Section A

Identification Information

Objectives

- State the intent of Section A Identification Information.
- Describe the information required to complete Section A.
- Code Section A correctly and accurately.

Intent of Section A

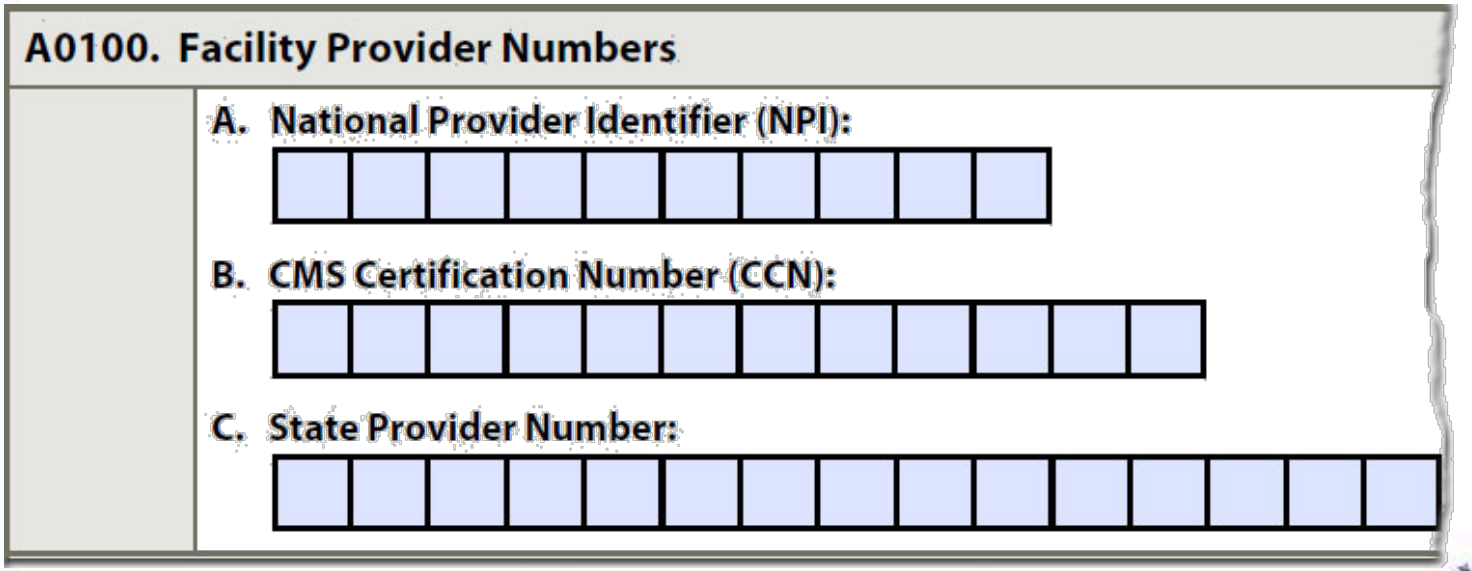
- Documents a variety of data.
- Intent is to obtain key information to uniquely identify:
  - Each resident
  - Facility where resident resides
  - Type of provider (nursing home or swing bed)
  - Reason for assessment

Items A0100 & A0200

Facility Provider Numbers
&
Type of Provider

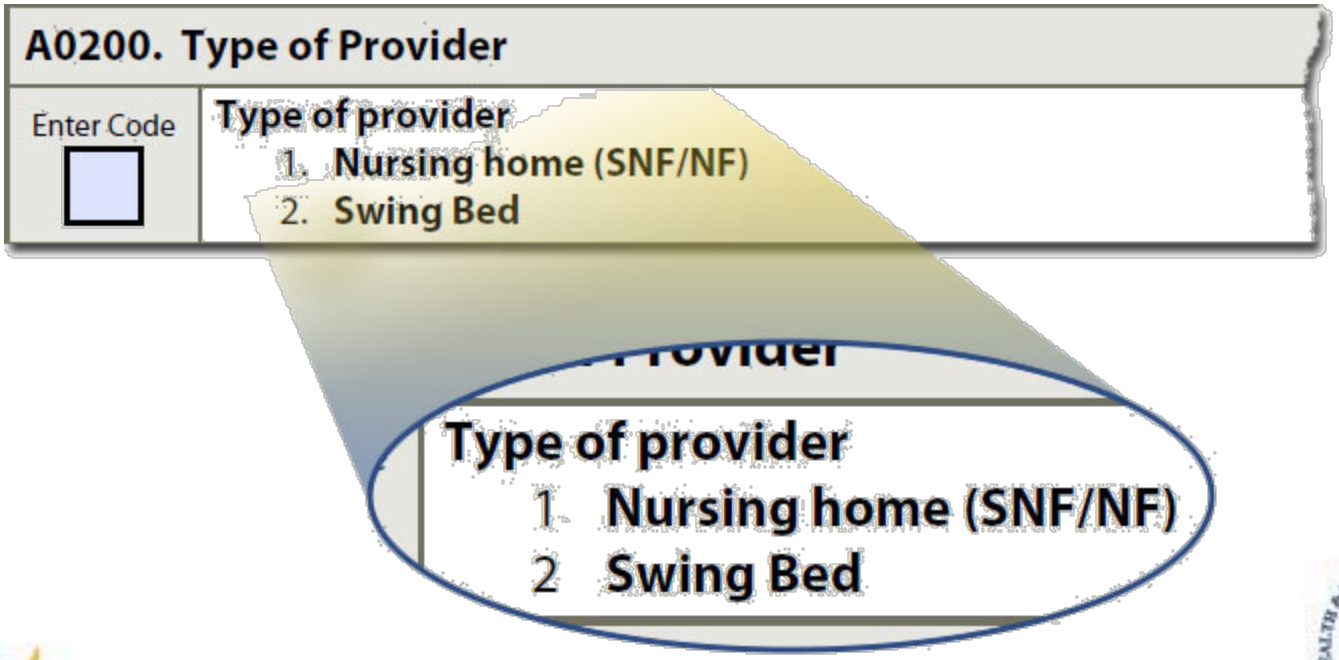
A0100 Facility Provider Numbers

- Allows identification of the nursing home submitting the assessment.
- Enter numbers in the spaces provided.



A0200 Type of Provider

- New item for MDS 3.0.
- Designate type of provider.



Items A0310/ A0410

Type of Assessment
&
Submission Requirement

A0310 Purpose

- Identifies the information required to complete the type of assessment.
- May be completed for more than one reason.
- Must meet all requirements for each type of assessment.

