

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

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Medicare assessments in nursing homes and the mandated Medicare assessments in swing bed hospitals.

2.1 Introduction to the Requirements for the RAI

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

The OBRA regulations require nursing homes to conduct initial and periodic assessments for all their residents. The RAI process is the catalyst to the accurate assessment of each nursing home resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA required assessments will be described in detail in section 2.6.

MDS assessments are also required for Medicare payment (Prospective Payment System (PPS)) purposes under Medicare Part A (described in detail in section 2.9).

It is important to note that when the OBRA and Medicare PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. (Refer to section 2.12 for combining assessments).

2.2 State Designation of the RAI for Nursing Homes

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

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional section S Items. As such, each state must have CMS approval of the State's comprehensive and Quarterly assessments.

- CMS's approval of a state's RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.

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

Additional information about State specification of the RAI, variations in format and CMS approval of a state's RAI can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual. For more information about your state's assessment requirements, contact your state RAI coordinator (see Appendix B).

2.3 Responsibilities of Nursing Homes for Completing Assessments

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

An RAI (MDS + CAA process + utilization guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice Residents:** When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between, and participation of both, the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required, however, a discharge assessment is required:
 - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("") (See chapter 3 for more information).
 - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet those needs upon admission.
 - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g. pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed Facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level care in order to be reimbursed under the SNF PPS. In addition, effective October 1, 2010, CMS will begin to collect MDS data for quality monitoring purposes of swing bed facilities. Therefore, swing bed providers must also complete the entry record, discharge assessments, and death in facility record. Requirements for the Medicare-required PPS assessments, entry record, discharge assessments and death in facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.

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

- **Newly Certified Nursing Homes:**
 - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
 - The OBRA assessments are a condition of participation and therefore should be performed prior to certification *as if the beds were already certified*.
 - Then, assuming a survey is completed where the SNF has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey.

- NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.
- For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. If a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment - the facility simply continues the OBRA schedule using the actual admission date as Day 1.
- Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare PPS assessments.
- **Adding Certified Beds:**
 - If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
 - Medicare and Medicaid residents should not be placed in a bed until the facility has been notified that the bed has been certified.
- **Change In Ownership:** There are two types of change in ownership transactions:
 - The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case:
 - o The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
 - o **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare PPS assessment was combined with the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.
 - There are also situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
 - o The beds are no longer certified.
 - o There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures, debts, provider number, etc.
 - o Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.
- **Resident Transfers:**
 - When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.
 - When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within

14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-day Medicare-required PPS assessment.

- The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.
- The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper (i.e., the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff).
- When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Medicare contractor for guidance.
- When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their State agency and their Regional Office, State agency, and Medicare contractor for guidance.

2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

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

- The 15-month period for maintaining assessment data does not restart with each readmission to the facility:
 - In some states, when a resident is discharged return anticipated, the state requires the medical record be closed. In these instances, when the resident returns to the facility, the facility must open a new record. The facility should copy the previous RAI and transfer that copy to the new record. Unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it in the new record.
 - Facilities may develop their own specific policies regarding how to handle these return situations, including linking the prior electronic MDS to the new admission record, but the 15-month requirement for maintenance of the RAI data must be adhered to.

- In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record to familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) must be maintained in the active clinical record until the resident is discharged return not anticipated.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident.
- Nursing homes that are not capable of maintaining MDSs electronically must adhere to the current requirement that either (not both) a hand written or a computer-generated copy be maintained in the clinical record – either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.
- All state licensure and state practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard.

- In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

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

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

- when the resident has never been admitted to this nursing home before; OR
- when the resident has been in this nursing home previously and was discharged return not anticipated; OR
- when the resident has been in this nursing home previously and was discharged return anticipated but did not return within 30 days (see discharge assessment below).

Assessment Combination refers to the use of one assessment to satisfy both OBRA and Medicare PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. Section 2.9 provides more detailed information on combining assessments. In addition, when allowed one assessment may satisfy two OBRA assessment requirements, such as Admission and Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA. Some States require an OBRA assessment in order to determine the resident's case mix for Medicaid payment purposes. Please contact your State agency for more State-specific information.

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

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

- For non-comprehensive and discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.

In general, assessments must be completed within 14 days after the ARD of the assessment. However, completion requirements are dependent on the assessment type and timing requirements. Specifics by assessment type will be discussed later in this chapter.

Assessment Reference Date (ARD) refers to the last day of the observation (or “look back”) period that the assessment covers for the resident. In other words, it is the last day of the period of time that the MDS assessment covers for that particular assessment for that particular resident. In completing sections of the MDS that require observations of a resident over specified time periods such as 7 and 14 days, the ARD is the common endpoint of these observation periods. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.

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

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

Assessment Timing refers to when and how often assessments must be conducted, based upon the resident’s length of stay and the length of time between ARDs.

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the IDT.
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a SCPA completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.
- This cycle (comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a SCSA has not occurred, 2) an uncorrected major error in prior full assessment was not determined and 3) was not discharged with return not anticipated.
- When a resident does have a SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.

- The table in section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the Medicare-required PPS assessment timing schedule is provided in section 2.8.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. However, early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.12).

Assessment Transmission refers to the electronic transmission of submission files to the QIES Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDSs include Admission, Annual, Significant Change in Status (SCSA), and Significant Correction to Prior Comprehensive (SCPA) assessments.

Death in facility refers to when the resident dies in the facility or dies while on a LOA (see LOA definition). The facility must complete a Death in facility record. A discharge assessment is not required.

Discharge refers to the date a resident leaves a nursing home. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are two types of discharges – return anticipated and return not anticipated. A Discharge assessment is required with both types of discharges. Section 2.7 provides detailed instructions regarding both discharge types. Any of the following situations warrant a discharge assessment, regardless of facility policies regarding opening and closing clinical records and “bed holds”:

- resident is permanently discharged from the nursing home to a private residence (as opposed to going on an LOA)
- resident is discharged by the nursing home and admitted to a hospital or other care setting
- resident is admitted to a hospital (regardless of whether the nursing home discharges or formally closes the record)
- resident has a hospital observation stay > 24 hours, regardless of whether the hospital admits, or the nursing home discharges, the resident

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

Entry and Discharge reporting MDS assessments include a select number of items on the MDS used to track residents and gather important quality data at transitions points, such as when they enter or leave a nursing home. Entry/Discharge reporting MDSs include Entry record,

Discharge assessment return not anticipated, Discharge assessment return anticipated, and Death in facility record.

