, admissions, or transfer records.
	· Use month/ day/ year format.

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c. A2100 Discharge Status

  · Provides demographics and outcome information.

  · This item appears on discharge assessments and death in facility tracking record.

  · Review the medical record including the discharge plan and discharge orders for documentation of discharge location.

  · Complete only if A0310F is coded:

    - **10** Discharge assessment – return not anticipated

    - **11** Discharge assessment – return anticipated

    - **12** Death in facility record

d. A2100 Coding Instructions

  · Select the two-digit code that corresponds to the resident's discharge status.

SLIDES	INSTRUCTIONAL GUIDANCE

· **Code 01. Community (private home/ apt., board/ care, assisted living, group home)**

· **Code 02. Another nursing home or swing bed**

· **Code 03. Acute hospital**

· **Code 04. Psychiatric hospital**

· **Code 05. Inpatient rehabilitation facility**

· **Code 06. MR/ DD facility**

· **Code 07. Hospice**

· **Code 08. Deceased**

If resident is deceased.

· **Code 99. Other**

If discharge location is none of the above.

Coding instructions provided below.

SLIDES	INSTRUCTIONAL GUIDANCE

A2000 Detailed Coding Instructions

- **Code 01. Community (private home/ apt., board/ care, assisted living, group home)**

  If discharge location is a private home, apartment, board and care, assisted living facility, or group home.

- **Code 02. Another nursing home or swing bed**

  If discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons.

  Includes swing beds.

- **Code 03. Acute hospital**

  If discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

- **Code 04. Psychiatric hospital**

  If discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.

- **Code 05. Inpatient rehabilitation facility**

  If discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.

- **Code 06. MR/ DD facility**

  If discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental delay.

- **Code 07. Hospice**

  If discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/ or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient.

SLIDES	INSTRUCTIONAL GUIDANCE
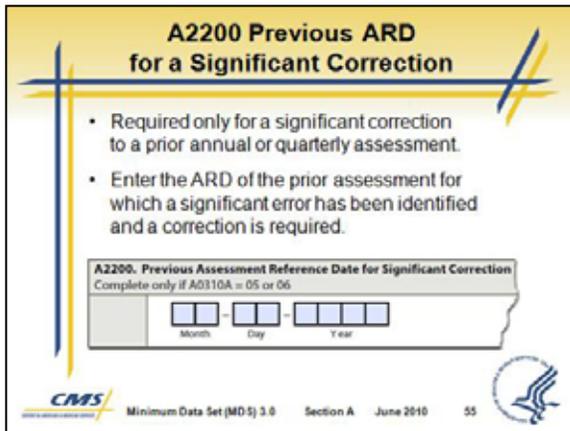
Slide 55
	19. A2200 Previous ARD for a Significant Correction
	
	   a. A2200 and A2300 document assessment reference data.
	
	   b. A2200 Previous Assessment Reference Date for a Significant Correction
	
	     · This item identifies the ARD of a previous comprehensive or quarterly assessment in which a significant error is discovered.
	
	     · Complete only for:
	       - A significant correction to a prior full assessment (A0310A = **05**)
	       - A significant change to a prior quarterly assessment (A0310A = **06**)
	
	     · Enter the ARD of the prior comprehensive or quarterly assessment in which a significant error has been identified and a correction is required.
	
	     · Use month – day – year format.

SLIDES	INSTRUCTIONAL GUIDANCE

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c. A2300 Assessment Reference Date

- Designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time.

- As the last day of the look-back period, the ARD serves as the reference point for determining the care and services are captured on the MDS assessment.

- Anything that happens after the ARD will not be captured on the current MDS.

- For example, for a MDS item with a 7-day look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period.

- For an item with a 14-day look-back period, the information is collected for a 14-day period ending on and including the ARD.

- The look-back period includes observations and events through the end of the day (midnight) of the ARD.

