Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A	—	Standardized wording/usage of term "QIES ASAP system" throughout the section.
3	A0050	A-1	• **Code 2, Modify existing record:** if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the Quality Improvement and Evaluation System (QIES-) Assessment Submission and Processing (ASAP) system.
3	A0100	A-3	**Coding Instructions** • ~~Facilities must have a National Provider Identifier (NPI) and a CMS Certification Number (CCN).~~ • Enter the facility provider numbers: 1. National Provider Identifier (NPI). 2. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank. 3. State Provider Number (optional). This number is assigned by the ~~Regional Office~~State survey agency and provided to the intermediary~~/carrier and the State survey agency~~. When known, enter the State Provider Number in A0100C. Completion of this is not required; however, your State may require the completion of this item.
3	A0300–A2400	A-4–A-40	Page length changed due to revised content.

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Chapter	Section	Page	Change
3	A0300	A-4	

A0300: Optional State Assessment

A0300. Optional State Assessment	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment

Item Rationale

- Allows for collection of data required for state payment reimbursement.

Coding Instructions for A0300, Optional State Assessment

- Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.
- If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.

Coding Instructions for A0300A, Is this assessment for state payment purposes only?

- Enter the value indicating whether your state requires this assessment for payment.

  0. No
  1. Yes

Track Changes
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Chapter	Section	Page	Change
3	A0300	A-4–A-5	**Coding Tips and Special Populations** • This assessment is optional, as it is not federally required; however, it may be required by your state. • For questions regarding completion of this assessment, please contact your State agency. • This must be a standalone assessment (i.e., cannot be combined with any other type of assessment). • The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes. • If your state does not require this record for state payment purposes, enter a value of "0" (No). If your state requires this record for state payment purposes, enter a value of "1" (Yes) and proceed to item A0300B, Assessment Type. **Coding Instructions for A0300B, Assessment Type** • Enter the number corresponding to the reason for completing this state assessment. **1.** Start of therapy assessment **2.** End of therapy assessment **3.** Both Start and End of therapy assessment **4.** Change of therapy assessment **5.** Other payment assessment

Track Changes
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to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-5	Replaced screenshot. OLD **A0310. Type of Assessment** Enter Code ☐☐ **A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above** Enter Code ☐☐ **B. PPS Assessment** **PPS Scheduled Assessments for a Medicare Part A Stay** 01. **5-day** scheduled assessment 02. **14-day** scheduled assessment 03. **30-day** scheduled assessment 04. **60-day** scheduled assessment 05. **90-day** scheduled assessment **PPS Unscheduled Assessments for a Medicare Part A Stay** 07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment) **Not PPS Assessment** 99. **None of the above** Enter Code ☐ **C. PPS Other Medicare Required Assessment - OMRA** 0. **No** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment Enter Code ☐ **D. Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2 0. **No** 1. **Yes** Enter Code ☐ **E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?** 0. **No** 1. **Yes** Enter Code ☐☐ **F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above** Enter Code ☐ **G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned** Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes** NEW **A0310. Type of Assessment** Enter Code ☐☐ **A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above** Enter Code ☐☐ **B. PPS Assessment** **PPS Scheduled Assessment for a Medicare Part A Stay** 01. **5-day** scheduled assessment **PPS Unscheduled Assessment for a Medicare Part A Stay** 08. **IPA** - Interim Payment Assessment **Not PPS Assessment** 99. **None of the above** Enter Code ☐ **E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?** 0. **No** 1. **Yes** Enter Code ☐☐ **F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above** Enter Code ☐ **G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned** Enter Code ☐ **G1. Is this a SNF Part A Interrupted Stay?** 0. **No** 1. **Yes** Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-6	If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B~~ and A0310C~~), all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.
3	A0310	A-6	**Coding Tips and Special Populations** • If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). The nursing home is required to complete an SCSA when the~~y~~ resident come**s** off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
3	A0310	A-7	**DEFINITION** **PROSPECTIVE PAYMENT SYSTEM (PPS)** Method of reimbursement in which Medicare payment is made based on the classification system of that service~~ (e.g., resource utilization groups, RUGs, for skilled nursing facilities)~~.
3	A0310	A-7	**Coding Instructions for A0310B, PPS Assessment** • Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01–~~07~~and 08, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded as 01–~~07~~or 08, enter code "99." • See Chapter 2 on assessment schedules for detailed information on the ~~scheduling and~~ timing of the assessments.