A0310. Type of Assessment

A0310 Type of Assessment

A. Federal OBRA Reason for Assessment

B. PPS Assessment

C. PPS Other Medicare Required Assessment - OMRA

D. Is this a Swing Bed clinical change assessment?

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

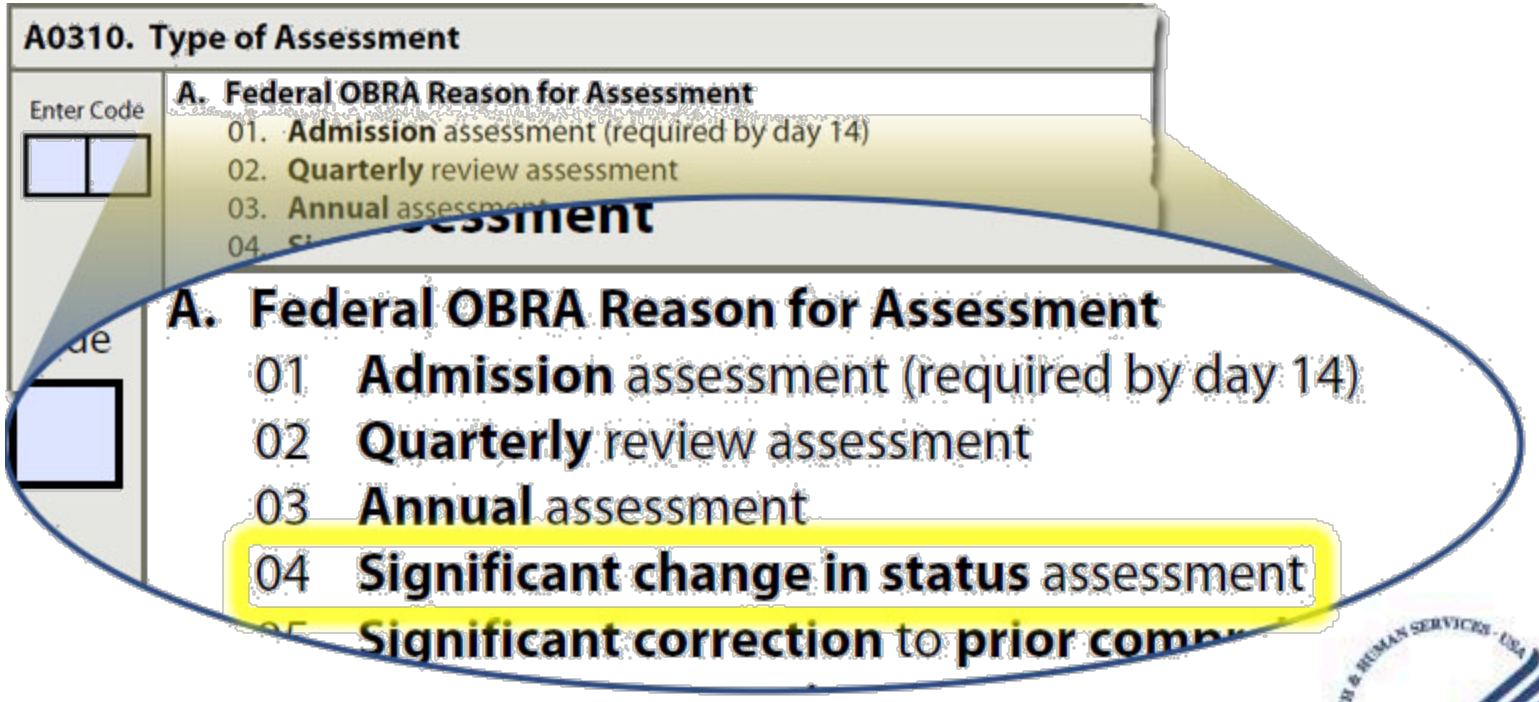
F. Entry/ discharge reporting

A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

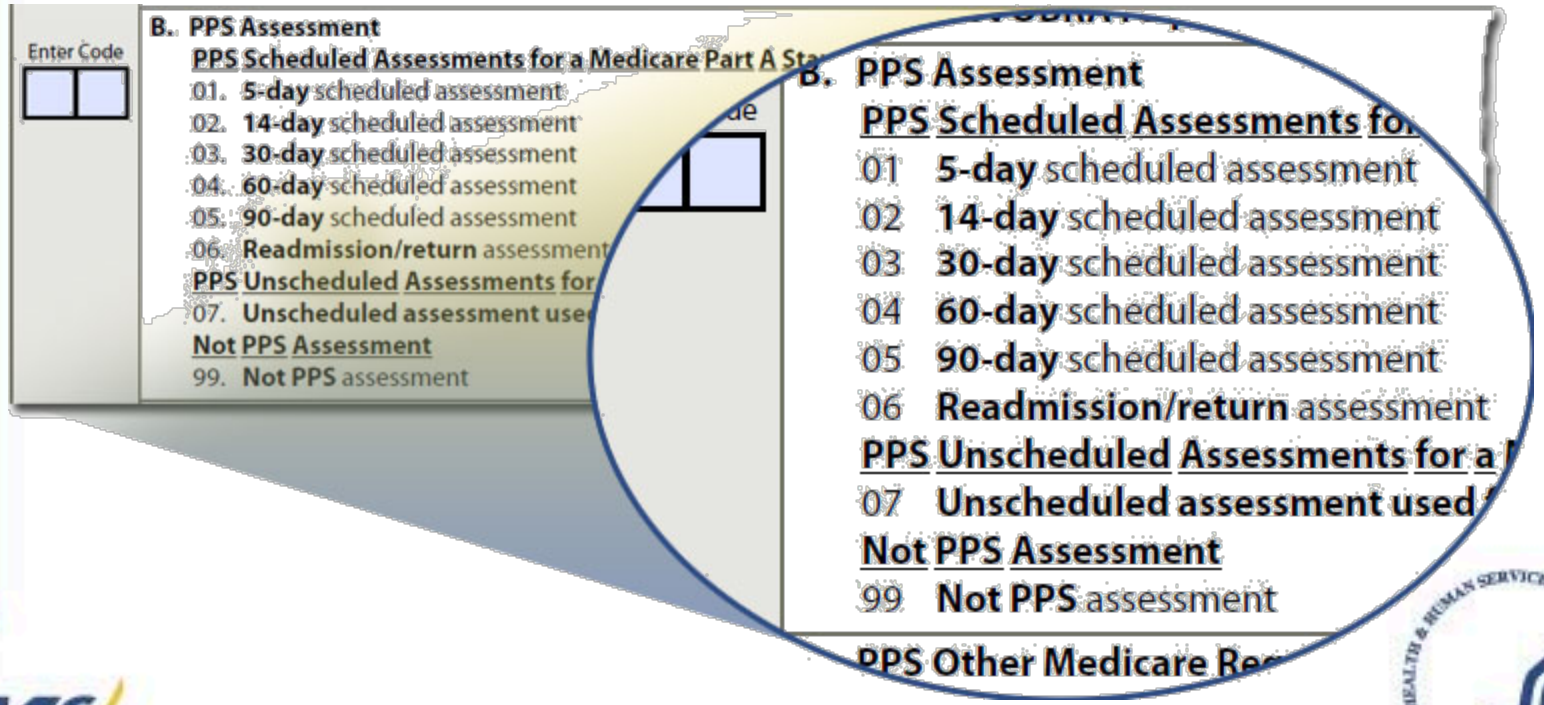
A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment.



A0310B PPS Assessment

- Includes scheduled and unscheduled assessments.

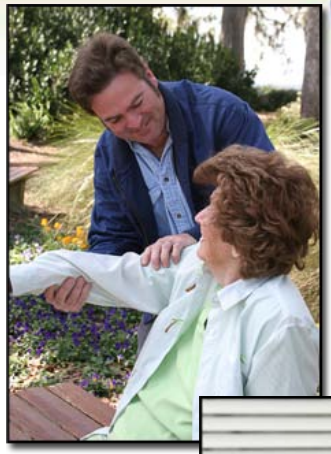


A0310C PPS Other Medicare Required Assessment - OMRA

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

A0310C OMRA
Coding Instructions

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



A0310D Swing Bed Clinical Change Assessment

- Complete only if A0200 is coded **2** to designate a swing bed provider.

Enter Code	D. Is this a Swing Bed clinical change assessment? Co
☐	0. No 1. Yes

A0200. Type of Provider	
Enter Code 2	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed

A0310E First Assessment Since Most Recent Admission

- Indicate whether this is the first OBRA, PPS, or discharge assessment since the most recent admission.
- Complete this item for all assessments.

