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NA	Title Page	NA	Change the revised date to July 2008
CH 2	2.2	2-11	Revise as follows: Delete the second sentence of the second paragraph, "~~The need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment~~." Insert the following in place of the deleted second sentence in the second paragraph: While the need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment, CMS encourages facilities to complete an SCSA due to the importance of ensuring that a coordinated plan of care between the hospice and nursing facility is put into place.
CH 2	2.5	2-29	Remove the first bullet from the first row on 5DAY AA8b = 1 AND Readmission/Return AA8b = 5 under Special Comment • ~~If a resident transfers or expires before the Medicare 5-Day assessment is finished, prepare an MDS as completely as possible for the RUG Classification and proper Medicare payment, or bill at the default rate.~~ Replace with "See Section 2.9 for instructions involving beneficiaries who transfer or expire."
CH 2	2.5	2-29	Remove the III from "RUG-III" under Other Medicare Required Assessment (OMRA), Special Comment, fourth bullet: • Not required if not previously in a RUG-~~III~~ Rehabilitation Plus Extensive Services or Rehabilitation group
CH 2	2.5	2-29	Add to the bullet under Significant Change in Status Assessment (SCSA), Special Comment, the following phrase: "as long as the resident continues to require a SNF level of care." • "Could establish a new RUG Classification and remains effective until the next assessment is completed as long as the resident continues to require a SNF level of care."
CH 2	2.6(2)	2-30	Remove the word "or" from the fourth sentence under subsection 2. Medicare 30-Day Assessment, "The 30-Day assessment authorizes payment from days 31 through 60

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			of the stay, ~~or~~ as long as the resident remains eligible for Part A SNF-level services." The sentence should read, "The 30-Day assessment authorizes payment from days 31 through 60 of the stay, as long as the resident remains eligible for Part A SNF-level services."
CH 2	2.6(3)	2-30	Remove the phrase "or as long as the resident remains eligible for Part A SNF-level services" from the first sentence under subsection 3. Medicare 60-Day Assessment: "Medicare assessment that must have an ARD (Item A3a) established between days 50-59 of the SNF stay ~~or as long as the resident remains eligible for Part A SNF-level services~~." The sentence should read: "Medicare assessment that must have an ARD (Item A3a) established between days 50-59 of the SNF stay."
CH 2	2.6(3)	2-30	Remove the word "or" from the fourth sentence under subsection 3. Medicare 60-Day Assessment, "The 60-Day assessment authorizes payment from days 61 through 90 of the stay, ~~or~~ as long as the resident remains eligible for Part A SNF-level services." The sentence should read, "The 60-Day assessment authorizes payment from days 61 through 90 of the stay, as long as the resident remains eligible for Part A SNF-level services."
CH 2	2.6(4)	2-31	Remove the word "or" from the fourth sentence under subsection 4. Medicare 90-Day Assessment, "The 90-Day assessment authorizes payment from days 91 through 100 of the stay, ~~or~~ as long as the resident remains eligible for Part A SNF-level services." The sentence should read, "The 90-Day assessment authorizes payment from days 91 through 100 of the stay, as long as the resident remains eligible for Part A SNF-level services."
CH 2	2.6(7)	2-31	Remove the phrase "or as long as the resident remains eligible for Part A SNF-level services" from the first sentence under subsection 7. Medicare 14-Day Assessment, "Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay ~~or as long as the resident remains eligible for Part A SNF-level services~~." The sentence should read, "Medicare assessment that must have an ARD (Item A3a)

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			established between days 11-14 of the SNF stay.
CH 2	2.6(7)	2-31	Remove the word "or" from the fourth sentence under subsection 7. Medicare 14-Day Assessment, "The 14-Day assessment authorizes payment from days 15 through 30 of the stay, ~~or~~ as long as the resident remains eligible for Part A SNF-level services." The sentence should read, "The 14-Day assessment authorizes payment from days 15 through 30 of the stay, as long as the resident remains eligible for Part A SNF-level services."
CH 2	2.6(8)	2-31	Remove the last sentence under subsection 8., Other Medicare-Required Assessment: ~~If the OMRA falls in the assessment window of a regularly schedule Medicare assessment, code the assessment as an OMRA to affect the change in payment status.~~
CH 2	2.6(8)	2-31	Remove the III from "RUG-III" under subsection 8. Other Medicare-Required Assessment in the first sentence and the fourth sentence: The OMRA is completed only if the resident was in a RUG~~-III~~ Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The OMRA will establish a new non-therapy RUG~~-III~~ group and Medicare payment rate.
CH 2	2.8	2-37	In the first bullet, remove the III from "RUG-III": • If the State requires only a two page or RUG~~-III~~ Quarterly, for an assessment designated as AA8a=05 and AA8b=4, either a full MDS or MPAF w3ould be completed.
CH 2	2.9	2-37	Remove the subsection, Resident Expires or Transfers: ~~If a beneficiary expires or transfers to another facility before the 5-Day assessment is completed, the nursing facility prepares a Medicare assessment as completely as possible to obtain the RUG-III Classification so the provider can bill for the appropriate days. If the Medicare assessment is not completed then the nursing facility provider will have to bill at the default rate.~~ Replace with the following: If the SNF transfers a beneficiary or the beneficiary expires before the eighth day of covered SNF care within a benefit period a SNF must prepare a Medicare