Leave of Absence (LOA), which does not require completion of either a discharge assessment or an entry record, occurs when a resident has a:

- temporary home visit; or
- temporary therapeutic leave; or
- hospital observation stay less than 24 hours and the hospital does **not** admit the resident.

MDS assessment codes are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Medicare-required PPS assessments provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA) - they include:

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- Readmission/Return
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)
- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA

Non-comprehensive MDS assessments include a select number of items on the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive MDSs include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.

Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will agree on this period for the Admission assessment. For subsequent assessments, the observation period for a particular assessment for a

particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS.

OBRA-required assessments are federally mandated and, therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting) – they include:

- Entry record
- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- Significant correction to prior quarterly
- Discharge reporting
 - Discharge assessments –
 - o return not anticipated
 - o return anticipated
 - * Death in facility record

Reentry refers to situations when a resident had been in the nursing home previously and was discharged return anticipated. Upon the resident's return to the facility, the facility is required to complete an Entry record.

2.6 Required OBRA Assessments for the MDS

The MDS has been constructed to identify the OBRA reasons for assessment and the SNF PPS reasons for assessment in Items A0310A and A0310B respectively. The Entry and Discharge reporting reasons for assessment are identified in Item A0310F. If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in Item A0310A. The Entry/Discharge reporting and Medicare reasons for assessment are described later in this chapter (Sections 2.7 and 2.9 respectively) while the OBRA reasons for assessment are described below.

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

RAI OBRA-required Assessment Summary

Assessment Type	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A=01	14 th 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)	Same as MDS Completion Date	MDS/CAA(s) Completion Date + 7 calendar days	MDS/CAA(s) 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 another 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	Same as MDS Completion Date	MDS/CAA(s) Completion Date + 7 calendar days	MDS/CAA(s) Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with another assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A=04	14 th 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	14 th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	Same as MDS Completion Date	MDS/CAA(s) Completion Date + 7 calendar days	MDS/CAA(s) Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with another assessment
Significant Change to Prior Comprehensive (SCPA) (Comprehensive)	A0310A=05	14 th 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	14 th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	Same as MDS Completion Date	MDS/CAA(s) Completion Date + 7 calendar days	MDS/CAA(s) Completion Date + 14 calendar days	42 CFR 483.20(f) (3)(iv)	May be combined with another assessment

(continued)

RAI OBRA-required Assessment Summary (con't)

Assessment Type	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
Quarterly (Non-Comprehensive)	A0310A=02	ARD of previous OBRA Quarterly assessment + 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 another assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A=06	14 th 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	14 th 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 another assessment
Entry record (Non-Comprehensive)	A0310F=01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
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 another assessment
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 another assessment
Death in facility record (Non-Comprehensive)	A0310F=12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date + 14 calendar days		May not be combined with another assessment

Comprehensive Assessments

OBRA-required comprehensive MDS assessments include the completion of both the MDS and the CAA process as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. Each of the assessment types will be discussed in detail in this section. They are **not** required for Swing Bed residents.

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge-return anticipated) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident dies or is discharged during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.¹ In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and a SCPA, if it is identified that a significant (major) error occurred in a previous assessment that has already been submitted and accepted into the MDS system and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and chapter 5 for detailed information on processing corrections.

¹ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in chapter 5.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the CAA(s) completion date (Item V0200B2) (i.e., CAA(s) completion date + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a Medicare-required PPS assessment (see section 2.11 for details).

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

01. Admission Assessment (A0310A=01)

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

- this is the resident's first stay, OR
- the resident has just returned to the nursing home after being discharged as return not anticipated, OR
- the resident has just returned to the nursing home after a 30-day absence even though he or she was discharged return anticipated.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 am or 11:59 pm, is considered day "1" of admission.
- The ARD must be set no later than Day 14, counting the date of admission as Day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (Day 1), a completed RAI is required by the end of the day Tuesday (Day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than Day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of Day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.

- The MDS completion date (Item Z0500B) must be no later than Day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (Item V0200B2) must be no later than Day 14.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (i.e., CAA(s) completion date + 7 calendar days).
- If a resident dies or is discharged during the Admission assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.² In closing the record, the nursing home should note why the RAI was not completed.

03. Annual Assessment (A0310A=03)

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

Assessment Management Requirements and Tips for Annual Assessments:

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

04. Significant Change In Status Assessment (SCSA) (A0310A=04)

The SCSA is a comprehensive assessment for an existing resident that must be completed when the IDT has determined that a resident meets criteria for a SCSA. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the resident met the criteria for a SCSA.

² The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

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

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

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

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

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

- When a resident’s status changes and it is not clear whether the criteria for a SCSA will be met, the nursing home may take up to 14 days to determine whether the criteria are met.
- After determining that the criteria for a SCSA are met, nursing homes should document the initial identification of a significant change in the resident’s status in the progress notes.
- A SCSA is appropriate when:
 - There is a determination that a significant change (either improvement or decline) in a resident’s condition from his/her baseline has occurred as indicated by comparison of the resident’s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
 - The resident’s condition is not expected to return to baseline within two weeks.
 - For a resident who goes in and out of the facility on a relatively frequent basis and readmission is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry record each time the resident returns to the facility and a discharge assessment each time the resident is discharged. However, if the IDT determines that the criteria are met for a Significant Change in Status assessment during the intervening period, the staff should complete a SCSA.
- The ARD must be within 14 days after the determination that the criteria are met for a SCSA (determination date + 14 calendar days) but no later than day 14 after the determination is made that the criteria for a SCSA are met.
- The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD (i.e., ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When a SCSA is completed, the nursing home must review all triggered care areas compared to the resident’s previous status. If the CAA process indicates no change in a

care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.

- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (i.e., ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (i.e., CAA(s) completion date + 7 calendar days).

Guidelines for Determining A Significant Change In A Resident's Status

Note: this is not an exhaustive list

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

Some guidelines to assist in deciding if a change is significant or not:

- A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a SCSA. This time frame may vary depending on clinical judgment and resident needs. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.
- A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, “potential for weight loss.” This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, a SCSA may be warranted.
- If there is only one change, staff may still decide that the resident would benefit from a SCSA. It is important to remember that each resident's situation is unique and the IDT must make the decision as to whether or not the resident will benefit from a SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.

- Other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns).
- Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through the RAI reassessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent," but a change does not necessarily need to be both major and permanent.
- A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- A SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning;
- Decline in two or more of the following:
 - Resident's decision-making changes;
 - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©); Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior);
 - Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
 - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
 - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
 - Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status;
 - Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
 - Overall deterioration of resident's condition.

Examples (SCSA):

Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change, and a SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the

behavior. Mr. T's behavioral symptoms could have many causes, and a SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

- Improvement in two or more of the following:
 - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
 - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
 - Resident's decision-making changes for the better;
 - Resident's incontinence pattern changes for the better;
 - Overall improvement of resident's condition.

Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. A SCSA will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions

Note: this is not an exhaustive list

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

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.
- If a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) but remains a resident at the nursing home, a SCSA should be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure that a coordinated plan of care between the hospice and nursing home is put into place. Because a Medicare-certified hospice must also conduct an assessment at the initiation of its services, this is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

Examples (SCSA):

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

Mrs. K came into the nursing home with identifiable problems and has steadily responded to treatment. Her condition has improved over time and has recently hit a plateau. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if Mrs. K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if she is not discharged, an assessment is required by the end of the allotted 14-day period.

Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring a SCSA at this time. However, if her condition was to stabilize and her discharge was not imminent, a SCSA would be in order.

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

- If a SCSA occurs for an individual *known* or *suspected* to have a mental illness, mental retardation, or condition related to mental retardation (as defined by 42 CFR 483.102), a referral to the state mental health or mental retardation/DD authority (SMH/MR/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act³.
- PASRR is not a requirement of the resident assessment process, but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.

³ The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the state MH/MR/DD authorities and the state Medicaid agency is available at <http://www.cms.hhs.gov/>.
- The nursing facility must provide the SMH/MR/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/MR/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

Referral for Level II Resident Review evaluations are required for individuals previously identified by PASRR to have mental illness, mental retardation, or a condition related to mental retardation in the following circumstances:

Note: this is not an exhaustive list

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

Examples (PASRR & SCSAs):

- Mr. L has a diagnosis of serious mental illness, but his primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and he becomes ambulatory, even if other conditions exist for which Mr. L receives medical care, he should be referred for a PASRR evaluation to determine whether a change in his placement or services is needed.
- Ms. K has mental retardation. She is normally cooperative, but after she sustains a fall requiring a cast, becomes agitated and combative with the physical therapist and with staff who try to clean the area. She does not understand why her normal routine has changed and why staff need to touch a painful area of her body.

Referral for Level II Resident Review evaluations are also required for individuals who may not have previously been identified by PASRR to have mental illness, mental retardation, or a condition related to mental retardation in the following circumstances: Note: this is not an exhaustive list

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

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

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

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

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

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

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

- Nursing homes should document the initial identification of a significant error in an assessment in the progress notes.
- A SCPA is appropriate when:
 - the erroneous comprehensive assessment has been completed (MDS completion date (Item Z0500B), regardless of whether transmitted/submitted into the MDS system yet; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment has occurred (i.e., determination date + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred.

- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (i.e., ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (i.e., ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (i.e., CAA(s) completion date + 7 calendar days).

Non-Comprehensive Assessments

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include the Quarterly and Significant Correction to Prior Quarterly assessments. They are **not** required for Swing Bed residents.

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

- The ARD is considered the last day of the observation/look back period, but considered day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge-return anticipated) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident dies or is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.⁴ In closing the record, the nursing home should note why the RAI was not completed.

⁴ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.

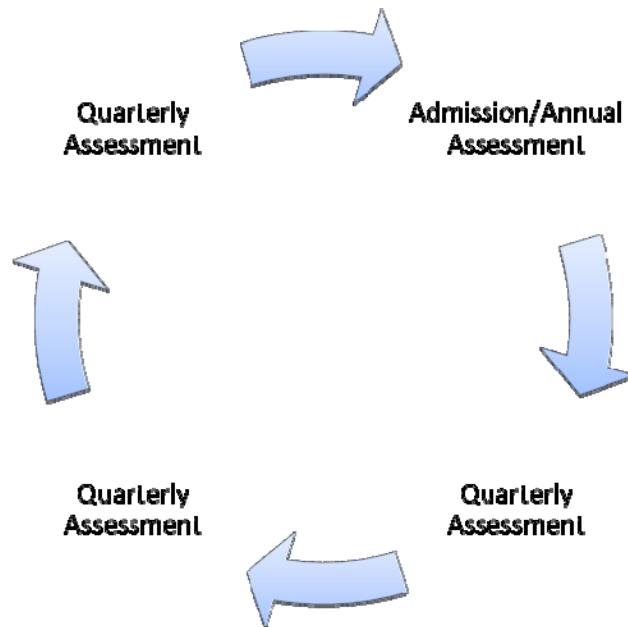
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and a SCPA, if it is identified that a significant (major) error occurred in a previous assessment that has already been submitted and accepted into the MDS system and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (i.e., ARD of previous OBRA assessment (such as Quarterly, Admission, or Annual assessment) + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment, nursing homes are still required to review the information from these assessments, determine if a revision(s) to the resident's care plan is necessary, and make the revision(s) if applicable.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Item Z0500B) (i.e., MDS completion date + 14 calendar days).
- Non-comprehensive assessments may be combined with a Medicare-required PPS assessment (see section 2.11 for details).
- OBRA-required non-comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (Item A0310A).

02. Quarterly Assessment (A0310A=02)

The Quarterly assessment is a non-comprehensive assessment for an existing resident that must be completed at least every 92 days following the Admission and Annual assessments. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) and completion (Z0500B) dates depend on the ARD and completion date of the most recent Admission or Annual assessment.