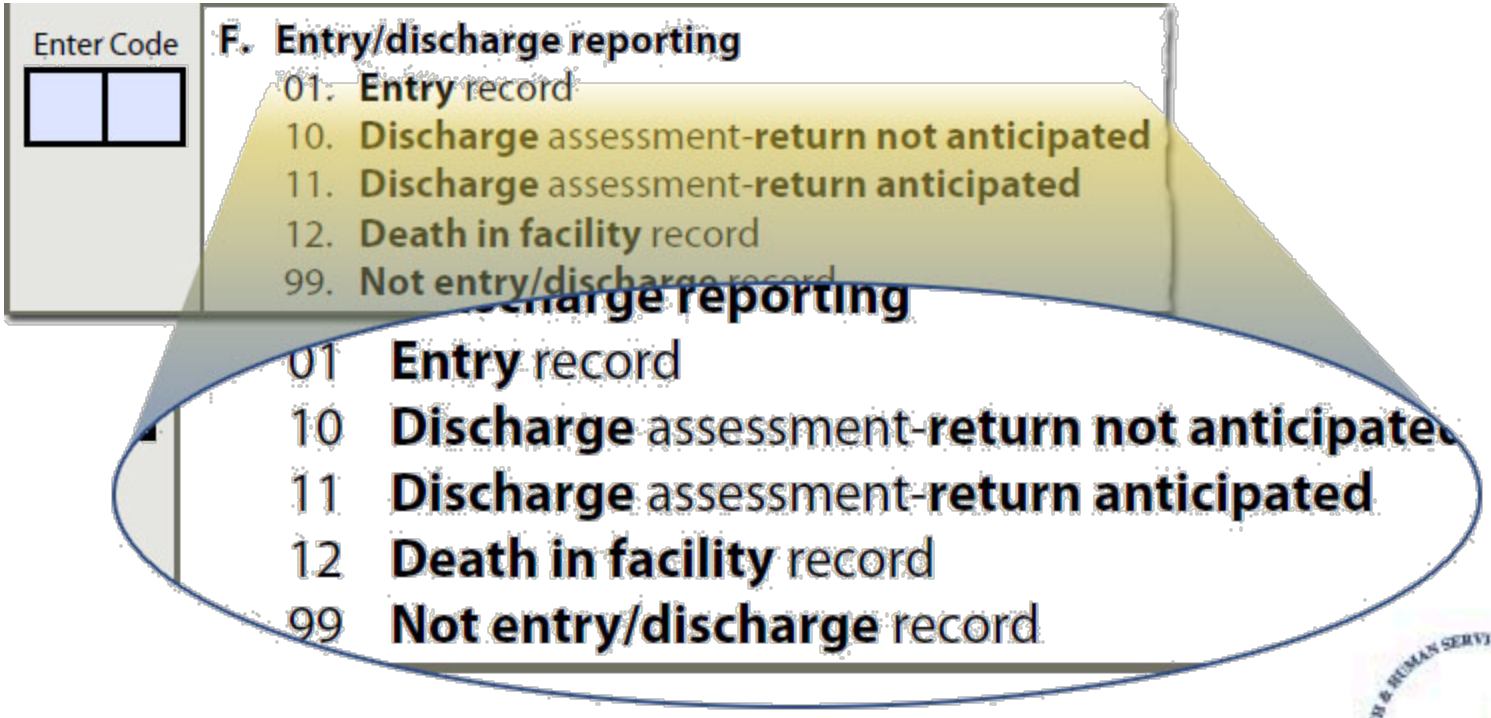
E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent a**

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

A0310F
Entry/ Discharge Reporting

- Indicate the applicable reason for completing this assessment or tracking record.



A0410 Submission Requirement

- Designates the submission authority for the resident assessment.
- Must be a federal or state authority to submit the MDS assessment to the QIES ASAP system.

A0410. Submission Requirement	
Enter Code ☐	1. **Neither federal nor state required submission** 2. **State but not federal required submission** (FOR NURSING HOMES ONLY) 3. **Federal required submission**

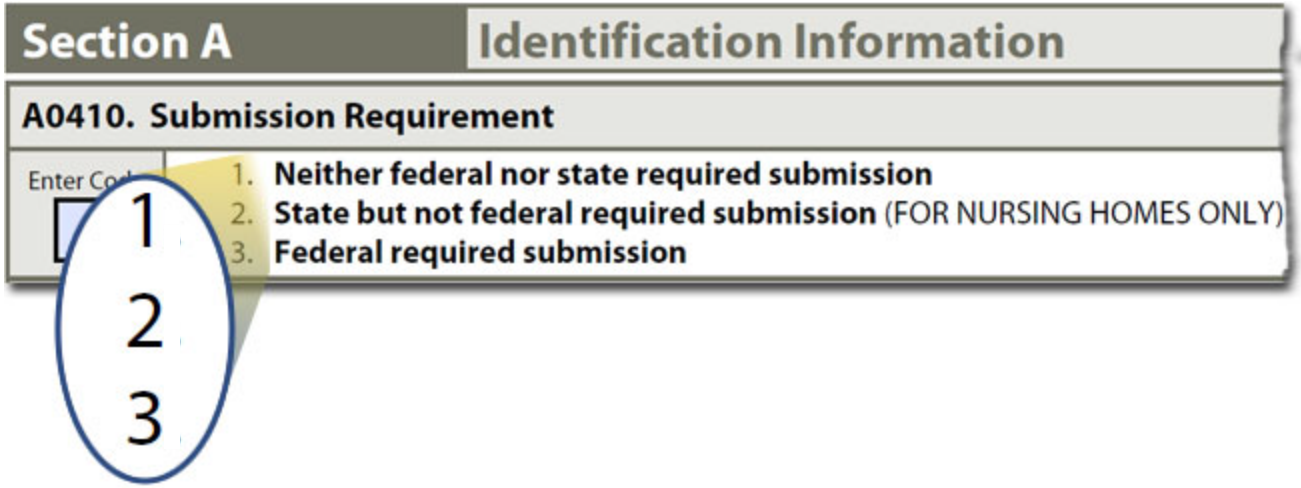
A0410 Conduct the Assessment

- Ask the nursing home administrator or representative.
  - Units that are Medicare certified
  - Units that are Medicaid certified
  - Units that are not certified

- Does the State have the authority to collect information about a resident.

A0410 Coding Instructions

- Enter the code most appropriate for this assessment.

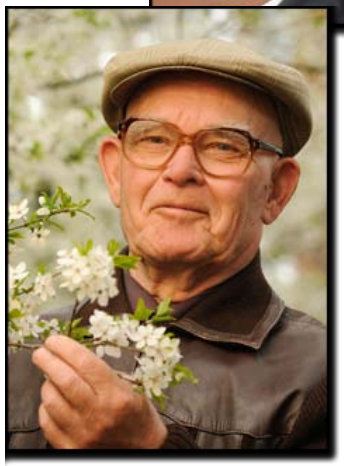


Items A0500 – A2400

Resident Data

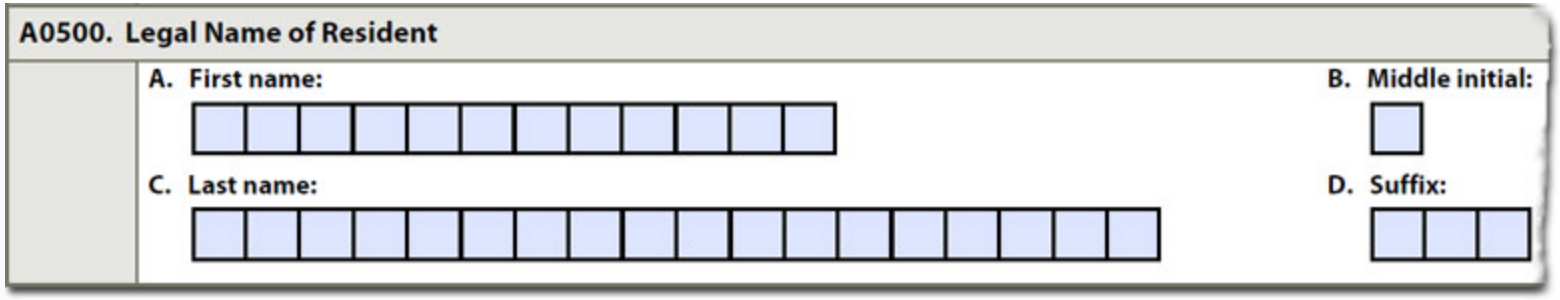
Resident Data

- A0500 through A1300
  - Personal data
- A1500 and A1550
  - Mental Illness/ Mental Retardation (MI/ MR) status
  - Mental Retardation/ Developmental Disability (MR/ DD) status
- A1600 through A2400
  - Entry and discharge data
  - Assessment Reference Date
  - Medicare stay