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			assessment as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no Medicare assessment is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code. In instances where the beneficiary is transferred and then returns to a SNF to continue receiving covered SNF services within the same benefit period, and the total number of covered days used by the beneficiary is less than 8 days out of the potential 100 (including the covered days previously utilized), the SNF may choose not to complete a Medicare assessment and instead submit a claim using the HIPPS default rate code. However, if the covered stay upon admission/readmission exceeds 8 days within the same benefit period the SNF shall not bill the default rate code, but shall complete a Medicare assessment to be paid. In these situations, if no Medicare assessment is completed, no payment will be made.
CH 2	2.9	2-39	Delete the last two sentences in the second paragraph of the subsection, Combining Assessments: ~~This procedure is an exception to the rule that OMRAs are performed only to show discontinuation of therapy for residents in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification. In some circumstances, an SCSA can be used as an OMRA and a scheduled Medicare assessment.~~
CH 2	2.9	2-39	Insert in the subsection, Non-Compliance with the Assessment Schedule, "Part 42" prior to "Code" in the first sentence. Should read: According to Part 42 Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate.
CH 2	2.9	2-39	Insert in the subsection, Non-Compliance with the Assessment Schedule, at the end of the paragraph, the following sentence: The default code 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 or BC1, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.
CH 2	2.9	2-40	Remove the title and text of subsection, "~~Default Rate~~"

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			~~MDS assessments are completed according to an assessment schedule specifically designed for Medicare payment, and each assessment applies to specific days within a resident's SNF stay to determine the appropriate reimbursement for the resident. Compliance with this assessment schedule is critical to ensure that the appropriate level of payment is established. Accordingly, SNFs that fail to perform assessments timely are to be paid a RUG-III default rate for the days of a resident's care for which they are not in compliance with this schedule. THE RUG-III default rate takes the place of the otherwise applicable Federal rate. The RUG-III default rate is equal to the rate paid for the RUG-III 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.~~
CH 2	2.9	2-40	Change the title of subsection "~~Late or Missed Assessment Criteria~~ to "Late Assessment". Remove the text of subsection, "Late or Missed Assessment Criteria": ~~A late or missed assessment may be completed as long as the window for the allowable ARD (including grace days) has not passed. If a late/missed assessment has an ARD within the allowable grace period, no financial penalty is assessed. If the assessment has an ARD after the mandated grace period, payment will be made at the default rate for covered services from the first day of the coverage period to the ARD of the late assessment. A late assessment cannot replace the next regularly scheduled assessment. Therefore, if the ARD of the 14-Day assessment was day 22, it cannot be used as both the Medicare 14-Day and Medicare 30-Day assessments.~~ ~~In this situation, the late 14-Day assessment would be used to support payment for days 22-30 of the Part A stay. A new 30-Day assessment would need to be completed within the assessment window for the Medicare 30-Day assessment.~~ Insert the following text into subsection "Late Assessment": If the SNF fails to set the ARD within the assessment

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			window for a Medicare-required assessment, including the grace days, the SNF may file a late assessment. The late assessment shall have an ARD that falls after the assessment window, including the grace days. 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 HIPPS rate code established by the late assessment. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment.
CH 3	A3	3-29	Remove all but the first sentence from the Clarifications NOTE: Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment. ~~For Part A billing, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; e.g., Significant Change in Status or OMRA. In these situations, the ARD of the non-scheduled assessment has sometimes been referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.~~
CH 3	G1(A)	3-81	Remove all but the first sentence in the first paragraph of the third bullet under 8. Activity Did Not Occur During the Entire 7-day Period: To code Item G1hA=8, consider if in the past 7 days the resident truly did not receive any nourishment. ~~It should go without saying that this is a serious issue. Be careful not to confuse total dependence in eating (coded "4") with the activity itself (receiving nourishment and fluids). Keep in mind that as a resident who receives nourishment via tube feeding and manages the tube feeding independently is coded as G1hA=0 (Independent). In addition, the definition for G1h includes IV fluids. Therefore, code G1hA=4 (Total Dependence) rather than "8" for a resident who is receiving IV fluids or TPN.~~ Add to last bullet the following: To code a resident as a "4" (Total Dependence) in G1hA, the resident would have to be totally dependent in eating, drinking and be non-participatory in the TPN, IV or tube feeding administration. If the resident participated in the