SLIDES	INSTRUCTIONAL GUIDANCE
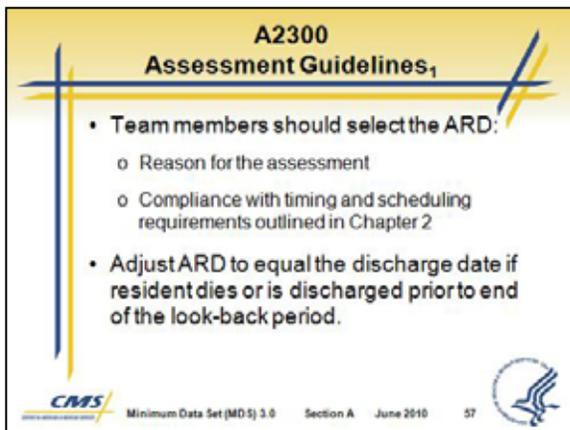
Slide 57
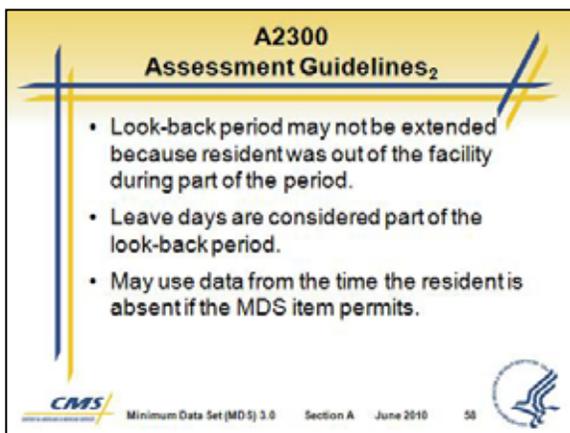
d. A2300 Assessment Guidelines

- Interdisciplinary team members should select the ARD based on:

  - Reason for the assessment

  - Compliance with all timing and scheduling requirements outlined in Chapter 2 of the RAI Manual.

- If resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.

- The look-back period may not be extended simply because a resident was out of the facility during part of the look-back period.

  - Home visit

  - Therapeutic leave

  - Hospital observation stay less than 24 hours when resident is not admitted

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- Leave days are considered part of the look-back period.

- May use data from the leave period if the MDS item permits.

SLIDES	INSTRUCTIONAL GUIDANCE
	· For example, if the family takes the resident to the physician during the leave, the visit would be counted in Item O0600, **Physician Examination** (if criteria are otherwise met).
	· This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

20. A2400 Medicare Stay

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   a. This item serves several purposes:

      · Identifies when a resident is receiving services under the SNF PPS.

      · Identifies when a resident's Medicare Part A stay begins and ends.

      · The end date is used to determine if the resident's stay qualifies for the short stay assessment.

Slide 60

   b. In A2400A, indicate whether the resident has had a Medicare-covered stay since the most recent entry.

      · **Code 0. No**

      If the resident has not had a covered Medicare Part A-covered stay since the most recent entry

      Skip to B0100. Comatose.

Emphasize skip pattern here.

SLIDES	INSTRUCTIONAL GUIDANCE

· **Code 1. Yes**

If the resident has had a Medicare Part A-covered stay since the most recent entry.

Continue to A2400B.

Instructor Notes

Notes

Most Recent Medicare Stay

This is a Medicare Part A covered stay that has started on or after the most recent entry (admission or reentry) to the facility.

Instructor Notes

Instructor Notes

Notes

Medicare-Covered Stay

Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

Instructor Notes

Instructor Notes

Notes

Current Medicare Stay

NEW ADMISSION: Day 1 of Medicare Part A stay.

READMISSION: Day 1 of Medicare Part A coverage after readmission following a discharge.

**Instructor Notes**
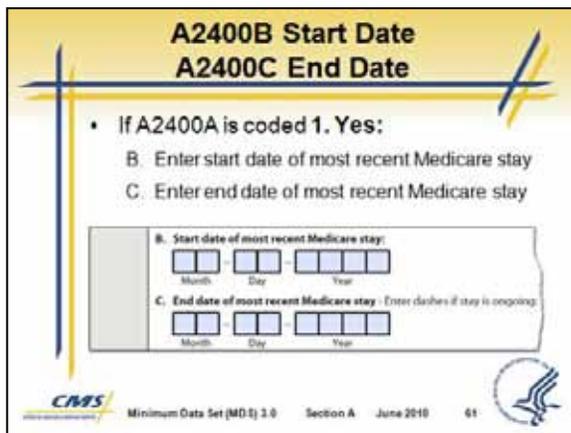
Slide 61

21. A2400B and A2400C Medicare Stay

   a. If A2400A is coded **1. Yes,** then enter the start and end dates of the Medicare stay.

   b. A2400B Start date of the most recent Medicare stay

      · Code the date of day 1 of this Medicare stay.

   c. A2400C End date of the most recent Medicare stay

SLIDES	INSTRUCTIONAL GUIDANCE
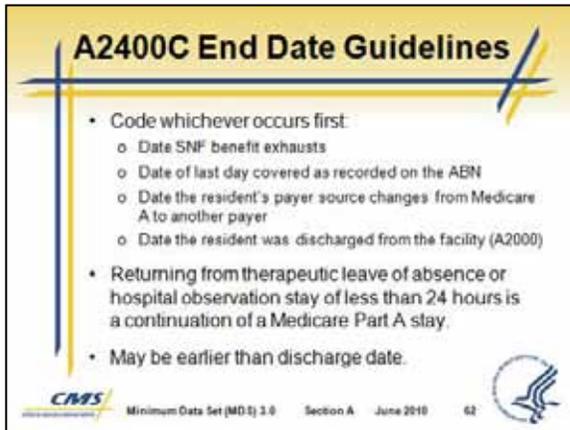
· Code the date of last day of this Medicare stay.