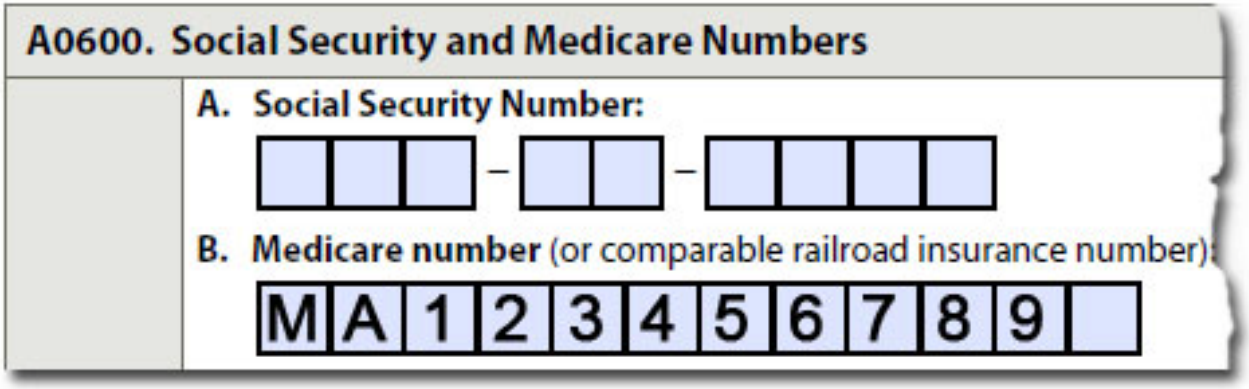
A0500 Legal Name of Resident

- Enter the resident's name as it appears on the resident's Medicare card.
- Must match exactly for the purpose of MDS 3.0.
- Used to identify resident and match records.



A0600 Social Security and Medicare Numbers

- Can use a comparable railroad insurance number instead of a Medicare number.
- **Do not** use an HMO number.

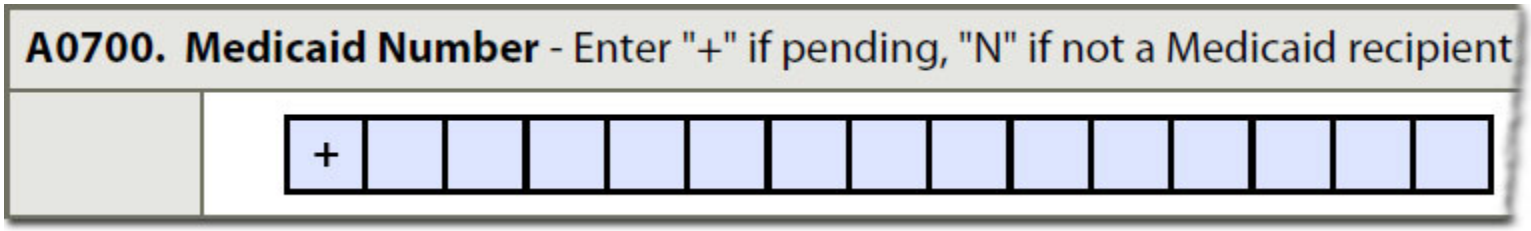


A0700 Medicaid Number

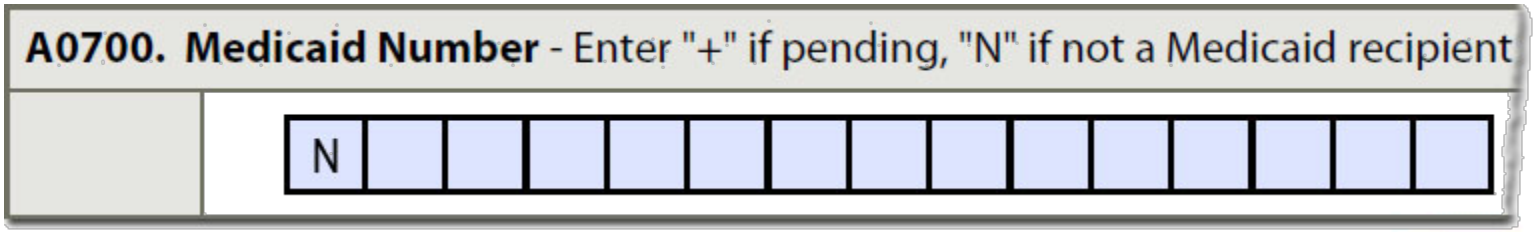
- Record number if resident is a Medicaid recipient.
- Check resident's Medicaid card, admission or transfer records, or medical record.
- Confirm the resident name on the MDS matches the Medicaid card.
- Not necessary to correct a prior MDS to add a Medicaid number.
- Corrections may be a State requirement.

A0700 Coding Instructions

- Enter “+” in the left space if pending.

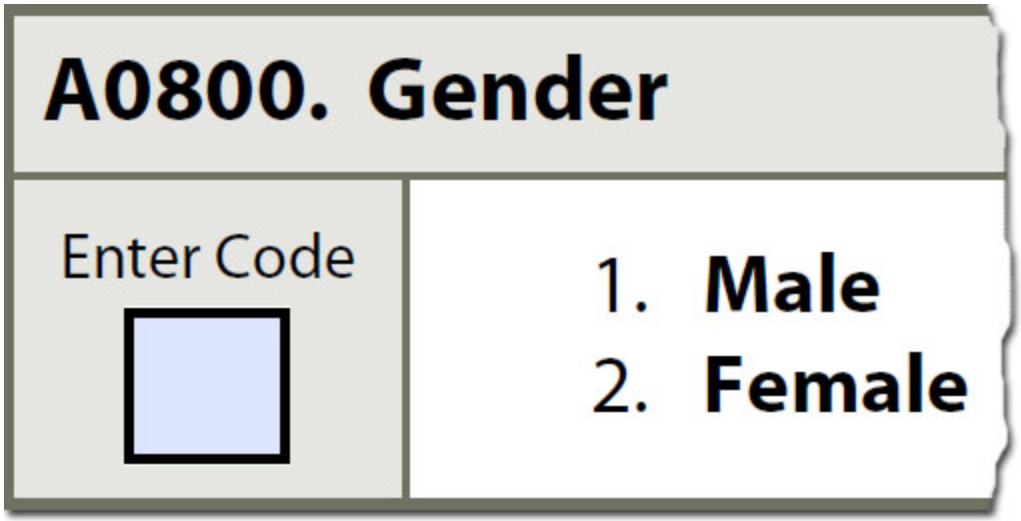


- Enter “N” in the left space if not applicable.



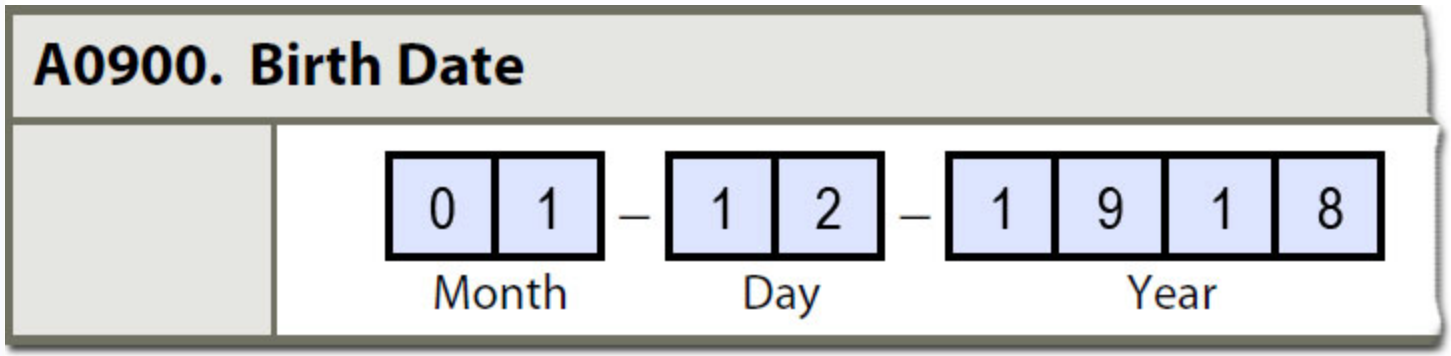
A0800 Gender

- Should match data in the Social Security system.



A0900 Birth Date

- Complete any single digit value with a leading zero.
  - For example, January would be coded as 01.
- Provide a complete birth date if known.
- Leave any unknown component blank.



A1000 Race/ Ethnicity

- Categories follow common uniform language.
- NOT used to determine eligibility for participation in any federal program.