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			act of drinking and/or eating and was totally dependent in the TPN, IV or tube feeding, the facility must evaluate all of the methods that food and fluids are being provided to the resident to determine the resident's level of self-performance.
CH 3	R2b	3-212	Add the following bullet point under Clarifications: • The term "backdating" means to give or assign a date to a document that is earlier than the actual date.
CH 3	R2b	3-212	Under the Coding Section, delete the 2nd, 3rd and 4th sentences: Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. ~~Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If for some reasons, the MDS cannot be signed on the date it is completed it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record. Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.~~ Insert the following: Use the actual date that the MDS was completed, reviewed and signed as complete by the RN Assessment Coordinator. This date will generally be later than the date(s) at AA9 which documents when portions of the assessment information were completed by assessment team members.
CH 3	T1B	3-216	Delete the last sentence in the first paragraph of Process, ~~"If therapy treatment(s) will not be scheduled, skip to Item T3."~~ Replace with: "Skip to Item T3 if the therapy evaluation is not completed, or the evaluation is completed but no treatment is scheduled."
CH 3	W2	3-240 – 3-241	Replace the sentence under Process, "~~Review the resident's medical record and interview the resident or responsible party/legal guardian to determine Influenza vaccination status during this year's flu season, defined as~~

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			~~October 1 through March 31~~." with the following: "Review the resident's medical record and interview the resident or responsible party/legal guardian to determine Influenza vaccination status during this year's flu season. The current influenza (flu) season begins when this season's flu vaccine is made available to the public."
CH 5	5.4	5-5	Delete the 5th sentence from the HIPPS Codes subsection, "~~One the MDS record has been accepted into the State MDS database clinical staff should give the HIPPS code to the billing office.~~" Replace with: "The SNF must submit the RAI to the State RAI database to receive a final Validation report indicating that the assessment has been accepted by the State and the beneficiary must have used the covered day, prior to submitting a claim."
CH 5	5.4	5-5	Replace the last sentence in the last paragraph in the subsection HIPPS Codes, "~~When such discrepancies occur, the RUG-III code reported on the Final Validation Report should always be used for billing~~." with the following: When such discrepancies occur, the RUG code reported on the Final Validation Report should always be used for billing, except in those cases where the SNF is required to bill the default code. Add an additional sentence: The Grouper program does not contain the first three alpha characters of the HIPPS default code AAA, instead the lowest RUG group BC1 appears on the report.
CH 6	6.4(1)	6-4	Remove the 2nd sentence in subsection 1. Assessment Reference Date (ARD): ~~If an MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate.~~
CH 6	6.4(3)	6-4	In the first two paragraphs under subsection 3 (Health Insurance PPS (HIPPS) Codes, change RUG-III to RUG. The HIPPS code must be entered on each claim, and must accurately reflect which assessment is being used to bill

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			the RUG ~~-III~~ group for Medicare reimbursement. **The CMS HIPPS codes contain a three position code to represent the RUG ~~-III~~ of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was completed.**
CH 6	**6.4(3)**	**6-5**	**Remove the first part of the first sentence in the third paragraph under subsection Health Insurance PPS (HIPPS) Codes: "~~HIPPS modifier codes~~ have been established for each type of assessment used to support Medicare payment."** **Replace with:** **"Assessment indicators have been established for each type of assessment used to support Medicare payment."**
CH 6	**6.4(3)**	**6-5**	**Remove the fourth full paragraphs under subsection Health Insurance PPS (HIPPS) Codes:** **~~Under the SNF PPS, there are situations when two assessments may be needed to fulfill Medicare requirements. Rather than requiring such duplication of effort, providers have the ability to combine assessments (see Chapter 2 for more detailed information). For example, if an OMRA is required during the assessment window for a Medicare 30-Day assessment (i.e., days 2 1-34), the SNF is required to perform only one assessment. There is no way to code two Medicare Reasons for Assessment. The combined OMRA/30-Day Medicare assessment is coded on the MDS as an OMRA and identified on the Part A billing by using a HIPPS modifier code of "28". The combined assessment can then be used when billing the Medicare claim. Similarly, if an assessment is a combined 30-Day and an SCSA, the SCSA is coded as the Primary Reason for Assessment. The 30-Day is shown as the Medicare Reason for Assessment, and the HIPPS modifier code used for billing is "32".~~**
CH 6	**6.4(3)**	**6-5**	**Remove the title ~~SNF HIPPS MODIFIERS~~/ASSESSMENT ~~TYPE~~ INDICATORS from the table of indicators.** **Replace with the following title:** **ASSESSMENT INDICATORS**

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	A	A-2	Remove the last sentence in Assessment Window: The period of time defined by Medicare regulations that specify when the Assessment Reference Date must be set. ~~For example, the assessment window for a Medicare 5-Day assessment is between days 1-8, including grace days.~~
	A	A-13	Remove the last phrase from the definition of Skilled Nursing Facility (SNF): A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, ~~or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.~~ Definition should read: A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons.
	B	B-2, B-3	Update contact information for MDS RAI Coordinators for the following states: Florida, Georgia, Louisiana, New York and Oklahoma.
	B	B-5	Update contact information for MDS RAI Automation Coordinators for the following states: California
	B	B-9	Update contact information for Region VI.