Chapter	Section	Page	Change
3	A0310	A-7	A0310: Type of Assessment (cont.) **PPS Scheduled Assessments for a Medicare Part A Stay** **01.** 5-day scheduled assessment ~~**02.** 14-day scheduled assessment~~ ~~**03.** 30-day scheduled assessment~~ ~~**04.** 60-day scheduled assessment~~ ~~**05.** 90-day scheduled assessment~~ **PPS Unscheduled Assessments for Medicare Part A Stay** ~~**07.** Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)~~ **08. IPA-**Interim Payment Assessment **Not PPS Assessment** **99.** None of the above
3	A0310	A-7	~~Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA~~ • ~~**Code 0, no:** if this assessment is not an OMRA.~~ • ~~**Code 1, Start of therapy assessment (OPTIONAL):** with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a Short Stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.~~ • ~~**Code 2, End of therapy assessment:** with an ARD that is 1 to 3 days after the last day therapy services were provided.~~ • ~~**Code 3, both the Start and End of therapy assessment:** with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a Short Stay assessment, see Chapter 6).~~ • ~~**Code 4, Change of therapy assessment:** with an ARD that is Day 7 of the COT observation period.~~

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-7	~~**Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?**~~ • ~~**Code 0, no:** if this assessment is not a Swing Bed Clinical Change assessment.~~ • ~~**Code 1, yes:** if this assessment is a swing bed clinical change assessment.~~
3	A0310	A-7	**Coding Tips and Special Populations** • A0310E = 0 for: o Entry or Death in Facility tracking records (A0310F = 01 or 12); o A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or o ~~A standalone unscheduled PPS assessment~~An Interim Payment Assessment (A0310A = 99, A0310B = 0~~7~~8, ~~and~~ A0310F = 99, and A0310H=0). • A0310E = 1 on the first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: the first submitted assessment may not be ~~the~~ an OBRA Admission assessment.
3	A0310	A-8	**DEFINITION** **Part A PPS Discharge Assessment** A discharge assessment developed to inform current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-8	**Coding Instructions for A0310G, Type of Discharge (complete only if A0310F = 10 or 11)** • Enter the number corresponding to the type of discharge. • **Code 1:** if type of discharge is a planned discharge. • **Code 2:** if type of discharge is an unplanned discharge.
3	A0310	A-9	**DEFINITIONS** **Interrupted Stay** Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window. **Interruption Window** Is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-9	 **Coding Instructions for A0310G1, Is this a SNF Part A Interrupted Stay?** • **Code 0, no:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but **did not** resume SNF care in the same SNF within the interruption window. • **Code 1, yes:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did resume SNF care in the same SNF within the interruption window.
3	A0310	A-9	**Coding Tips** • Item A0310G1 indicates whether or not an interrupted stay occurred. • The interrupted stay policy applies to residents who either leave the SNF, then return to the same SNF within the interruption window, or to residents who are discharged from Part A-covered services and remain in the SNF, but then resume a Part A-covered stay within the interruption window.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-10	• The following is a list of examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services within the interruption window. Examples include, but are not limited to, the following: o Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window. o Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window. o Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window. o Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window. o Resident leaves against medical advice and returns to the same SNF within the interruption window.

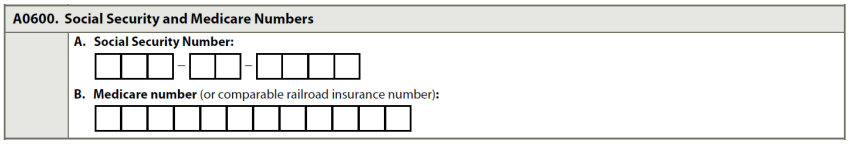
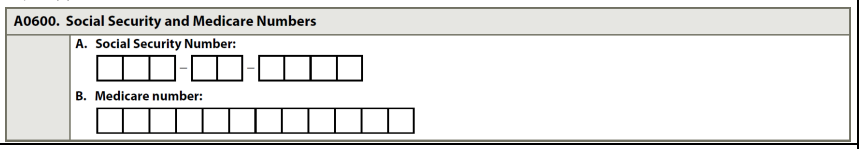
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-10	• The following is a list of examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following: o Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window. o Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes. o Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.
3	A0310	A-10	• If a resident is discharged from SNF care, remains in the SNF, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption. • If a resident leaves the SNF and returns to resume Part A-covered services in the **same** SNF within the interruption window, this is an interrupted stay. Although this situation does not end the resident's Part A PPS stay, the resident left the SNF, and therefore an OBRA Discharge assessment is required. On return to the SNF, no 5-Day would be required. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-11	• When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay. • If a resident is discharged from SNF care, remains in the SNF and **does not** resume Part A-covered services within the interruption window, an interrupted stay did **not** occur. In this situation, a Part A PPS Discharge is required. If the resident qualifies and there is a resumption of Part A services within the 30-day window allowed by Medicare, a 5-Day would be required as this would be considered a **new** Part A stay. The OBRA schedule would continue from the resident's original date of admission (item A1900). • If a resident leaves the SNF and **does not** return to resume Part A-covered services in the **same** SNF within the interruption window, an interrupted stay did **not** occur. In this situation, both the Part A PPS and OBRA Discharge assessments are required (and may be combined). If the resident returns to the same SNF, this would be considered a **new** Part A stay. An Entry Tracking record and 5-Day would be required on return. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required. • The OBRA assessment schedule is unaffected by the interrupted stay policy. Please refer to Chapter 2 for guidance on OBRA assessment scheduling requirements.
3	A0410	A-12	• Nursing homes ~~and swing bed facilities~~ must be certain they are submitting MDS assessments to the QIES ASAP system for those residents who are on a Medicare and/or Medicaid certified unit. Swing bed facilities must be certain that they are submitting MDS assessments only for those residents whose stay is covered by Medicare Part A benefits. For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to QIES ASAP or directly to the state in accordance with state requirements.