A1000 Conduct the Assessment

- Ask resident to select categories that most closely correspond to his or her race/ ethnicity.
- Inform resident that the goal is to ensure that all residents receive the best care possible.
- Ask family member or significant other.
- Provide category definitions only if requested.
- Check the medical record only if necessary.

A1000 Coding Instructions

- Check all that apply.
- More than one category may be selected.

A1000. Race/Ethnicity	
↓ Check all that apply	
☐	A. American Indian or Alaska Native
☐	B. Asian
☐	C. Black or African American
☐	D. Hispanic or Latino
☐	E. Native Hawaiian or Other Pacific Islander
☐	F. White

A1100 Language

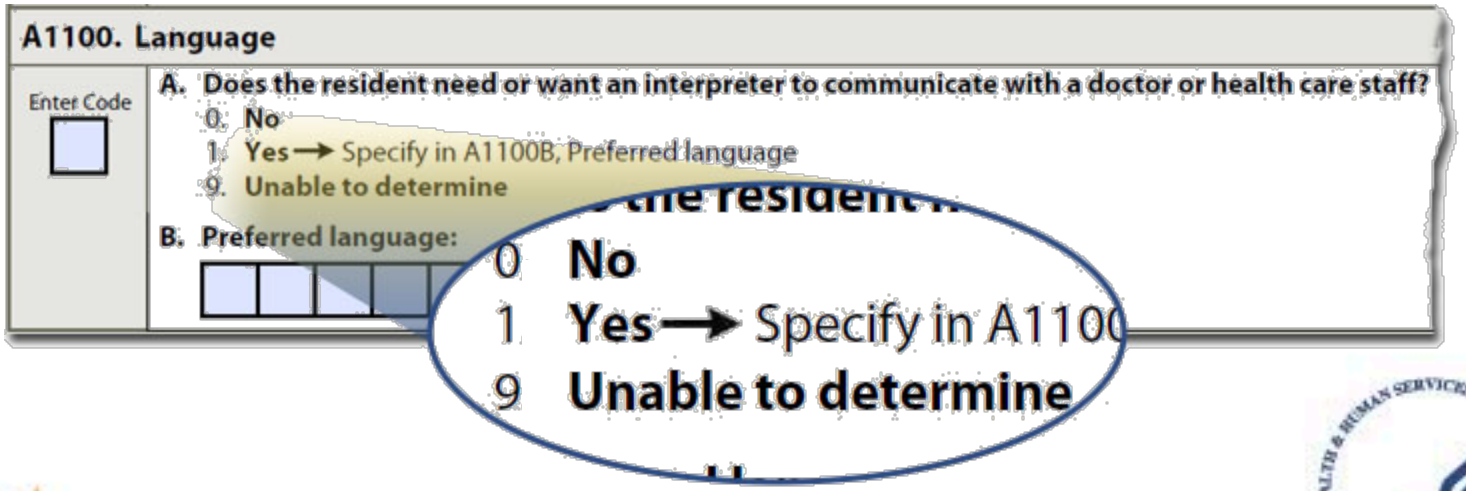
- Inability to make needs known and engage in social interaction:
  - Can be frustrating.
  - Can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.
- Identifies residents who may need an interpreter.
  - To answer MDS 3.0 interview items.
  - To participate in the consent process.

A1100 Conduct the Assessment

- To determine if an interpreter is needed:
  - Ask the resident if needs or wants an interpreter.
  - Consult a family member or significant other.
  - Review the medical record if no other source is available.
- Ask for the preferred language if needed.
- A family member or significant other can be an interpreter if:
  - Resident is comfortable with this.
  - Will translate exactly what resident says without providing own interpretation.

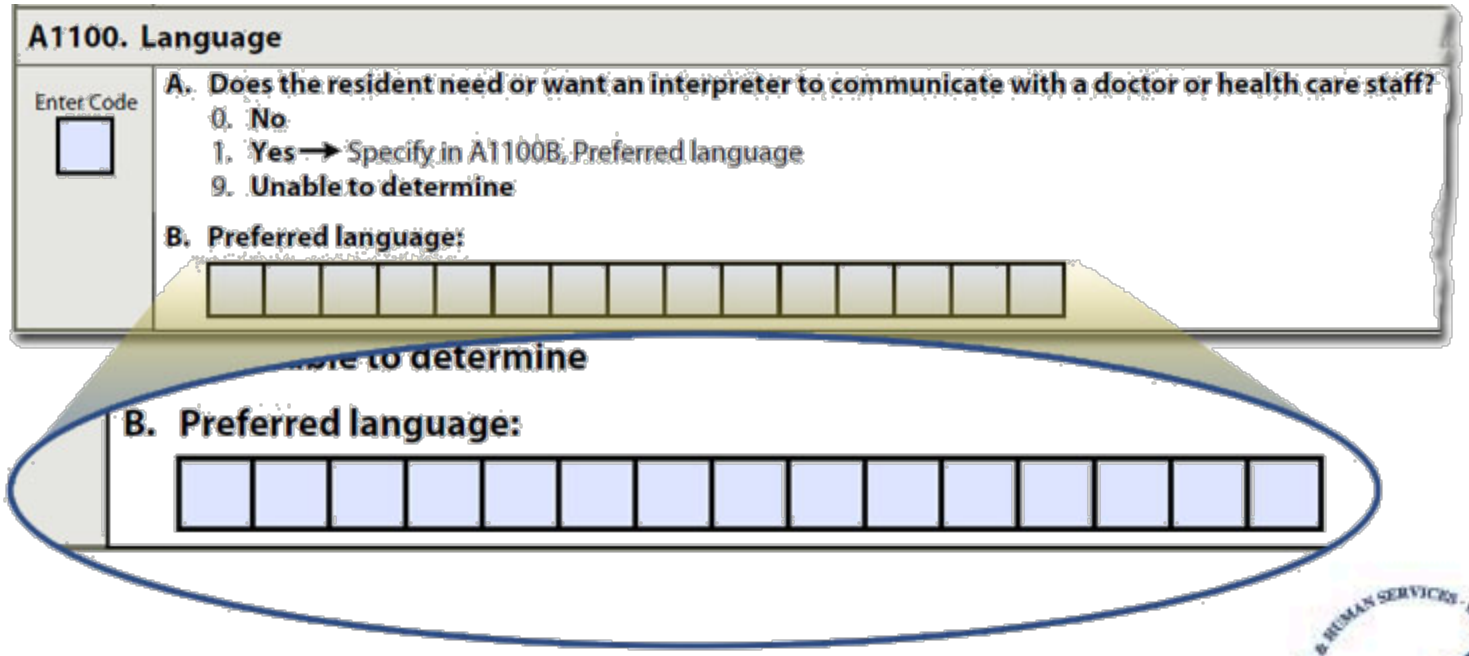
A1100A Coding Instructions

- **Code 0.** Interpreter not wanted or needed.
- **Code 1.** Interpreter is wanted or needed.
- **Code 9.** Unable to determine.



A1100B Coding Instructions

- Complete only if an interpreter is needed or wanted.