GUIDELINES FOR DETERMINING THE NEED FOR AN SCSA FOR RESIDENTS WITH TERMINAL CONDITIONS

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual. If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment is required. Similarly, if the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at the facility, an SCSA should be performed. The facility is 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 facility and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. While the need to complete a SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment, CMS encourages facilities to complete an SCSA due to the importance of ensuring that a coordinated plan of care between the hospice and nursing facility 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 facility to evaluate the MDS information to determine if it reflects the current condition of the resident. The nursing facility and the hospice's plans of care should be reflective of the current status of the resident.

- Complete an SCSA for a newly diagnosed resident with end-stage disease when:

  - a change is reflected in more than one area of decline; and
  - the resident's status will not normally resolve itself; and
  - the resident's status requires interdisciplinary review and/or revision of the care plan.

- Complete subsequent SCSA's based upon the degree of decline and the impact upon the comprehensive care plan. Consider the following criteria:

  - completion date of the last MDS;
  - clinical relevancy and accuracy of the MDS to the resident's current status; and
  - the need to change the resident's care plan to reflect the current status.

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MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE PERIOD DAYS ARD can also be set on these days	BILLING CYCLE Used by the business office	SPECIAL COMMENT
5 DAY AA8b = 1 AND Readmission/ Return AA8b = 5	Days 1-5	6-8	Set payment rate for Days 1-14	• See Section 2.9 for instructions involving beneficiaries who transfer or expire. • RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA.
14 Day AA8b = 7	Days 11-14	15-19	Set payment rate for Days 15-30	• RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment. • Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment.
30 Day AA8b = 2	Days 21-29	30-34	Set payment rate for Days 31-60	
60 Day AA8b = 3	Days 50-59	60-64	Set payment rate for Days 61-90	
90 Day AA8b = 4	Days 80-89	90-94	Set payment rate for Days 91-100	• Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment.
Other Medicare Required Assessment (OMRA)	• 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Set payment rate effective with the ARD	• 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 the resident is dis-charged from Medicare prior to day 8. • Not required if not previously in a RUG Rehabilitation Plus Extensive Services or Rehabilitation group
Significant Change in Status Assessment (SCSA)	Completed by the end of the 14th calendar day following determination that a significant change has occurred.	N/A	Set payment rate effective with the ARD	• Could establish a new RUG Classification and remains effective until the next assessment is completed as long as the resident continues to require a SNF level of care.

***NOTE:** Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

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2.6 Types of MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment in Items AA8a and A8a. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item AA8b and A8b. The Medicare and State reasons for assessment are described in this section. In many cases, assessments are combined to meet both OBRA and Medicare requirements. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Section 2.8.

Codes for Assessments Required for Medicare or in States When Required - It is possible to select a code for the MDS from both AA8a and AA8b (e.g., Item AA8a coded "3" (Significant Change in Status assessment), and Item AA8b coded "3" (60-Day assessment).

1. **Medicare 5-Day Assessment** - The first Medicare assessment completed upon admission to the nursing facility for Part A SNF-level services. The 5-Day Medicare assessment must have an ARD (Item A3a) established between days 1-5 of the SNF stay. The ARD (Item A3a) can be extended to day 8 if using the designated "Grace Days." The 5-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 14-day calculation is based on calendar days and includes weekends. The 5-Day assessment authorizes payment from days 1 through 14 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission.

2. **Medicare 30-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 21-29 of the SNF stay. The ARD (Item A3a) can be extended to day 34 if using the designated "Grace Days." The 30-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 30-Day assessment authorizes payment from days 31 through 60 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

3. **Medicare 60-Day assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 50-59 of the SNF stay. The ARD (Item A3a) can be extended to day 64 if using the designated "Grace Days." The 60-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 60-Day assessment authorizes payment from days 61 through 90 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

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4. **Medicare 90-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 80-89 of the SNF stay. The ARD (Item A3a) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). (NOTE: When combined with an OBRA Quarterly assessment, see Section 2.2).

5. **Medicare Readmission/Return Assessment** - Medicare assessment that is completed when a resident whose stay was being reimbursed by Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (Item A3a) established between days 1-8 of the return. The Readmission/Return assessment must be completed (Item R2b) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

6. **Other State-Required Assessment – This assessment is not used for Medicare purposes.** In some cases, States have established assessment requirements in addition to the OBRA and Medicare assessments. Contact your RAI Coordinator for State specific requirements.