Assessment Management Requirements and Tips:

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



- The ARD must be within 92 days after the ARD of the previous OBRA assessment (i.e., Quarterly, Admission, or Annual assessment + 92 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (i.e., ARD + 14 calendar days).

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

The SCQA is a non-comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (A2300) and completion (Z0500B) dates depend on the ARD and completion date of the most recent Admission or Annual assessment.

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

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

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

Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the progress notes.
- A SCQA is appropriate when:
 - the erroneous Quarterly assessment has been completed (MDS completion date (Item Z0500B), regardless of whether transmitted/submitted into the MDS system yet; and

- there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment has occurred (i.e., determination date + 14 calendar days) and no later than 14 days after determining that the significant error occurred.
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (i.e., ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

Entry and Discharge Reporting

Other OBRA-required tracking records and assessments consist of the entry record, the discharge assessments, and the death in facility record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a nursing home – they do not include completion of the CAA process and care planning. The discharge assessments include items for quality monitoring. Entry and discharge reporting is required for Swing Bed residents.

If the resident has several readmissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit discharge assessments and entry records until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

OBRA-required entry and discharge reporting records/assessments include the following types, which are numbered according to their MDS 3.0 assessment code (Item A0310F):

01. Entry Record (A0310F=01)

There are two types of entries – admission and reentry.

Assessment Management Requirements and Tips for Entry Records:

- Must be completed every time a person is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility).
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (i.e., entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a stand-alone tracking document.
- May not be combined with an assessment.
- May be submitted with an assessment or without an assessment.

1. Admission (A1700=1)

- The first OBRA assessment for a resident will be an Admission assessment.

- Must be completed every time a person is admitted for the first time to, or is readmitted after being discharged return not anticipated, to a nursing home (or swing bed facility).

Example (Admission):

Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the entry record for the August 27, 2011 return as follows:

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

2. Reentry (Item A1700=2)

- Must be completed every time a person is readmitted to a nursing home (or swing bed facility) after being discharged return anticipated from that nursing home (or swing bed facility).

Example (Reentry):

Mr. W. was admitted to the nursing home on April 11, 2011. One week later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital. On April 23, 2011, Mr. W. returned to the facility. Code the Entry Record for the April 23, 2011 return, as follows:

A0310F = 01
A1600 = 04-23-2011
A1700 = 2

Discharge Reporting

There are two discharge assessments – discharge return anticipated and discharge return not anticipated. There is also a death in facility record used to report the death of a resident while in the facility.

Assessment Management Requirements and Tips for Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of discharge).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay longer than 24 hours.
- Determine which OBRA and/or PPS assessment will be completed when the resident returns to the facility.

- Are **not** associated with the nursing home bed hold status or opening and closing of the medical record.
- Consists of two categories:
 - Discharge assessments; and
 - Death in facility record.

10. Discharge assessment—return not anticipated (A0310F=10)

- Must be completed when the resident is discharged from the nursing home and the resident is not expected to return to the facility.
- When the resident is discharged from the nursing home return anticipated but does not return to the facility within 30 days, the original discharge assessment must be modified from “return anticipated” (Item A03010F = 11) to “return not anticipated” (Item A0310F = 10) (see Chapter 5 for greater detail).
- Must be completed within 14 days after the discharge date (Item A2000) (i.e., discharge date (A2000) + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns, the OBRA schedule for assessments will start with a new Admission assessment.
- If resident’s stay will be covered by Medicare Part A, the PPS schedule starts with a Medicare-required 5-day scheduled assessment or a combination of the Admission and 5-day PPS assessment.

Example (Discharge-return not anticipated):

Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 Discharge Assessment as follows:

A0310F = 10
A2000 = 03-29-2011
A2100 = 01

11. Discharge assessment—return anticipated (A0310F=11)

- For a resident discharged to a hospital admission or a respite resident who comes in and out of the facility on a relatively frequent basis and readmission can be expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return. This status requires an entry record each time the resident returns to the facility and a discharge assessment each time the resident is discharged. However, if the IDT determines that the criteria are met for a SCSA during the intervening period, the staff should complete a SCSA.
- Must be completed when the resident is discharged to a hospital admission or when a respite resident who comes in and out of the facility on a relatively frequent basis is

discharged and readmission can be expected, unless it is known on discharge that he or she will not return.

- Must be completed within 14 days after the discharge date (Item A2000) (i.e., discharge date (A2000) + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns to the nursing home, the IDT must determine if criteria are met for a SCSA.
 - If criteria are met, complete a Significant Change in Status assessment.
 - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment.

Example (Discharge-return anticipated):

Ms. C. was admitted to the nursing home on May 22, 2011. She tripped while at a restaurant with her daughter. She was discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 Discharge Assessment as follows:

A0310F = 11
 A2000 = 05-31-2011
 A2100 = 03

12. Death in facility record (A0310F=12)

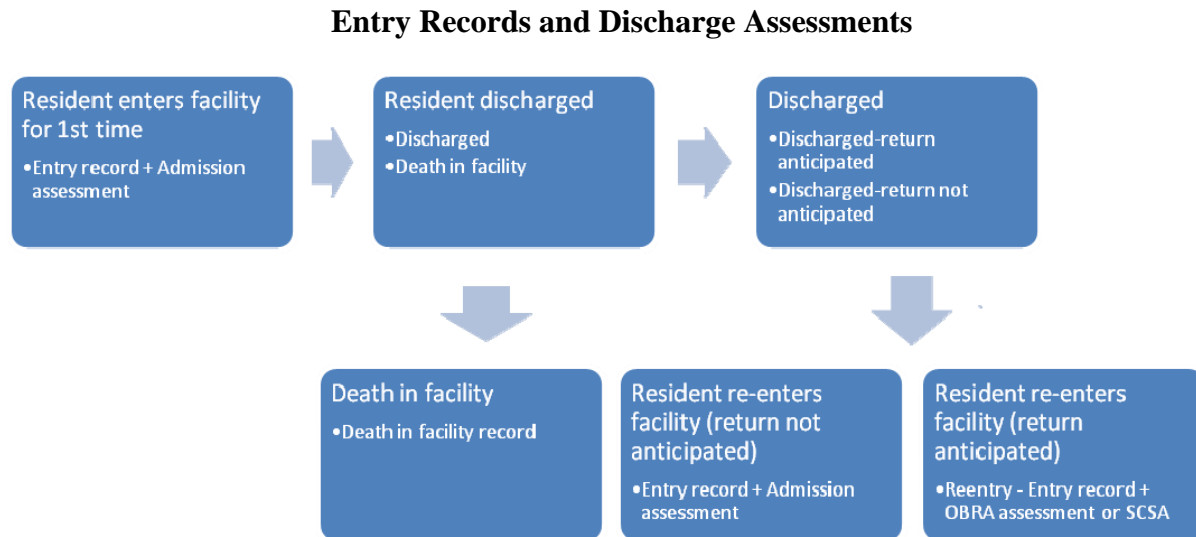
- Must be completed when the resident dies in the facility (discharge assessment should not be completed).
- Must be completed within 14 days after the resident's death (which is the discharge date (Item A2000)) (i.e., discharge date (A2000) + 7 calendar days).
- Must be submitted within 14 days after the resident's death (which is the discharge date (A2000)) (i.e., discharge date (A2000) + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any other type of assessment.

Example (Death in Facility):

Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility Record as follows:

A0310F = 12
 A2000 = 11-13-2011
 A2100 = 08

The following chart details the nursing home's requirement for transmission of Discharge assessments and Entry records.



2.7 The CAA Process and Care Plan Completion

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

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

CAA(s) Completion:

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive, PPS, or entry/discharge assessments.
- After completing the MDS portion of the comprehensive assessment, the IDT then proceed(s) to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in chapter 3 (Section V) and chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (Item V0200B2) must be either later than or the same date as the MDS completion date (Item Z0500B). The MDS completion date (Item Z0500B)

must be earlier than or the same date as the CAA(s) completion date (Item V0200B2). In no event can either date be later than the established timeframes as described in section 2.6.

- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/problems. In many cases, interventions will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a preliminary care plan initiated. However, a final CAA(s) review and associated documentation is still required no later than the 14th calendar day of admission.
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

Care plan completion:

- Is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive, PPS, or entry/discharge assessments.
- After completing the MDS and CAA(s) portions of the comprehensive assessment, the IDT then proceed(s) to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problem. Subsequently, the IDT proceeds to evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in chapter 4 of this manual).
- The care plan completion date (Item V0200C2) must be either later than or the same date as the CAA(s) completion date (Item V0200B2), but no later than 7 calendar days after the CAA(s) completion date. The MDS completion date (Item Z0500B) must be earlier than or the same date as the care plan completion date. In no event can either date be later than the established timeframes as described in section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/problems. In many cases, interventions will already have been implemented to address priority issues prior to completion of the final care plan. At this time,, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a preliminary care plan initiated. However, a final CAA(s) review and associated documentation is still required no later than Day 14 of the admission counting the admission date as Day1.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.

- Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and on an on-going basis, and modify the care plan if appropriate.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

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

Assessment Window

Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 5. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS Assessments chart below for the allowed ARDs for each of the Medicare-required assessments and other assessment information.

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

Grace Days

There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. For example, the Medicare-required 5-Day ARD can be extended 1 to 3 grace days (i.e., days 6 to 8). The use of grace days allows clinical flexibility in setting ARDs. See chart below for the allowed grace days for each of the scheduled Medicare-required assessments. Grace days are not applied to unscheduled Medicare PPS Assessments.

Scheduled Medicare PPS Assessments

The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments, each with a predetermined time period for setting the ARD for that assessment. The Readmission/Return assessment is also a scheduled assessment.

The SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Applicable Standard Medicare Payment Days^
5-day Readmission/Return	01 06	Days 1-5	6-8	1 through 14
14-day	02	Days 11-14	15-19	15 through 30
30-day	03	Days 21-29	30-34	31 through 60
60-day	04	Days 50-59	60-64	61 through 90
90-day	05	Days 80-89	90-94	91 through 100

+Grace Days: a specific number of days that can be added to the ARD window without penalty.

^Applicable Standard Medicare Payment Days may vary when assessments types are combined. For example, when a provider combines an unscheduled assessment, such as a Significant Change in Status, with a scheduled assessment, such as a 30-day Medicare-required assessment, the new resource utilization group (RUG) would take effect on the ARD of the assessment. If the ARD of this assessment was day 28, the new RUG would take effect on day 28 of the stay. The exception would be if the ARD fell within the grace days. In that case, the new RUG would be effective on the first day of the regular payment block. For example, if the ARD of an unscheduled assessment combined with the 60-day assessment was day 62, the new RUG would take effect on day 60.

Unscheduled Medicare PPS Assessments

There are situations when a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments. These assessments are known as unscheduled assessments. A provider must complete an unscheduled assessment when any of the following occur:

1. The beneficiary meets the criteria for a Significant Change in Status Assessment (see Section 2.6) (for swing bed providers this unscheduled assessment is called the Swing Bed Clinical Change assessment);
2. A Significant Correction to Prior Comprehensive assessment must be completed (see Section 2.6);
3. The beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group, all therapies have been discontinued and the beneficiary continues to receive skilled services; this is an End of Therapy Other Medicare-required Assessment (OMRA) (see Section 2.9).

For RUG-IV, a SNF provider may complete an assessment that indicates rehabilitation services (OT and/or PT and/or SLP) have started. This is known as the Start of Therapy OMRA. This assessment is completely optional (see Section 2.9).

