A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status (cont.)

- **Code E:** if an ID/DD condition is present but the resident does not have any of the specific conditions listed.
- **Code Z:** if ID/DD condition is not present.

### DEFINITION

**OTHER ORGANIC CONDITION RELATED TO ID/DD**

Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

A1600–A1800: Most Recent Admission/Entry or Reentry into this Facility
A1600: Entry Date

**Item Rationale**
- To document the date of admission/entry or reentry into the facility.

**Coding Instructions**
- Enter the most recent date of admission/entry or reentry to this facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

---

**A1700: Type of Entry**

**Item Rationale**
- Captures whether date in A1600 is an admission/entry or reentry date.

**Coding Instructions**
- **Code 1, admission:** when one of the following occurs:
  1. resident has never been admitted to this facility before; OR
  2. resident has been in this facility previously and was discharged return not anticipated; OR
  3. resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- **Code 2, reentry:** when all three of the following occurred prior to this entry; the resident was:
  1. admitted to this facility, AND
  2. discharged return anticipated, AND
  3. returned to facility within 30 days of discharge.

---

**DEFINITION**

**ENTRY DATE**
The initial date of admission to the facility, or the date the resident most recently returned to your facility after being discharged.
A1800: Entered From

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Community (private home/apt., board/care, assisted living, group home)</td>
</tr>
<tr>
<td>02</td>
<td>Another nursing home or swing bed</td>
</tr>
<tr>
<td>03</td>
<td>Acute hospital</td>
</tr>
<tr>
<td>04</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>05</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>06</td>
<td>ID/DD facility</td>
</tr>
<tr>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>09</td>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Item Rationale**

- Understanding the setting that the individual was in immediately prior to facility admission/entry or reentry informs care planning and may also inform discharge planning and discussions.
- Demographic information.

**Steps for Assessment**

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

**Coding Instructions**

*Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission/entry or reentry.*

- **Code 01, community (private home/apt., board/care, assisted living, group home):** if the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
- **Code 02, another nursing home or swing bed:** if the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- **Code 03, acute hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

**DEFINITIONS**

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

**BOARD AND CARE/ASSISTED LIVING/GROUP HOME**
A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
A1800: Entered From (cont.)

- **Code 04, psychiatric hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- **Code 05, inpatient rehabilitation facility (IRF):** if the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled, or sick persons. Includes IRFs that are units within acute care hospitals.
- **Code 06, ID/DD facility:** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- **Code 07, hospice:** if the resident was admitted from a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
- **Code 09, long term care hospital (LTCH):** if the resident was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
- **Code 99, other:** if the resident was admitted from none of the above.

**Coding Tips and Special Populations**

- If an individual was enrolled in a home-based hospice program enter **07, Hospice**, instead of **01, Community**.

A1900: Admission Date (Date this episode of care in this facility began)

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**Item Rationale**

- To document the date this episode of care in this facility began.

**Coding Instructions**

- Enter the date this episode of care in this facility began. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
- The Admission Date may be the same as the Entry Date (A1600) for the entire stay (i.e., if the resident is never discharged).
A1900: Admission Date (Date this episode of care in this facility began) (cont.)

Examples

1. Mrs. H was admitted to the facility from an acute care hospital on 09/14/2013 for rehabilitation after a hip replacement. In completing her Admission assessment, the facility entered 09/14/2013 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 09/14/2013 in item A1900, Admission Date.

2. The facility received communication from an acute care hospital discharge planner stating that Mrs. H, a former resident of the facility who was discharged home return not anticipated on 11/02/2013 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/2014 and wished to return to the facility for rehabilitation after hospital discharge. Mrs. H returned to the facility on 2/15/2014. Although Mrs. H was a resident of the facility in September of 2013, she was discharged home return not anticipated; therefore, the facility rightly considered Mrs. H as a new admission. In completing her Admission assessment, the facility entered 02/15/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 02/15/2014 in item A1900, Admission Date.