7. **Medicare 14-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay. The ARD (Item A3a) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (Item R2b) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission. (NOTE: When combined with an OBRA Admission assessment, see instructions in Sections 2.2 and 2.8.)

8. **Other Medicare-Required Assessment** - The OMRA is completed only if the resident was in a RUG Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG group and Medicare payment rate. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

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assessment. The ARD must also be set within the proper window for the Medicare requirement. Then the facility must decide which form to complete.

- If the State requires only a two page or RUG Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, either a full MDS or MPAF would be completed. The full MDS or MPAF is the more extensive MDS form; the most stringent requirement must be met.
- If the State requires a full assessment for a Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, a full MDS form must be completed. It is the more extensive MDS form; the most stringent requirement must be met.

NOTE: It is extremely important to understand the MDS requirements established in your state. Your decision to use the MPAF may be dependent upon your State Medicaid agency's MDS assessment requirements and the State-designated Quarterly assessment.

For a resident who was already in the nursing facility but is now beginning a new Medicare Part A stay, it might be appropriate to combine a Quarterly with a Medicare 5-Day, depending on the resident's status.

A Significant Change in Status assessment might be combined with any Medicare assessment including an OMRA, presuming that the ARD is within the assigned Medicare assessment window and the assessment is completed within 14 days of the identification of the change. At all times, when the nursing facility chooses to complete one assessment to meet both an OBRA and a Medicare requirement, staff must carefully review the standards for each assessment to assure that the most stringent requirement is met.

2.9 Factors Impacting the SNF Medicare Assessment Schedule

Resident Expires or Transfers

If the SNF transfers a beneficiary or the beneficiary expires before the eighth day of covered SNF care within a benefit period a SNF must prepare a Medicare assessment as completely as possible to assign a HIPPS rate code for Medicare payment purposes within the required assessment schedule. If no Medicare assessment is completed under these specific circumstances, the SNF may submit a claim using the HIPPS default rate code.

In instances where the beneficiary is transferred and then returns to a SNF to continue receiving covered SNF services within the same benefit period, and the total number of covered days used by the beneficiary is less than 8 days out of the potential 100 (including the covered days previously utilized), the SNF may choose not to complete a Medicare assessment and instead submit a claim using the HIPPS default rate code. However, if the covered stay upon admission/readmission exceeds 8 days within the same benefit period the SNF shall not bill the default rate code, but shall complete a Medicare assessment to be paid. In these situations, if no Medicare assessment is completed, no payment will be made.

Resident Discharges to Hospital Prior to the Admission Assessment Completion

Since the Admission assessment was not completed, the facility must complete a Discharge Tracking form with a reason for assessment A8a = 8, discharged prior to completion of admission assessment. In most cases, the facility will have completed a 5-Day Medicare assessment covering the period from the date of admission to the earlier of the Assessment Reference Date (which can be assigned up through day 8 of the Part A stay) or the actual date of discharge. This Medicare assessment will be needed to bill for Part A days

window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as AA8a = 3 and AA8b = 8, Other Medicare Required assessment.

Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the nursing facility provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of a physician hold could occur when a resident is admitted to the nursing facility for rehabilitation services but is not ready for weight-bearing exercises. The physician will write an order to start therapy when the resident is able to do weight bearing. Once the resident is able to start the therapy, the Medicare Part A stay begins, and the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the resident is able to start therapy services.

Combining Assessments

Significant Change in Status Assessment (SCSA) or the Other Medicare Required Assessment (OMRA) may be combined with the regularly scheduled Medicare assessments. If the Medicare assessment window coincides with the SCSA assessment, a single assessment may be coded as both a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and an SCSA. If the Assessment Reference Date of an OMRA coincides with a regularly scheduled Medicare assessment, it is coded only as the OMRA. For billing purposes, it is identified as an OMRA replacing a 14-Day, 30-Day, 60-Day or 90-Day.

Currently there is no way to code that a SCSA performed outside the assessment window is a Medicare assessment. Until this problem can be corrected, code AA8a = 3 to show the SCSA and AA8b = 8 to indicate that the record is a Medicare assessment.

Non-Compliance with the Assessment Schedule

According to the Part 42 Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate. Frequent early or late assessment scheduling practices may result in onsite review. The default code 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 or BC1, 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 Assessment

An assessment should be completed according to the designated Medicare 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.

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Late Assessment

If the SNF fails to set the ARD within the assessment window for a Medicare-required assessment, including the grace days, the SNF may file a late assessment. The late assessment shall have an ARD that falls after the assessment window, including the grace days. 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 HIPPS rate code established by the late assessment. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment.