The following chart summarizes the Medicare-required scheduled and unscheduled assessments:

Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	Grace Days ARD can also be set on these days	Allowed ARD Window	Billing Cycle Used by the business office	Special Comment
5-day A0310A = 01 and Readmission/return A0310B = 06	Days 1-5	6-8	Days 1-8	Sets payment rate for days 1-14	<ul style="list-style-type: none"> See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA.
14-day A0310B = 02	Days 11-14	15-19	Days 11-19	Sets payment rate for days 15-30	<ul style="list-style-type: none"> CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.
30-day A0310B = 03	Days 21-29	30-34	Days 21-34	Sets payment rate for days 31-60	
60-day A0310B = 04	Days 50-59	60-64	Days 50-64	Sets payment rate for days 61-90	
90-day A0310B = 05	Days 80-89	90-94	Days 80-94	Sets payment rate for days 91-100	<ul style="list-style-type: none"> If combined with the OBRA Quarterly Review assessment the completion date requirements for the OBRA Quarterly Review assessment must also be met.
Start of Therapy Other Medicare-required Assessment (OMRA) A0310B = 07 and A0310C = 01 or 03	<ul style="list-style-type: none"> 5-7 days after the start of therapy The first day of therapy counts as day 1 	N/A	N/A	Sets payment rate starting on the earliest start of therapy date	<ul style="list-style-type: none"> Voluntary assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG.

(continued)

Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE DAYS ARD can also be set on these days	ALLOWED ARD WINDOW	A BILLING CYCLE Used by the business office	Special Comment
End of Therapy OMRA A0310B = 07 and A0310C = 02 or 03	<ul style="list-style-type: none"> 1-3 days after all therapy (PT, OT, SLP) services are discontinued and resident continues to require skilled care. The first non-therapy day counts as day 1. 	N/A	N/A	Sets payment rate starting on the day after the latest therapy end date	<ul style="list-style-type: none"> Not required if the resident has been determined to no longer meet Medicare skilled level of care. Establishes a new non-therapy RUG Classification. Not required if not in a Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment.
Significant Change in Status Assessment (SCSA) A0310A = 04	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Sets payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Swing Bed Clinical Change Assessment (CCA) A0310B = 07 and A0310D = 1	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Sets payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Significant Correction to Prior Full Assessment (SCPA) A0310A = 05	Completed by the end of the 14th calendar day after identification of a major, uncorrected error in prior comprehensive assessment.	N/A	N/A	Sets payment rate effective with the ARD when not combined with another assessment*	May establish a new RUG Classification.
Entry record A0310F = 01	N/A	N/A	N/A	N/A	May not be combined with another assessment
Discharge Assessment A0310F = 10 or 11	N/A	N/A	N/A	N/A	May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment
Death in facility record A0310F = 12	N/A	N/A	N/A	N/A	May not be combined with another assessment

*NOTE: When SCSA, SCPA, and CCA are combined with another assessment, payment rate may not be effective on the ARD. For example, a provider combines the 30-day Medicare-required assessment with a Significant Change in Status assessment with an ARD of day 33, a grace day, payment rate would become effective on day 31, not day 33. See Chapter 6, Section 6.4.

2.9 MDS Medicare Assessments for SNFs

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

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (ASAP) system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission.
- Is the first Medicare-required assessment to be completed when the resident is first admitted for SNF Part A stay.
- Is the first Medicare-required assessment to be completed when the resident is re-admitted to the facility following a discharge assessment—return not anticipated.

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 11 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 19 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 21 through 29 of the Part A SNF covered stay.
- ARD may be extended up to day 34 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 31 through 60 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

04. Medicare-required 60-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 50 through 59 of the Part A SNF covered stay.
- ARD may be extended up to day 64 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 61 through 90 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

05. Medicare-required 90-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 80 through 89 of the Part A SNF covered stay.
- ARD may be extended up to day 94 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 91 through 100 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

06. Medicare-required Readmission/Return Assessment

- Completed when a resident whose SNF stay was being reimbursed by Medicare Part A is hospitalized, discharged return anticipated, and then readmitted to the SNF from the hospital and continues to require and receive Part A SNF-level care services.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the Day 14 counting the date of admission as Day 1.

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled Assessments Used for PPS

There are several unscheduled assessment types that may be required to be completed during a resident's Part A SNF covered stay.

OTHER MEDICARE-REQUIRED ASSESSMENTS. There are two types of Other Medicare-Required Assessments (OMRA) that are completed based on the start or cessation of rehabilitation services (OT, PT, and SLP).

Start of Therapy (SOT) OMRA

- Optional.
- Completed only to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will **not** be accepted by CMS.
- Completed only if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group.
- ARD (Item A2300) must be set on days 5-7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided. When a SNF provides rehabilitation therapies five days a week (Monday through Friday), day 1 would correspond to the first day on which therapy services would normally be provided after the last day therapy was provided.
- Must be completed (Item Z0500B) within 14 days after the ARD (completion + 14 days).
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be submitted electronically to the QIES ASAP system and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Significant Change in Status Assessment (SCSA)

- Is the OBRA required assessment. See section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification.
- When a SCSA for a SNF PPS resident is not combined with a PPS assessment (A0310A = 04 and A0310B = 07), the RUG-IV classification (and thus payment) begins on the ARD. For example, a SCSA is completed with an ARD of day 20 then the RUG-IV classification begins on day 20.
- When the SCSA is completed with a scheduled Medicare-required assessment and grace days are not used when setting the ARD, the RUG-IV classification begins on the ARD. For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.
- When the SCSA is completed with a scheduled Medicare-required assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. For example, the SCSA is combined with the Medicare-required 30-day scheduled assessment, which pays for days 31 to 60, and the ARD is set at day 33, the RUG-IV classification begins day 31.

Swing Bed Clinical Change Assessment

- Is a required assessment for swing bed providers. Staff are responsible for determining whether a change (either an improvement or decline) in a patient's condition constitutes a "clinical change" in the patient's status.
- Is similar to the OBRA Significant Change in Status Assessment with the exception of the CAA process. See Section 2.6 of this chapter.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Significant Correction to Prior Comprehensive Assessment

- Is the assessment required by OBRA. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

2.10 Combining Medicare Scheduled and Unscheduled Assessments

There may be instances when more than one Medicare-required assessment is due in the same time period. To reduce provider burden, CMS allows the combining of assessments. Two Medicare-required Scheduled Assessments may **never** be combined since these assessments have specific ARD windows that do not occur at the same time. However, it is possible that a Medicare-required Scheduled Assessment and a Medicare Unscheduled Assessment may be combined.