3. Mr. K was admitted to the facility on 10/05/2013 and was discharged to the hospital, return anticipated, on 10/20/2013. He returned to the facility on 10/26/2013. Since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record on return from the hospital, they entered 10/26/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

Approximately a month after his return, Mr. K was again sent to the hospital, return anticipated on 11/05/2013. He returned to the facility on 11/22/2013. Again, since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record, they entered 11/22/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

4. Ms. S was admitted to the facility on 8/26/2014 for rehabilitation after a total knee replacement. Three days after admission, Ms. S spiked a fever and her surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent Ms. S to the emergency room and completed her Discharge assessment as return anticipated. The hospital called the facility to inform them Ms. S was admitted. A week into her hospitalization, Ms. S developed a blood clot in her affected leg, further complicating her recovery. The facility was contacted to readmit Ms. S for rehabilitative services following discharge from the hospital on 10/10/2014. Even though Ms. S was a former patient in the facility’s rehabilitation unit and was discharged return anticipated,
she did not return within 30 days of discharge to the hospital. Therefore, Ms. S is considered a new admission to the facility. On her return, when the facility completed Ms. S’s Admission assessment, they entered 10/10/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 10/10/2014 in item A1900, Admission Date.

**Coding Tips and Special Populations**

- Both swing bed facilities and nursing homes must apply the above instructions for coding items A1600 through A1900 to determine whether a patient or resident is an admission/entry or reentry.
- In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 days” requirement.
- If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same.
- If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900.
- Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1800 (Entered From). It is also tied to the concepts of a “stay” and an “episode.” A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident’s time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.
- A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.
- When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1800 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay
A1900: Admission Date (Date this episode of care in this facility began) (cont.)

would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1800 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began his or her first stay in the episode).

A2000: Discharge Date

<table>
<thead>
<tr>
<th>A2000. Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete only if A0310F = 10, 11, or 12</td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

**Item Rationale**
- Closes case in system.

**Coding Instructions**
- Enter the date the resident was discharged (whether or not return is anticipated). This is the date the resident leaves the facility.
- For discharge assessments, the discharge date (A2000) and ARD (A2300) must be the same date.
- Do not include leave of absence or hospital observational stays less than 24 hours unless admitted to the hospital.
- Obtain data from the medical, admissions or transfer records.

**Coding Tips and Special Populations**
- If a resident was receiving services under SNF Part A PPS, the discharge date may be later than the end of Medicare stay date (A2400C).

A2100: Discharge Status
A2100: Discharge Status (cont.)

Item Rationale

- Demographic and outcome information.

Steps for Assessment

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

Coding Instructions

Select the 2-digit code that corresponds to the resident’s discharge status.

- **Code 01, community (private home/apt., board/care, assisted living, group home):** if discharge location is a private home, apartment, board and care, assisted living facility, or group home.

- **Code 02, another nursing home or swing bed:** if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.

- **Code 03, acute hospital:** if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

- **Code 04, psychiatric hospital:** if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.

- **Code 05, inpatient rehabilitation facility:** if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.

- **Code 06, ID/DD facility:** if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.

- **Code 07, hospice:** if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based (e.g., home) or inpatient hospice programs.

- **Code 08, deceased:** if resident is deceased.

- **Code 09, long term care hospital (LTCH):** if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare
A2100: Discharge Status (cont.)

payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

- **Code 99, other**: if discharge location is none of the above.

A2200: Previous Assessment Reference Date for Significant Correction

**Item Rationale**

- To identify the ARD of a previous comprehensive (A0310 = 01, 03, or 04) or Quarterly assessment (A0310A = 02) in which a significant error is discovered.

**Coding Instructions**

- Complete only if A0310A = 05 (Significant Correction to Prior Comprehensive Assessment) or A0310A = 06 (Significant Correction to Prior Quarterly Assessment).

- Enter the ARD of the prior comprehensive or Quarterly assessment in which a significant error has been identified and a correction is required.

A2300: Assessment Reference Date

**Item Rationale**

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

As the last day of the look-back period, the ARD serves as the reference point for determining the care and services 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 look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period. For an item with a 14-day look-back period, the information is collected for a 14-day period ending on and including the ARD. The look-back period includes observations and events through the end of the day (midnight) of the ARD.
A2300: Assessment Reference Date (cont.)