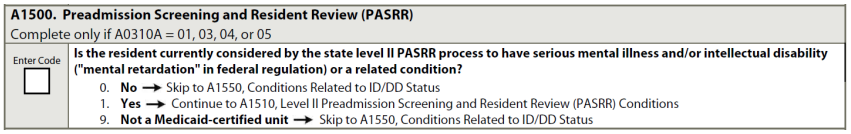
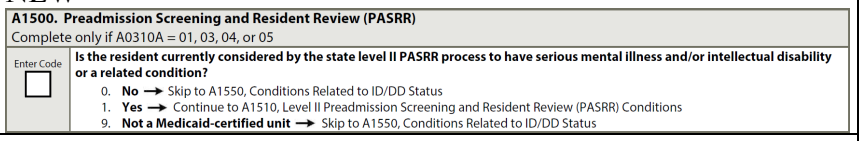
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0410	A-13	• **Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State:** if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and neither CMS nor the state ~~does not~~ ha~~ves~~s authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any records are submitted under this certification designation, they will be rejected by the QIES ASAP system.
3	A0600	A-14	Replaced screenshot. OLD  NEW 
3	A0600	A-14	**DEFINITIONS** **SOCIAL SECURITY NUMBER** A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes. **MEDICARE NUMBER ~~(OR COMPARABLE RAILROAD INSURANCE NUMBER)~~** An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier ~~may be~~is different from the resident's Social Security Number (SSN) and may contain both letters and numbers. ~~For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.~~

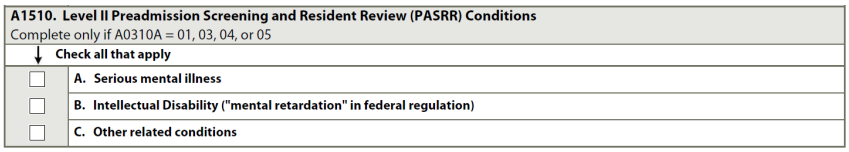
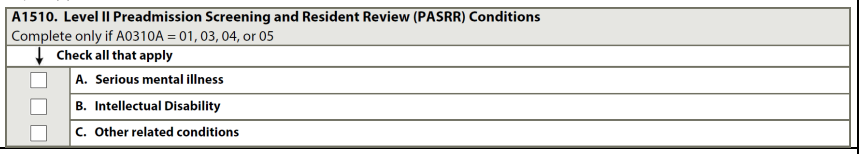
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0600	A-14	• Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no ~~social security number~~SSN is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank. Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible. • Enter Medicare number in A0600B exactly as it appears on the resident's documents. • ~~If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the leftmost space followed by one letter/digit per space. If no Medicare number or RRB number is known or available, the item may be left blank.~~ • For PPS assessments (A0310B = 01~~, 02, 03, 04, 05, and 07~~or 08), ~~either~~ the Medicare ~~or Railroad Retirement Board (RRB)~~ number (A0600B) must be present (i.e., may not be left blank). ~~Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.~~ • A0600B ~~can only~~must be a Medicare number~~ or a Railroad Retirement Board number~~.
3	A0700	A-15	**Coding Instructions** • Record this number if the resident is a Medicaid recipient. • Enter one number or letter per box beginning in the leftmost box.
3	A0800	A-15	**Coding Tips and Special Populations** • Resident gender on the MDS ~~should~~must match what is in the Social Security system.