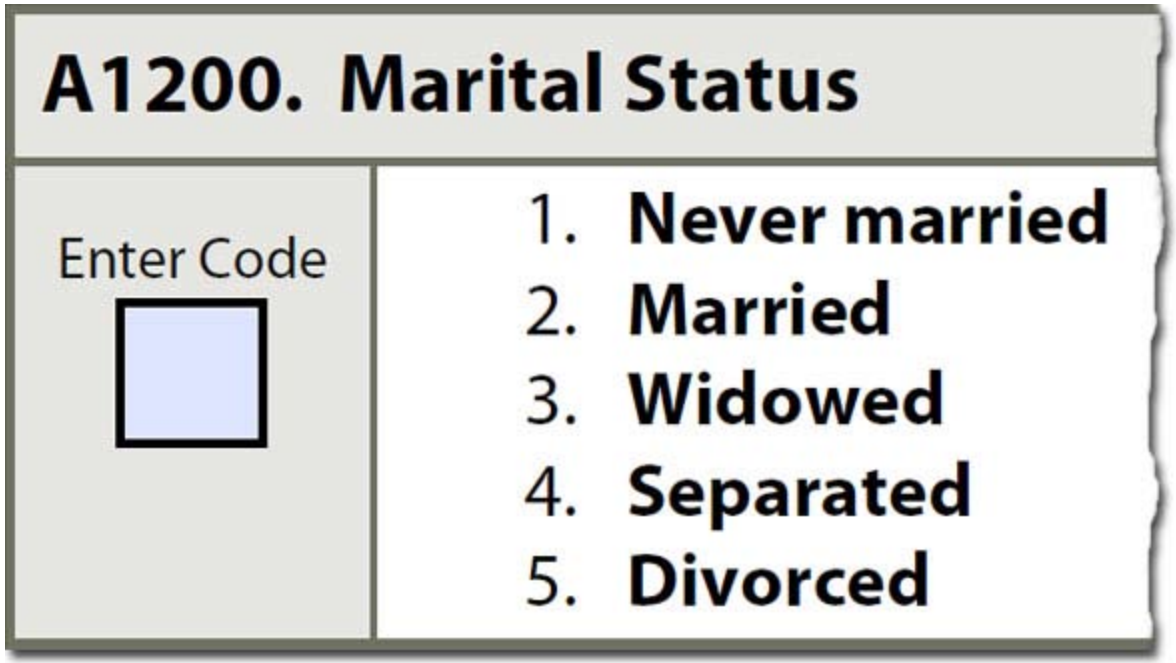


A1200 Marital Status

- Defines resident's formal relationship.
- Can be important for care and discharge planning.
- Conduct the assessment.
  - Ask the resident.
  - Ask family member or significant other.
  - Review the medical record.

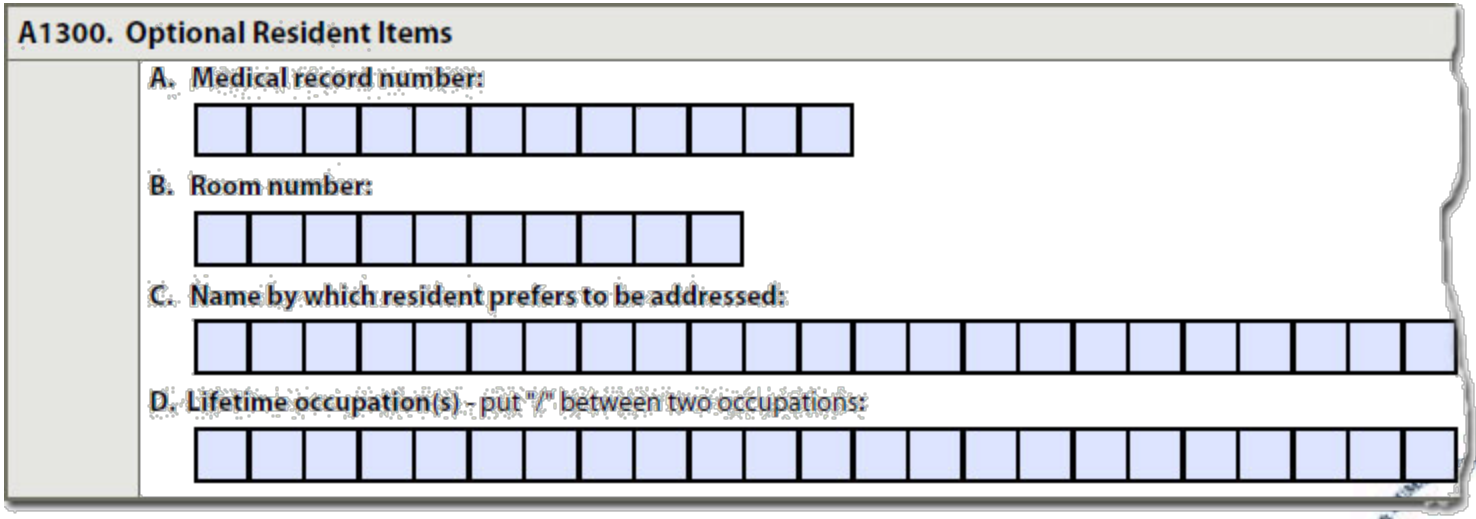
A1200 Coding Instructions

- Enter the code that reflects the resident's current marital status.



A1300 Optional Resident Items

- Document data helpful to the facility.
- Track resident data.
- Improve resident interaction and care.



A1500 PASRR Overview

- PASRR is a preadmission screening process.
- Applies to the Medicaid unit of a facility only.
- A positive screen indicates that resident has a mental illness, mental retardation, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Does not call for judgment about an individual's mental illness, mental retardation, or a related condition.
- Only reports on the results of the PASRR process.

1500 PASRR/ Medicaid

- All individuals admitted to Medicaid NFs must complete a Level I PASRR.
- If the Level I screen is positive, a Level II evaluation is performed.
- Individuals suspected to have MI/ MR or a related condition may not be admitted unless approved through a Level II PASRR determination.
- Consult your state Medicaid agency for PASRR procedures.

A1500 PASRR Reporting

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

A1500 Conduct the Assessment

- All admissions require a Level I PASRR report.
- Review the PASRR I report to determine if a Level II evaluation was required.
- If a Level II PASRR report was to be completed, it must accompany the resident on admission.
  - Has the resident been determined to have a serious mental illness and/ or mental retardation or a related condition?

A1500 Coding Instructions$_1$

- **Code 0. No** if any of the following apply.
  - Level I screening did not result in a referral.
  - Level II evaluation determined that resident does not have serious MI/ MR or a related condition.
  - PASRR screening not required due to a hospital discharge exemption.

A1500 Coding Instructions$_2$

- Requirements for a hospital discharge exemption:
  - Admitted from hospital after acute inpatient care

  AND

  - Receiving services for condition that received care for in the hospital

  AND

  - Certified before admission to likely require less than 30 days of nursing home care

A1500 Coding Instructions$_3$

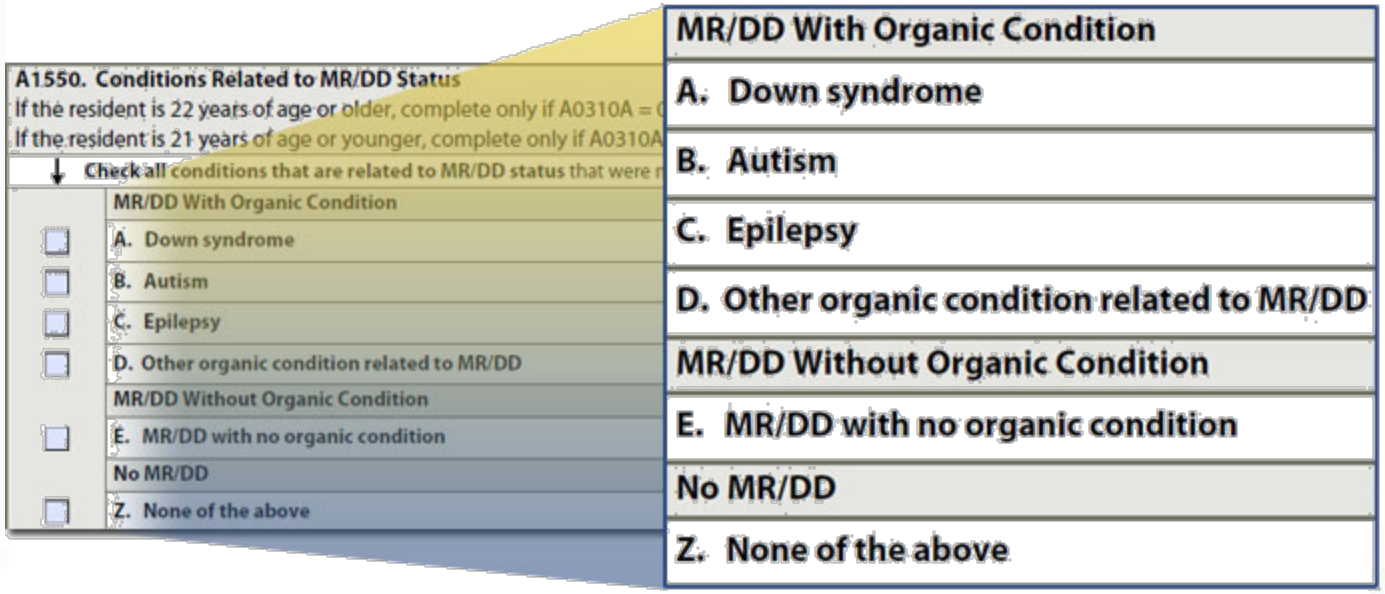
- **Code 1. Yes**
  - Level II evaluation determined that resident has a serious mental illness and/ or mental retardation or a related condition.
- **Code 9. Not a Medicaid certified unit**
  - Bed not in a Medicaid-certified nursing home.
  - Requirement is based on the certification of the part of the nursing home the resident will occupy.