Steps for Assessment
1. Interdisciplinary team members should select the ARD based on the reason for the assessment and compliance with all timing and scheduling requirements outlined in Chapter 2.

Coding Instructions
- Enter the appropriate date on the lines provided. Do not leave any spaces blank. If the month or day contains only a single digit, enter a “0” in the first space. Use four digits for the year. For example, October 2, 2010, should be entered as: 10-02-2010.
- For detailed information on the timing of the assessments, see Chapter 2 on assessment schedules.
- For discharge assessments, the discharge date item (A2000) and the ARD item (A2300) must contain the same date.

Coding Tips and Special Populations
- When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the look-back period, the 2 leave days are still considered part of the look-back period.
- When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to the physician during the leave, the visit would be counted in Item O0600, Physician Examination (if criteria are otherwise met).

This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

A2400: Medicare Stay

<table>
<thead>
<tr>
<th>A2400. Medicare Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>A. Has the resident had a Medicare-covered stay since the most recent entry?</td>
</tr>
<tr>
<td>No [⇒] Skip to B0100, Comatose</td>
</tr>
<tr>
<td>Yes [⇒] Continue to A2400B, Start date of most recent Medicare stay</td>
</tr>
<tr>
<td>B. Start date of most recent Medicare stay:</td>
</tr>
<tr>
<td>[ ] [ ] [ ] Month</td>
</tr>
<tr>
<td>C. End date of most recent Medicare stay: [⇒] Enter dashes if stay is ongoing:</td>
</tr>
<tr>
<td>[ ] [ ] Year</td>
</tr>
</tbody>
</table>
A2400: Medicare Stay (cont.)

Item Rationale

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

Coding Instructions for A2400A, Has the Resident Had a Medicare-covered Stay since the Most Recent Entry?

- **Code 0, no:** if the resident has not had a covered Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.
- **Code 1, yes:** if the resident has had a Medicare Part A covered stay since the most recent admission/entry or reentry. Continue to A2400B.

Coding Instructions for A2400B, Start of Most Recent Medicare Stay

- **Code the date of day 1** of this Medicare stay if A2400A is **coded 1, yes**.

Coding Instructions for A2400C, End Date of Most Recent Medicare Stay

- **Code the date of last day** of this Medicare stay if A2400A is **coded 1, yes**.
- If the Medicare Part A stay is ongoing there will be no end date to report. Enter dashes to indicate that the stay is ongoing.
- The end of Medicare date is coded as follows, whichever occurs first:
  - Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
  - Date of last day covered as recorded on the effective date from the Generic Notice; or
  - The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
  - Date the resident was discharged from the facility (see Item A2000, Discharge Date).
A2400: Medicare Stay (cont.)

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.
- The end date of the Medicare stay may be earlier than actual discharge date from the facility (Item A2000).

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and a Generic Notice with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her Discharge assessment:

   - A2000 = 11-24-2010
   - A2400A = 1
   - A2400B = 10-14-2010
   - A2400C = 11-23-2010
Medicare Stay End Date Algorithm
A2400C

Is the resident's Medicare stay ongoing?
  Yes → Enter dashes
  No →

Did the resident's SNF benefit exhaust?
  Yes → Enter the date of the last covered day, i.e., the 100th day
  No →

Was a generic notice issued to the resident?
  Yes → Enter the effective date on the Generic Notice for last covered day*
  No →

Did the resident's payer source change from Part A to another payer?
  Yes → Enter the date of the last paid day of Medicare A
  No →

Enter the date resident was discharged from facility

*If resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.
A2400: Medicare Stay (cont.)

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

   - A2400A = 1
   - A2400B = 12-11-2010
   - A2400C = ---------

3. Mr. R. began receiving services under Medicare Part A on October 15, 2010. He was discharged return anticipated on October 20, 2010, to the hospital. Code the following on his Discharge assessment:

   - A2000 = 10-20-2010
   - A2400A = 1
   - A2400B = 10-15-2010
   - A2400C = 10-20-2010