Errors on a Medicare Assessment

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

- **Modification:** This procedure should be used if any of the item responses were incorrect, e.g., Medicare number, number of therapy minutes, etc.
- **Inactivation:** This procedure should be used if the assessment itself was invalid, e.g., the Reason for Assessment for Medicare (AA8b) was incorrect. This might be an assessment completed to meet the 30-Day assessment requirement, but incorrectly submitted as a 60-Day assessment. The assessment should be resubmitted with the corrected reason for assessment.

A Significant Correction assessment is not done when the assessment in error has been completed to meet the Medicare schedule only. However, if the assessment had been completed to meet an OBRA requirement, as well as the Medicare schedule, normal MDS correction procedures might require the completion of a Significant Change in Status assessment or a Significant Correction assessment, depending on the type of errors identified. Payment will be based on the new Assessment Reference Date if appropriate. Correction procedures are explained in detail in Chapter 5.

A3. Assessment Reference Date

a. Last Day of MDS Observation Period

Intent: To establish a common reference point for all staff participating in the resident's assessment. As staff members may work on a resident's MDS assessment on different days, establishing the Assessment Reference Date ensures a common assessment period. In other words, the ARD designates the end of the observation period so that all assessment items refer to the resident's objective performance and health status during the same period of time. See Chapter 2 for completion timing requirements for each assessment type.

Definition: This date refers to a specific end-point for a common observation period in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, the observation period is a 7-day period ending on this date. Some observation periods cover the 14 days ending on this date, and some cover 30 days ending on this date.

Clarifications:

- The ARD is the common date on which all MDS observation periods end. The observation period is also referred to as the look-back period. It is the time period during which data is captured for inclusion on the MDS assessment. The ARD is the last day of the observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7th day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (Item A3a).

  NOTE: Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment.

3. **Extensive Assistance** - While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

   -- Weight-bearing support provided three or more times;
   -- Full staff performance of activity (3 or more times) during part (but not all) of last seven days.

4. **Total Dependence** - Full staff performance of the activity during entire seven-day period. There is complete non-participation by the resident in all aspects of the ADL definition task. If staff performed an activity for the resident during the entire observation period, but the resident performed part of the activity himself/herself, it would not be coded as a "4" (Total Dependence).

   Example: Eating is coded based on the resident's ability to eat and drink, regardless of skill, and includes intake of nourishment by other means (e.g., tube feeding, or total parenteral nutrition). For a resident to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity Did Not Occur During the Entire 7-Day Period** - Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

   - If the resident is bed bound and does not walk, there was no locomotion via bed, wheelchair, or other means, then you would code both Self Performance and Staff Support as "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code the items according to the definitions provided in Section G1.
   - A resident who was restricted to bed for the entire 7-day period and was never transferred from bed would be coded for both Self Performance and Staff Support as "8", since the activity (transfer) did not occur.
   - To code Item G1hA = 8, consider if in the past 7 days the resident truly did not receive any nourishment. To code a resident as a "4" (Total Dependence) in G1hA, the resident would have to be totally dependent in eating, drinking and be non-participatory in the TPN, IV or tube feeding administration. If the resident participated in the act of drinking and/or eating and was totally dependent in the TPN, IV or tube feeding, the facility must evaluate all of the methods that food and fluids are being provided to the resident to determine the resident's level of self-performance.

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Process: The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding: Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed by the RN Assessment Coordinator. This date will generally be later than the date(s) at AA9 which documents when portions of the assessment information were completed by assessment team members.

Clarifications:

- The use of signature stamps is allowed. The facility must have policies in place to ensure proper use and secure storage of the stamps. The State may have additional regulations that apply.

- The term "backdating" means to give or assign a date to a document that is earlier than the actual date.

- The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment."

  For facilities that use a sign-in form for care planning and MDS completion, the facility would need to have a written policy that explains how the sign-in process and format are used. It would have to provide attestation by the registered nurse regarding the completion of the assessment, and for each individual, who must certify the accuracy of the portion of the assessment that they completed. The State may have additional regulations that apply.

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completed and therapy treatment(s) has been scheduled. Skip to Item T3 if the therapy evaluation is not completed, or the evaluation is completed but no treatment is scheduled.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A.

c. ESTIMATE OF NUMBER OF DAYS (Through day 15)

Coding: **Estimate of Number of Days** - Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number or days through day 15, even if the resident is discharged prior to day 15. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

Clarifications:

- Do not count the evaluation day in the estimate number of days unless treatment is rendered.

- When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7.

d. ESTIMATE OF NUMBER OF MINUTES (Through day 15)

Coding: **Estimate of Number of Minutes** - Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission. Include the number of minutes already provided from MDS Items P1ba(B), P1bb(B), and P1bc(B). Calculate the expected number of minutes through day 15, even if the resident is discharged prior to day 15.

Clarification:

- Do not include evaluation minutes in the estimate of number of minutes.