A1550 Conditions Related to MR/ DD Status

- Document conditions associated with mental retardation (MR) or developmental disabilities (DD).
- Resident is 22 years or older on ARD:
  - Admission assessment only (A0310A = **01**)
- Resident is 21 years or younger on ARD:
  - Admission assessment (A0310A = **01**)
  - Annual assessment (A0310A = **03**)
  - Significant change in status assessment (A0310A = **04**)
  - Significant correction to prior comprehensive assessment (A0310A = **05**)

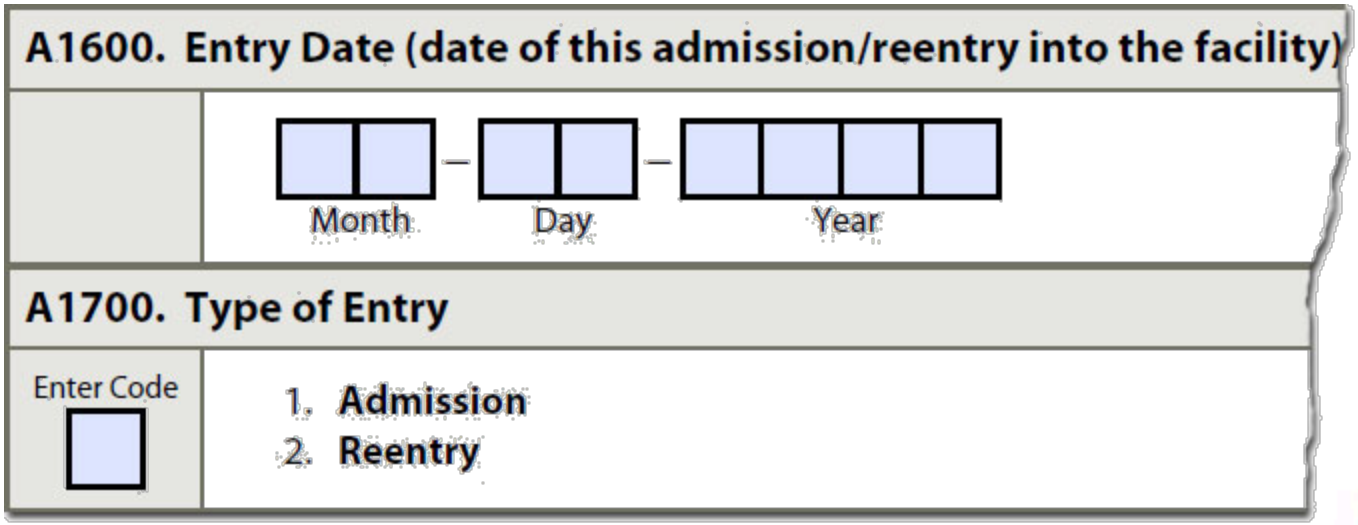
A1550 Coding Instructions

- Check all conditions related to MR/ DD status present before age 22.
- When age of onset if not specified, assume that the condition meets this criterion **AND** is likely to continue indefinitely.



A1600 & A1700 Entry Data

- A1600 Entry Date
- A1700 Type of Entry
  - Reflects whether A1600 is an admission or reentry date.



A1700 Coding Instructions$_1$

- **Code 1.** Admission when **<u>one</u>** of the following occurs:
  - Resident never admitted to the facility before.

  OR

  - Resident discharged prior to completion of OBRA assessment.

  OR

  - Resident discharged return not anticipated.

  OR

  - Resident discharged return anticipated and did not return within 30 days.

A1700 Coding Instructions$_2$

- **Code 2. Reentry** when **all** of the following occur prior to entry:
  - Resident was admitted to this nursing home (i.e., OBRA admission assessment was completed) **AND**
  - Resident was discharged return anticipated **AND**
  - Resident returned to facility within 30 days of discharge.
- Day of discharge from the facility is not counted in the 30 days.
- Swing bed facilities always code resident's entry as an admission.

A1800 Entered From

- Reflects the setting the resident was in immediately prior to admission.
- Informs care planning.
- May also inform discharge planning and discussions.

A1800 Conduct the Assessment

- Review transfer and admission records.
- Ask the resident.
- Ask family and/ or significant others.

A1800 Coding Instructions

- Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission.

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000 Discharge Date$_1$

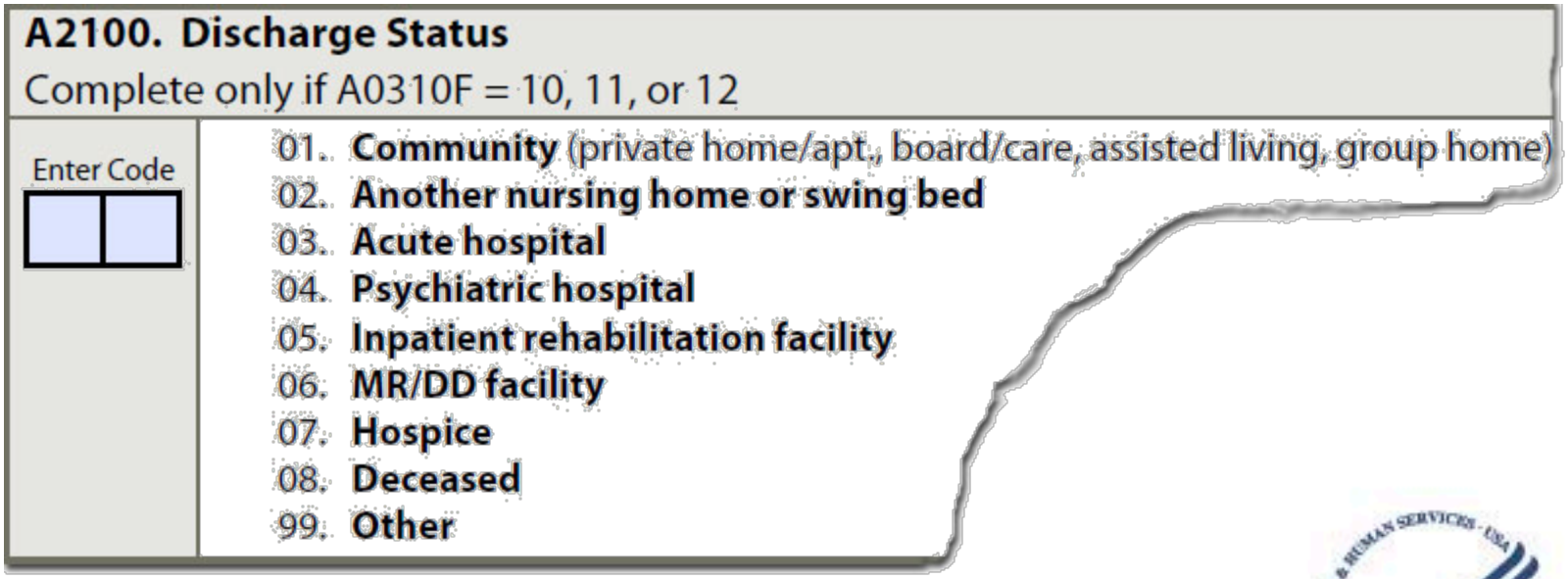
- Enter the date the resident leaves the facility.
- Do not consider whether return is anticipated or not.
- Discharge date and ARD must be the same for discharge assessments.
- Discharge date may be later than the end of Medicare stay date if resident is receiving services under SNF Part A PPS.