When combining assessments, the more stringent requirements must be met. For example, when a Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the Medicare PPS Assessment Form (MPAF) item set must be used, even though the Start of Therapy OMRA requires fewer items than the PPS MPAF, and the ARD must be set prior to day 19 to ensure that all required items are completed and all required time frames are met (for a swing bed provider, the swing bed PPS item set would need to be completed).

PPS Scheduled Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within the ARD window for the Medicare-required assessment **and** 5-7 days after the start of therapy (Item O4000A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.
- Complete the PPS MPAF item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
A0310C = 1

PPS Scheduled Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required assessment **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). If both ARD requirements are not met, the assessments may not be combined.
- Must complete the PPS MPAF item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
A0310C = 2

PPS Scheduled Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required assessment **and** 5-7 days after the start of therapy (Item O400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.
- Must complete the PPS MPAF item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310A = 99
A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
A0310C = 3

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310B = 01, 02, 03, 04, 05, or 06, as appropriate
A0310C = 0
A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O400A5 or O0400B5 or O0400C5, whichever is earliest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the PPS Swing Bed item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310B = 07
A0310C = 1
A0310D = 1

Swing Bed Clinical Change Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the PPS Swing Bed item set.
- Code the Item A0310 of the MDS 3.0 as follows:
A0310B = 07
A0310C = 2
A0310D = 1

Swing Bed Clinical Change Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6,

whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.

- Must complete the PPS Swing Bed item set.
- Code the Item A0310 of the MDS 3.0 as follows:

A0310B = 07

A0310C = 3

A0310D = 1

2.11 Combining Medicare Assessments and OBRA Assessments*

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

- The OBRA standards are designated by the reason selected in A0310A, **Federal OBRA Reason for Assessment**, and A0130F, **Entry/Discharge Reporting**.
- The Medicare standards are designated by the reason selected in A0310B, **PPS Assessment**, and A0310C, **PPS Other Medicare Required Assessment - OMRA**.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for MDS completion, ARD, and item set requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set between days 11 and 14, but the regulation allows grace days up to day 19. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD between days 11 and 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the OBRA Admission assessment completion date (Item Z0500B) must be day 14 or earlier. With the combined OBRA Admission/Medicare-required 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

Some States require providers to complete additional items (Section S) for specific assessments. Providers must ensure that they follow their State requirements in addition to any OBRA and/or Medicare requirements.

*Note—OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly/ PPS MPAF* Item Set	Other Required Assessments/Reporting Item Sets for Skilled Nursing Facilities
Assessment Types	<ul style="list-style-type: none"> • OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Full (SCPA) 	<ul style="list-style-type: none"> • Quarterly • Significant Correction to Prior Quarterly • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • PPS Readmission/Return 	<ul style="list-style-type: none"> • Entry Record • Discharge assessments • Death in Facility record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • OMRA • OMRA and Discharge
Combined Assessment Types	<ul style="list-style-type: none"> • OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required • Annual and any OMRA • SCSA and any Medicare-required • SCSA and any OMRA • SCPA and any Medicare-required • SCPA and any OMRA • Any OBRA comprehensive and any Discharge 	<ul style="list-style-type: none"> • Quarterly and any Medicare-scheduled • Quarterly and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Discharge and any Medicare-required • Quarterly and any Discharge • Significant Correction to Prior Quarterly and any Discharge • Any Medicare-required and any Discharge 	N/A

*Provider must check with State Agency to determine if the State requires additional items to be completed for the required CMS Quarterly/PPS MPAF.

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS	Other Required Assessments/Reporting Item Sets for Swing Bed Providers
Assessment Type	<ul style="list-style-type: none"> • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • PPS Readmission/Return • Clinical Change Assessment 	<ul style="list-style-type: none"> • Entry Record • Discharge assessments • Death in Facility record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • OMRA • OMRA and Discharge
Assessment Type Combinations	<ul style="list-style-type: none"> • Clinical Change and any Medicare-required • Any Medicare-required and any Discharge 	N/A

Tracking records (Entry and Death in Facility) are never combined with other assessments.

The OMRA item sets are all unique item sets and are never completed when combining with other assessments. For example, a **Start of Therapy OMRA** item set is completed only when an assessment is conducted to capture the start of therapy **and** assign a RUG-IV therapy group. In addition, a **Start of Therapy OMRA and Discharge** item set is only completed when the facility staff choose to complete an assessment to reflect the start of therapy and discharge from facility.

2.12 Medicare and OBRA Assessment Combinations

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay.
- See Section 2.7 for requirements for CAA process and care plan completion

Medicare-required 14-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 11 through 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 19 (i.e., grace days may not be used).
- Must be completed (Item Z0500B) by the end of day 14 of the stay.
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (A2300) must be set on a day that meets the requirements described earlier for each Medicare-required assessment in Section 2.9 **and** for the OBRA Quarterly assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Quarterly ARD is met.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Medicare-required Scheduled Assessment and Annual Assessment

- Comprehensive item set.
- ARD (A2300) must be set on a day that meets the requirements described earlier for each Medicare-required assessment in Section 2.9 **and** for the OBRA Annual assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Annual ARD is met.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required assessment **and** within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- Must be completed (Item Z0500B) within 14 days after determination that criteria for a Significant Change in Status assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Full Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required assessment **and** within 14 days after the determination that an uncorrected major error in the prior full assessment has occurred.
- Must be completed (Item Z0500B) within 14 days after the determination that an uncorrected major error in the prior full assessment has occurred.
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Quarterly Assessment

- See Medicare-required Scheduled Assessment and OBRA Quarterly Assessment.

Medicare-required Scheduled Assessment and Discharge Assessment

- PPS MPAF (or Swing Bed) item set.
- ARD (Item A2300) must be set on a day of discharge (Item A2000) **and** the date of discharge falls within the allowed window of the Medicare-required assessment as described earlier in section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 5-7 days after the start of therapy (Q0400A5 or Q0500B5 or Q0500C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- Must be completed (Item Z0500B) by day 14 of the stay.
- See Section 2.7 for requirements for CAA process and care plan completion

Start of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Q0400A5 or Q0500B5 or Q0500C5, whichever is the earliest date) **and** meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start of Therapy OMRA and Annual Assessment

- Comprehensive item set
- ARD (A2300) must be set 5-7 days after the start of therapy (O400A5 or O0400B5 or O0400C5) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Q0400A5 or Q0500B5 or Q0500C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that criteria for a Significant Change in Status assessment.

- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Full Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after determination that an uncorrected major error in a full assessment has occurred **and** 5-7 days after the start of therapy (Q0400A5 or Q0500B5 or Q0500C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected major error in a full assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment

Start of Therapy OMRA and Discharge Assessment

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set on day of discharge (Item A2000) **and** the date of discharge falls within 5-7 days after the start of therapy (Q0400A5 or Q0500B5 or Q0500C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- Must be completed (Item Z0500B) within 14 days after the ARD.

End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1-3 days after the last day therapy was furnished (difference is 3 or less for A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.

- ARD (Item A2300) must be 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 1-3 days after the end of therapy (Q0400A6 or Q0500B6 or Q0500C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Full Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected major error in the prior full assessment has occurred **and** 1-3 days after the end of therapy (Q0400A6 or Q0500B6 or Q0500C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected major error in prior full assessment has occurred.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and Discharge Assessment

- OMRA and Discharge item set.
- ARD (Item A2300) must be set on day of discharge (Item A2000) **and** the date of discharge falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start and End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 5-7 days after the start of therapy (Item O4000A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group **and** into a non-therapy group when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (Item A2300) must be 5-7 days after the start of therapy (Item O4000A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group **and** into a non-therapy group when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start and End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and**

meet the requirements for OBRA Annual assessment requirements as described in Section 2.6.

- Completed only when the resident will be classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (Q0400A6 or Q0500B6 or Q0500C6, whichever is the latest date).
- Must be completed (Z0500B) within 14 days after the ARD and within 14 days after the determination that criteria are met for a Significant Change in Status assessment.
- Completed only when the resident will be classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Full Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected major error in the prior full assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (Q0400A6 or Q0500B6 or Q0500C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected major error in prior full assessment has occurred.
- Completed to classify a resident who was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See Start and End of Therapy OMRA and OBRA Quarterly Assessment.

Start and End of Therapy OMRA and Discharge Assessment

- OMRA and Discharge item set.

- ARD (Item A2300) must be set on the day of discharge (Item A2000) and the date of discharge falls within 5-7 days after the start of therapy (Item O4000A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and into a non-therapy group when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS.
- Must be completed (Item Z0500B) within 14 days after the ARD.

2.13 Factors Impacting the SNF Medicare Assessment Schedule*

Resident Expires Before Eighth Day of SNF Stay

If the beneficiary dies in the SNF before the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). The provider must also complete a Death in Facility Record (see Section 2.6 for greater detail).

Resident Transfers or Discharged Before Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or transferred to another payer source before the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). When the beneficiary is discharged from the SNF, the provider must also complete a Discharge assessment (see Section 2.11 for greater detailing on combining a Medicare-required assessment with a discharge assessment).

Short Stay

If the beneficiary dies, is discharged from the SNF, or discharged from Part A level of care before the eighth day of covered SNF stay, the resident may be a candidate for the short stay policy. The short stay policy allows the assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident was not able to receive 5 days of therapy. See Chapter 6, Section 6.4 for greater detail.

Resident is Admitted to an Acute Care Facility and Returns

If a Medicare resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight), the Medicare assessment schedule is restarted. The type of discharge assessment completed by the staff determines whether a Medicare-required 5-day or a Medicare Readmission/Return assessment should be

completed. The provider will complete a Discharge Assessment as described in section 2.6. When the patient returns, the provider would complete an Entry Transaction as described in section 2.6.

When the Medicare resident returns to the SNF following a Discharge assessment—return anticipated (A0310F = 11), the first required Medicare assessment is the Medicare Readmission/Return assessment (A0310B = 06) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

When the Medicare resident returns to the SNF following a Discharge assessment—return not anticipated (A0301F = 10), the first required Medicare assessment is the Medicare-required 5-Day assessment (A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has day remaining in the benefit period.

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

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted, the Medicare assessment schedule is not restarted. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the “midnight rule.” The Medicare assessment schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment clock is adjusted by skipping that day in calculating when the next Medicare assessment is due. For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes day 22 of his Part A stay.

Resident Leaves the Facility and Returns During an Observation Period

The ARD is not altered if the beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary’s temporary absence (when permitted under MDS coding guidelines; see Chapter 3) but may not extend the observation period.

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation when a beneficiary is discharged from Medicare Part A services but remains in the facility in a Medicare and/or Medicaid certified bed with another pay source, the OBRA schedule will be continued. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary’s original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. If and when the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

The original date of entry (Item A1600) is retained. The beneficiary should be assessed to determine if there was a significant change in status. A SCSA could be completed with either the Medicare-required 5-day or 14-day assessment or separately.

Delay in Requiring and Receiving Skilled Services

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

Non-Compliance with the PPS Assessment Schedule

According to Part 42 Code of Federal Regulation (CFR) section 413.343, an assessment that does not have its ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for the Medicare-required assessment that was missed, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the Health Insurance Prospective Payment System (HIPPS) rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of day 41 would be paid the default rate for days 31 through 40 and at the HIPPS classification from the assessment beginning on day 41.

If the ARD of the late assessment is set after the end of the payment period for the Medicare-required assessment that was missed and the resident is still on Part A, the provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period at the default rate regardless of the HIPPS code calculated from the late assessment. For example, a Medicare-required 14-day assessment with an ARD of day 32 would be paid at the default rate for days 15 through 30. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment

which covers days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services.

Missed PPS Assessment

If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. See chapter 6, Section 6.8 for greater detail.

Errors on a Medicare Assessment

To correct an error on an MDS that has been submitted to the QIES ASAP system, the nursing facility must follow the normal MDS correction procedures (see Chapter 5).

*These requirements/policies also apply to swing bed providers.

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