SECTION W.
SUPPLEMENTAL ITEMS

W1. National Provider Identifier (NPI)

Intent: To record the NPI of the facility.

Definition: The NPI is a unique identifier for health care providers of health care services, supplies, and equipment. The HIPAA legislation required the Secretary of the Department of Health and Human Services (HHS) to establish a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES), developed by CMS, has begun assigning NPIs to health care providers.

Process: After the NPPES assigns an NPI to a provider, like a nursing facility, the NPI applies to the facility for all of its residents.

Coding: When the NPI is available, enter the 10-digit NPI in the spaces provided. The NPI has no embedded dashes or spaces. Recheck the number to ensure you have entered the 10 digits correctly. The facility is encouraged to begin using this number once it has obtained it.

W2. Influenza Immunization

Intent: To determine the rate of vaccination and causes for non-vaccination.

Section W2 must be completed for all residents on all assessment types (OBRA and/or PPS) with Assessment Reference Dates and all discharge tracking forms with Discharge Dates from October 1 through June 30. Discharge tracking forms are included in order to capture flu vaccines administered to residents whose flu vaccines were not captured on an MDS assessment.

Although flu season currently is defined as October 1 through March 31, assessments with an ARD and discharges with a discharge date through June 30 are included in order to capture any record that provides the only report of a vaccination received during the flu season.

> **Example:** A flu vaccine is administered to a resident in March, not within the window of an MDS assessment. Extending the date for completing W2 to June 30 provides the facility the ability to capture that flu vaccine on the next Quarterly, even if it is not due for another 92 days or on a discharge before the Quarterly is due.

Process: **Review the resident's medical record and interview the resident or**

responsible party/legal guardian to determine Influenza vaccination status during this year's flu season. The current influenza (flu) season begins when this season's flu vaccine is made available to the public. Use following steps:

- **Step 1.** Review the resident's medical record to determine whether an Influenza vaccination was received during the flu season. If vaccination status is unknown, proceed to the next step.

- **Step 2.** Ask the resident if he/she received a dose of Influenza vaccine outside of the facility for this year's flu season. If vaccination status is still unknown, proceed to the next step.

- **Step 3.** If the resident is unable to answer, then ask the same question of the responsible party/legal guardian. If vaccination status is still unknown, proceed to the next step.

- **Step 4.** If vaccine status cannot be determined, administer the vaccination to the resident according to standards of clinical practice.

The CDC has evaluated inactivated Influenza vaccine co-administration with the pneumococcal polysaccharide vaccine systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm[2,3]. If the resident is an amputee or if intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to standards of clinical practice.

Coding: W2a

Enter **"0" for a 'No' response and proceed to item W2b**

• If the resident did not receive the Influenza vaccine in this facility from October 1 – March 31.

Example: Mrs. J. received the Influenza vaccine in January 2005. The ARD of this assessment is October 2005. The facility has not yet administered the Influenza vaccine for the current flu season. W2a would be coded "0", No.

Enter **"1" for a 'Yes' response and proceed to item W3**

• If the ARD of this assessment or the discharge date of this discharge tracking form is from January 1 through June 30, include Influenza vaccine administered in the facility from October 1 of last year through March 31 of the current year.

Example: Mrs. T. received the Influenza vaccine in

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR § 413.343 (a) and (b), nursing facilities reimbursed under the SNF PPS "are required to submit the resident assessment data described at § 483.20…. in the manner necessary to administer the payment rate methodology described in § 413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in § 413.337 (c) related to the adjustment of the Federal rates for case-mix. SNFs must submit assessments according to an assessment schedule. This schedule must include performance of resident assessments on the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

RUG-III Codes: Every Medicare assessment (AA8b = 1, 2, 3, 4, 5, 7 or 8) submitted must include a RUG-III case mix code (T3a). The first three characters are the RUG-III group code and the last two characters are a valid RUG-III version code, e.g., RMC07. The RAVEN software calculates and inserts the correct RUG-III case mix code for each Medicare assessment. Every Medicare assessment that is submitted to the State MDS database must include a RUG-III case mix code. The version code is used solely for electronic submission purposes. The version code is included on all MDS files electronically submitted to the State MDS database. The version code is different from the HIPPS code, and is not used when filing Medicare Part A claims.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting claims to the fiscal intermediary (FI). The HIPPS codes contain a three-position alpha code to represent the RUG-III case mix code of the SNF resident, plus a two-position assessment indicator to indicate which assessment was completed. SNFs are **not** currently required to transmit the HIPPS code as part of the MDS data record. The HIPPS code is calculated manually or by nursing facilities' proprietary software. The SNF must submit the RAI to the State RAI database to receive a final Validation report indicating that the assessment has been accepted by the State and the beneficiary must have used the covered day, prior to submitting a claim. The HIPPS code must appear on the claim and the claim cannot be filed until the MDS has been accepted into the State MDS database.