· If the Medicare Part A stay is ongoing, there is no end date to report. Enter dashes to indicate the stay is ongoing.

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d. The end of Medicare date is coded as follows, whichever occurs first:

· Date SNF benefit exhausts (i.e., the 100th day of the benefit)

OR

· Date of last day covered as recorded on the Advance Beneficiary Notice of Noncoverage (ABN)

OR

· Date the resident's payer source changes from Medicare Part A to another payer (regardless if the resident was moved to another bed or not)

OR

· Date the resident was discharged from the facility (see A2000. Discharge Date)

e. When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours, this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.

SLIDES	INSTRUCTIONAL GUIDANCE
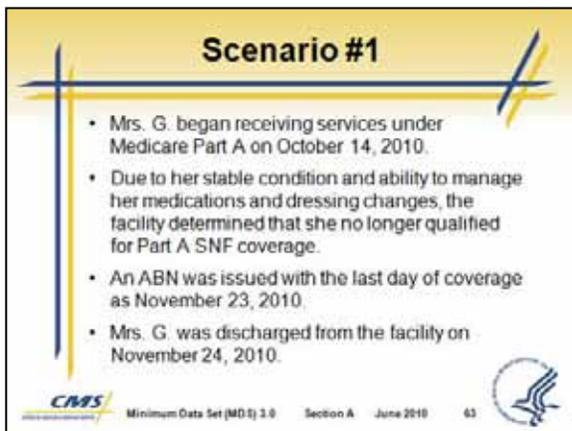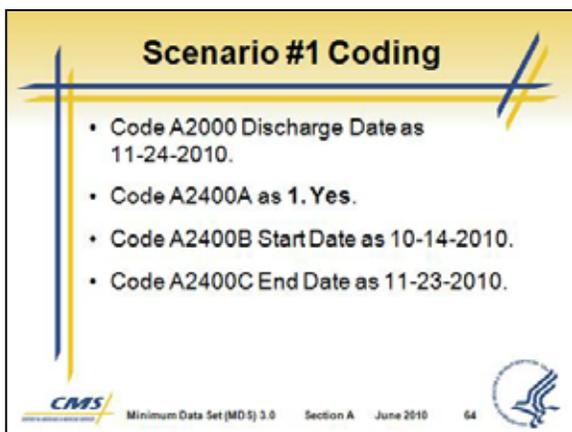
f. The end date of the Medicare stay may be earlier than actual discharge date from the facility (A2000).

g. Scenario #1

- Mrs. G. began receiving services under Medicare Part A on October 14, 2010.

- Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage.

- An ABN was issued with the last day of coverage as November 23, 2010.

- Mrs. G. was discharged from the facility on November 24, 2010.

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h. Scenario #1 Coding

- Code A2000 Discharge Date as 11-24-2010.

- Code A2400A *Has the resident had a Medicare-covered stay since the most recent entry?* as **1. Yes**.

- Code A2400B Start Date as 10-14-2010.

- Code A2400C End Date as 11-23-2010.

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SLIDES	INSTRUCTIONAL GUIDANCE

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i. Scenario #2

- · Mr. N began receiving services under Medicare Part A on December 11, 2010.

- · He was sent to the ER on December 19, 2010 at 8:30 pm and was not admitted to the hospital.

- · He returned to the facility on December 20, 2010, at 11:00 am.

- · The facility completed his 14-day PPS assessment with an ARD of December 23, 2010.

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j. Scenario #2 Coding

- · Code A2400A *Has the resident had a Medicare-covered stay since the most recent entry?* as **1. Yes**.

- · Code A2400B Start Date as 12-11-2010.

- · Code A2400C End Date as all dashes to indicate an ongoing stay.

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k. Scenario #3

- · Mr. R. began receiving services under Medicare Part A on October 15, 2010.

- · He was discharged return anticipated on October 20, 2010, to the hospital.

SLIDES	INSTRUCTIONAL GUIDANCE
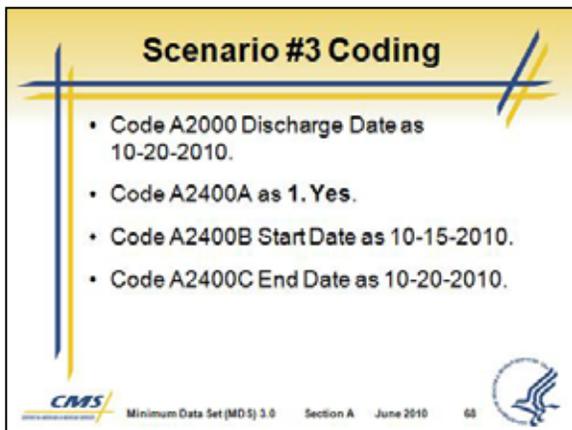
Slide 68

l. Scenario #3 Coding

- Code A2000 Discharge Date as 10-20-2010.