A2000 Discharge Date$_2$

- Do not include leaves of absence.
- Do not include hospital observational stays less than 24 hours unless resident is admitted to the hospital.
- Obtain data from medical, admissions, or transfer records.

A2100 Discharge Status

- Review the medical record including the discharge plan and discharge orders.
- Select the code that corresponds to the resident's discharge status.



A2100. Discharge Status

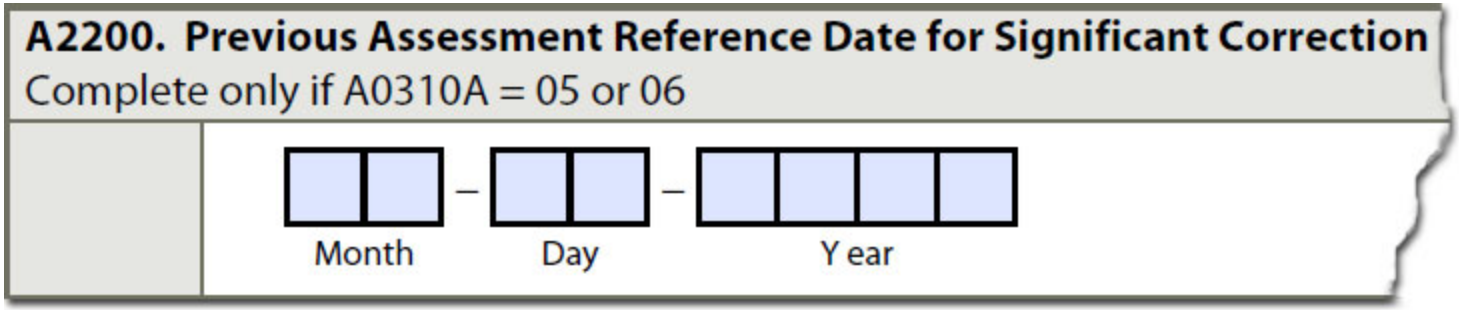
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200 Previous ARD for a Significant Correction

- Required only for a significant correction to a prior annual or quarterly assessment.
- Enter the ARD of the prior assessment for which a significant error has been identified and a correction is required.



A2300
Assessment Reference Date

- Designates the end of the look-back period.
- All assessment items for that section refer to the resident's status during the same period of time.
- Serves as the reference point for determining what care and services are captured on the MDS assessment.
- Anything that happens after the ARD will not be captured on the MDS.
- Look-back period includes observations and events through midnight of the ARD.

A2300
Assessment Guidelines$_1$

- Team members should select the ARD:
  - Reason for the assessment
  - Compliance with timing and scheduling requirements outlined in Chapter 2
- Adjust ARD to equal the discharge date if resident dies or is discharged prior to end of the look-back period.

A2300
Assessment Guidelines$_2$

- Look-back period may not be extended because resident was out of the facility during part of the period.
- Leave days are considered part of the look-back period.
- May use data from the time the resident is absent if the MDS item permits.

A2400 Medicare Stay$_1$

- Identifies when a resident is receiving services under the SNF PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.

A2400A Medicare Stay$_2$

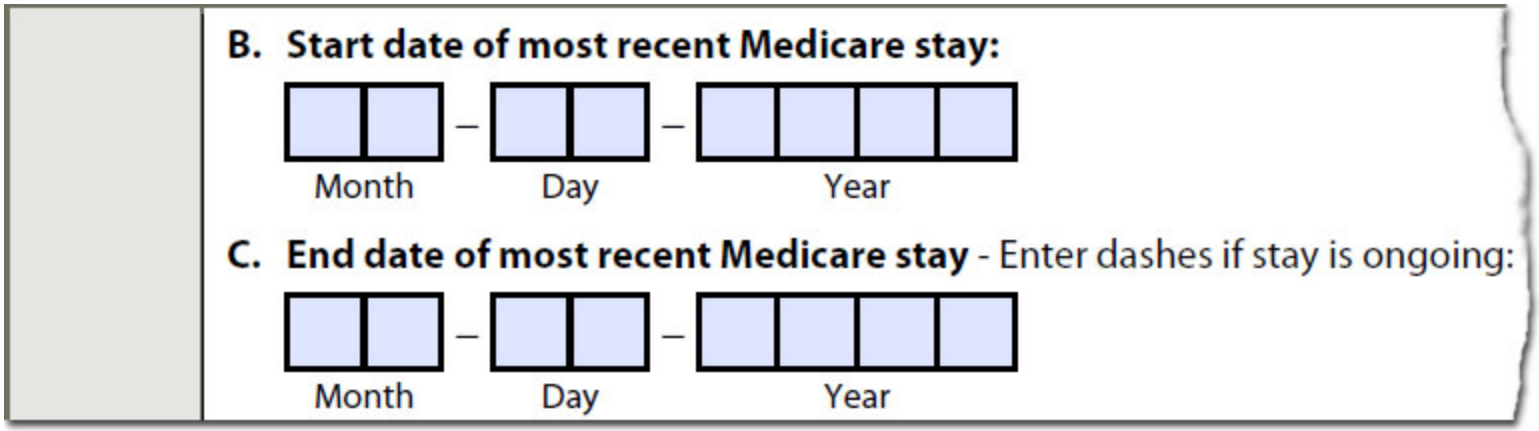
- Indicate whether the resident has had a Medicare-covered stay since the most recent entry.

A2400. Medicare Stay

Enter Code	A. Has the resident had a Medicare-covered stay since the most recent entry?
☐	0. **No** → Skip to B0100, Comatose 1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

A2400B Start Date
A2400C End Date

- If A2400A is coded **1. Yes:**
  - B. Enter start date of most recent Medicare stay
  - C. Enter end date of most recent Medicare stay



A2400C End Date Guidelines

- Code whichever occurs first:
  - Date SNF benefit exhausts
  - Effective Date from the Generic Notice
  - Date of the last paid day of Medicare A when payer source changes to another payer
  - Date the resident was discharged from the facility (A2000)
- Returning from therapeutic leave of absence or hospital observation stay of less than 24 hours is a continuation of a Medicare Part A stay.
- May be earlier than discharge date.

Scenario #1

- Mrs. G. began receiving services under Medicare Part A on October 14, 2010.
- Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage.
- A Generic Notice was issued with the last day of coverage as November 23, 2010.
- Mrs. G. was discharged from the facility on November 24, 2010.

Scenario #1 Coding

- Code A2000 Discharge Date as 11-24-2010.
- Code A2400A as **1. Yes**.
- Code A2400B Start Date as 10-14-2010.
- Code A2400C End Date as 11-23-2010.

Scenario #2

- Mr. N began receiving services under Medicare Part A on December 11, 2010.
- He was sent to the ER on December 19, 2010 at 8:30pm and was not admitted to the hospital.
- He returned to the facility on December 20, 2010, at 11:00 am.
- The facility completed his 14-day PPS assessment with an ARD of December 23, 2010.

Scenario #2 Coding

- Code A2400A as **1. Yes**.
- Code A2400B Start Date as 12-11-2010.
- Code A2400C End Date as all dashes to indicate an ongoing stay.

Scenario #3

- Mr. R. began receiving services under Medicare Part A on October 15, 2010.
- He was discharged return anticipated on October 20, 2010, to the hospital.

Scenario #3 Coding

- Code A2000 Discharge Date as 10-20-2010.
- Code A2400A as **1. Yes**.
- Code A2400B Start Date as 10-15-2010.
- Code A2400C End Date as 10-20-2010.

Section A

Summary

Section A

- Section A helps set the parameters for completing the MDS 3.0.
- Define the requirements for completing the assessment
- Ensure that any resources for completing the assessment are identified
  - Interpreter
  - Current documentation

Facility & Assessment Data

- Provide data to identify facility where the resident resides.
- Provide assessment data.
  - Purpose (type of assessment) is critical to define the requirements for the assessment.
  - Identify the submission authority.

Resident Data

- Provide information to identify the resident.
- Provide additional information describing the resident.
- Provide information defining the resident's Medicare stay.