It is important to remember that the record will be accepted into the State MDS database, even if the calculated RUG-III code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG-III code. When such discrepancies occur, the RUG code reported on the Final Validation Report should always be used for billing except in those cases where the SNF is required to bill the default code. The Grouper program does not contain the first three alpha characters of the HIPPS default code AAA, instead the lowest RUG group BC1 appears on the report.

5.5 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the State MDS Database

Facilities may not "change" a previously completed MDS assessment when the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is part of the facility's responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident's status is not required, unless a significant change in status has occurred.

6.4 Relationship Between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

1. ASSESSMENT REFERENCE DATE (ARD)

The ARD must be reported on the Medicare claim. CMS has developed mechanisms to link the assessment and billing records.

2. THE RUG-III GROUP

The RUG-III group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted MDS assessments. Nursing homes cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process.

RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB SE1, SE2, SE3
SSA, SSB, SSC
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
BA1, BA2, BB1, BB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
AAA (the default code)

3. HEALTH INSURANCE PPS (HIPPS) CODES

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG group for Medicare reimbursement.

The CMS HIPPS codes contain a three position code to represent the RUG of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was

completed. Together they make up the 5-position HIPPS code for the purpose of billing Part A covered days to the Fiscal Intermediary. The chart shown below list the HIPPS codes used by SNFs.

Assessment Indicators have been established for each type of assessment used to support Medicare payment. For example, the Medicare reason for assessment on a Medicare 5-Day assessment is "1", and the HIPPS code is "01".

ASSESSMENT INDICATORS

01	5-Day Medicare-required assessment/not an Admission assessment.
02	30-Day Medicare-required assessment.
03	60-Day Medicare-required assessment.
04	90-Day Medicare-required assessment.
05	Readmission/Return Medicare-required assessment.
07	14-Day Medicare-required assessment/not an Admission assessment.
08	Off-cycle Other Medicare-required assessment (OMRA).
11	5-Day (or readmission/return) Medicare-required assessment AND Admission assessment.
17	14-Day Medicare-required assessment AND Admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-Day Medicare assessments, regardless of whether it is also an OBRA Admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18	OMRA (Other Medicare Required Assessment) replacing 5-Day Medicare-required assessment
19	Special payment situation – 5-Day assessment
28	OMRA replacing 30-Day Medicare-required assessment
29	Special payment situation – 30-Day assessment

Glossary

Activities of **D**aily **L**iving	**ADL**	*Activities of daily living are those needed for self-care: bathing, dressing, mobility, toileting, eating, and transferring. The late-loss ADLs (eating, toileting, bed mobility, and transferring) are used in classifying a patient into a RUG-III group.*
Assessment Period		The time period during which the assessment coordinator starts the assessment until it is signed as complete.
Assessment **R**eference **D**ate	**ARD**	The last day of the observation period for the MDS assessment. All MDS items refer back in time from this common endpoint. May also be referred to as the "Target Date" in CMS system-generated reports. The MDS field name is A3a.
Assessment Window		The period of time defined by Medicare regulations that specify when the Assessment Reference Date must be set.
Browser		A program, such as Internet Explorer or Netscape, that allows access to the internet or a private intranet site. A browser with 128-bit encryption is necessary to access the CMS intranet for data submission or report retrieval.
Case **M**ix **I**ndex	**CMI**	Weight or numeric score assigned to each RUG-III group that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
Case Mix Reimbursement System		A payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.

Skilled **N**ursing **F**acility	**SNF**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons.
State **O**perations **M**anual	**SOM**	A manual provided by CMS that contains guidelines for the survey process.
Submission **Req**uirement	**SUB_REQ**	A field in the MDS electronic record that identifies the authority for data collection. CMS has authority to collect assessments for all residents (regardless of their payer source) who reside in Medicare- and/or Medicaid- certified units. States may or may not have regulatory authority to collect assessments for residents in non-certified units.
Swing-**B**ed **MDS**	**SB-MDS**	MDS assessments completed by swing-bed hospitals for Medicare Prospective Payment.
System **O**f **R**ecords	**SOR**	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Target Date		A term used in CMS system-generated reports. This date is the Assessment Reference Date for an assessment, date of discharge for a discharge, and date of reentry for a reentry.
Transfer		When a resident leaves a nursing facility either temporarily or permanently, and goes to another health care setting.
Triggers		Specific MDS item responses that indicate the presence of clinical factors that should be considered by the interdisciplinary team when making care planning decisions.
Utilization Guidelines		Comprehensive information for evaluating factors that may cause, contribute to, or exacerbate a triggered condition.
Validation Report		See FVR or Final Validation Report.
V Codes		A supplementary classification of ICD-9 codes used to describe the circumstances that influence a resident's health status and identify the reasons for medical visits resulting from circumstances other than a disease or injury.

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