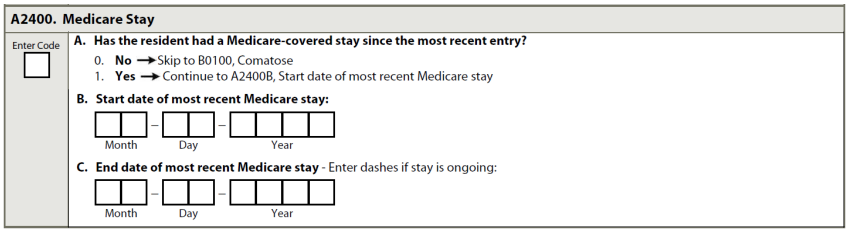
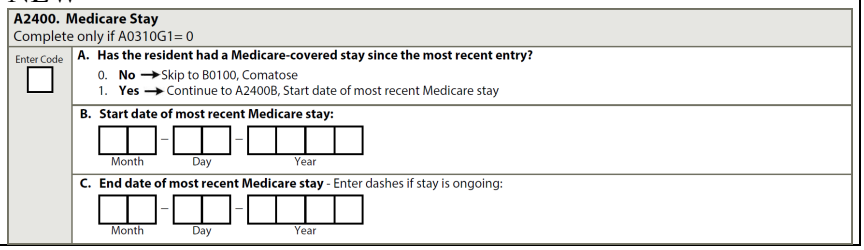
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1500	A-21	Replaced screenshot. OLD  **A1500. Preadmission Screening and Resident Review (PASRR)** Complete only if A0310A = 01, 03, 04, or 05 Enter Code **Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status NEW  **A1500. Preadmission Screening and Resident Review (PASRR)** Complete only if A0310A = 01, 03, 04, or 05 Enter Code **Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status
3	A1500	A-21	• All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ~~("mental retardation" (MR) in federal regulation)/~~developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
3	A1500	A-21	• A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when ~~a Significant Change in Status Assessment~~an SCSA is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.
3	A1500	A-22	**Steps for Assessment** 1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1500	A-22	**Coding Instructions** • **Code 0, no:** and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: — PASRR Level I screening did not result in a referral for Level II screening, or — Level II screening determined that the resident does not have a serious ~~mental illness~~MI and/or ~~intellectual/developmental disability~~ID/DD or related conditions, or
3	A1510	A-23	Replaced screenshot. OLD  A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions Complete only if A0310A = 01, 03, 04, or 05 Check all that apply A. Serious mental illness B. Intellectual Disability ("mental retardation" in federal regulation) C. Other related conditions NEW  A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions Complete only if A0310A = 01, 03, 04, or 05 Check all that apply A. Serious mental illness B. Intellectual Disability C. Other related conditions
3	A1510	A-23	**Steps for Assessment** 1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).
3	A1510	A-23	• **Code B, Intellectual Disability ~~("mental retardation" in federal regulation)/Developmental Disability:~~** if resident has been diagnosed with intellectual disability/developmental disability.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1550	A-24	**Steps for Assessment** 1. If resident is 22 years of age or older on the ~~assessment reference date~~ARD, complete only if A0310A = 01 (Admission assessment). 2. If resident is 21 years of age or younger on the ~~assessment reference date~~ARD, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).
3	A2000	A-31	**Coding Tips and Special Populations** • A Part A PPS Discharge assessment (NPE Item Set) is required under the ~~Skilled Nursing Facility Quality Reporting Program (~~SNF QRP~~)~~ when the resident's Medicare Part A stay ends, but the resident does not leave the facility.
3	A2400	A-35	Replaced screenshot to include new instructional language. OLD  **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 **B. Start date of most recent Medicare stay:** Month – Day – Year **C. End date of most recent Medicare stay** - Enter dashes if stay is ongoing: Month – Day – Year NEW  **A2400. Medicare Stay** Complete only if A0310G1= 0 Enter Code **A. Has the resident had a Medicare-covered stay since the most recent entry?** 0. **No** → Skip to B0100, Comatose 1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay **B. Start date of most recent Medicare stay:** Month – Day – Year **C. End date of most recent Medicare stay** - Enter dashes if stay is ongoing: Month – Day – Year

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A2400	A-36	**Coding Tips and Special Populations** • When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay. • When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
3	A2400	A-37	2. Mr. N began receiving services under Medicare Part A on December 11, 201~~6~~9. He was unexpectedly sent to the ~~ER~~ emergency department on December 19, ~~2016~~2019 at 8:30 p.m. and was not admitted to the hospital. He returned to the facility on December 20, ~~2016~~2019, at 11:00 a.m. Upon Mr. N's return, his physician's orders included significant changes in his treatment regime. The facility staff determined that an Interim Payment Assessment (IPA) was indicated as the PDPM nursing component was impacted. They completed the IPA with an ARD of December 24, 2019. Code the following on the IPA: ~~The facility completed his 14-day PPS assessment with an ARD of December 23, 2016. Code the following on his 14-day PPS assessment:~~ • A2400A = 1 • A2400B = 12-11-~~2016~~2019 • A2400C = ----------