- Code A2400A *Has the resident had a Medicare-covered stay since the most recent entry?* as **1. Yes**.

- Code A2400B Start Date as 10-15-2010.

- Code A2400C End Date as 10-20-2010.
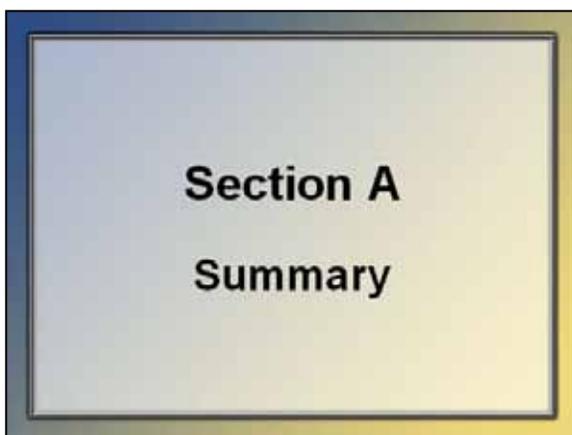

Slide 69

V.   Section A Summary
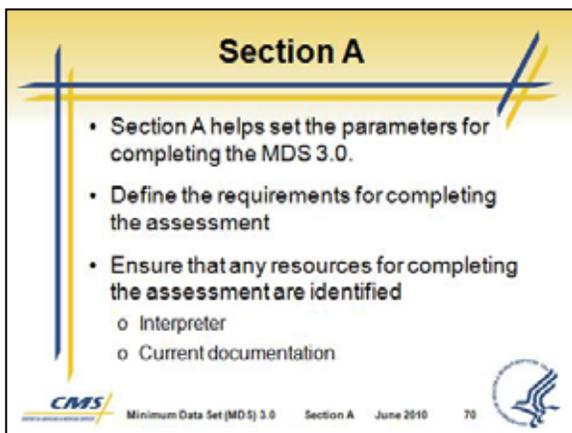
Slide 70

A. Section A

1. Section A helps set the parameters for completing the MDS 3.0.

  a. Define the requirements for completing the assessment

  b. Ensure that any resources for completing the assessment are identified

  - An interpreter

  - Current documentation

Centers for Medicare & Medicaid Services

SLIDES	INSTRUCTIONAL GUIDANCE
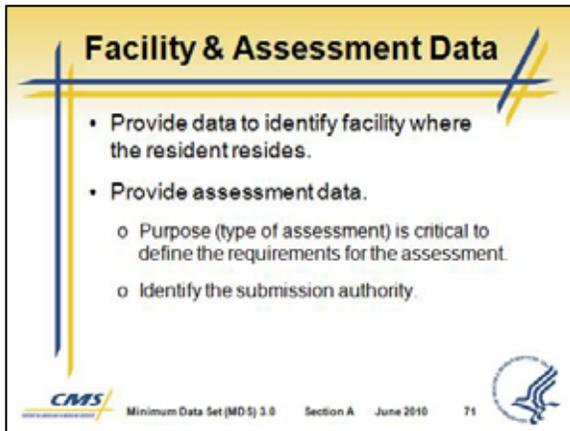
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B. Facility & Assessment Data

   1. Provide data to identify facility where the resident resides.

   2. Provide assessment data.

     a. Purpose (type of assessment) is critical to define the requirements for the assessment.

     b. Identify the submission authority.
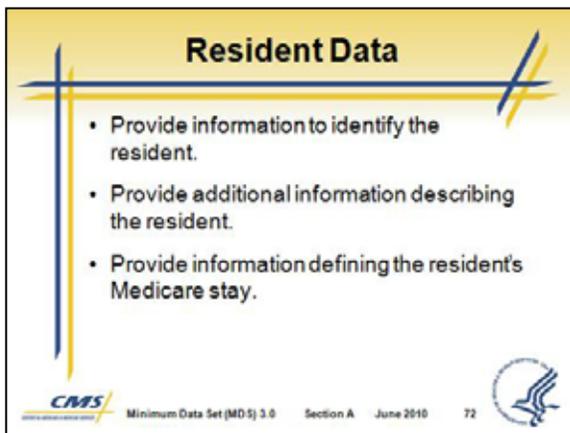
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C. Resident Data

   1. Provide information to identify the resident.

   2. Provide additional information describing the resident.

   3. Provide information defining the resident's Medicare stay.

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