

Active on these MDS 3.0 ISC:  
OBRA - NC, NQ, NT, ND,

**S0101 Admitted from at entry (if A1800 = 01 Community)**

- 1 Community with no home care  
 2 Community with Medicare certified home health agency care  
 3 Community with other home care

**Intent:**

To capture those residents admitted from the community and the community-based services provided before nursing home admission.

**Definitions:**

**Community with no home care:** Member is dwelling in the community without the provision of either medical or nonmedical care in the home.

**Community with Medicare certified home health agency care:** Member is dwelling in the community with the provision of either medical or nonmedical care by a Medicare certified home health agency.

**Community with other home care:** Member is dwelling in the community with care provided by family or non-family members, assisted living, religious communities, non-certified home health agencies or Program of All-Inclusive Care for the Elderly (PACE).

**Process:**

Review resident's admission records and transmittal records as necessary. Ask resident and family members as appropriate. Check with your facility's admission office. Determine the address where the resident last resided prior to nursing facility admission.

**Coding instructions:**

This item will be active for all assessments including: 1) assessments where 01 Community is not the value selected for A1800 and 2) non-admission assessments. Data item S0101 will be active for non-admission assessments that do not require completion of data items related to admission assessments. For all Admission Assessments, item A1800 should be completed with valid values (a dash cannot be used in A1800 for Admission Assessments). Please select one box: Option 1, 2, or 3. Select Option 1 if unclear whether home care was provided in community. For Admission Assessments select the valid option based on the individual's history. For other Assessments, Select '1' as the valid option.

**S0153 Resident Identifier**

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**Intent:**

To collect an additional unique identifier for the resident if resident does not have a social security number (SSN).

**Definition:**

An eleven-digit alphanumeric code that should be entered for all residents.

**Process:**

If the resident has never applied for a SSN, it is the responsibility of the nursing facility to obtain one by contacting the Social Security office in your area. Until the SSN is obtained or if the resident is not issued a SSN, enter the resident's US government issued state driver's license number based on coding instructions below. If the resident has no SSN or state driver's license, enter 888-88-8888 for in-state residents and 999-99-9999 for out-of-state residents (including dashes). If the resident has SSN, match the value in A0600.

**Coding instructions:**

This MDS item has an 11-space area. Enter the appropriate code based on what is available from the resident's admission, readmission, transmittal records. Always refer to US government issued documentation to update this field. Data entry has to be left justified using dashes when applicable. If the US government issued state license number is less than 11 characters, leave blanks at the end. If the state license number is greater than 11 characters, enter the last 11 characters. Medicare identifier may be used if no other identifier is available.

**S0180 Discharge Status (if A2100 = 01 Community)**

- 1 Community with no home care
- 2 Community with Medicare certified home health agency care
- 3 Community with other home care

**Intent:**

To determine the discharge status of the resident.

**Definitions:**

**Community with no home care:** Member is dwelling in the community without the provision of either medical or nonmedical care in the home.

**Community with Medicare certified home health agency care:** Member is dwelling in the community with the provision of either medical or nonmedical care by a Medicare certified home health agency.

**Community with other home care:** Member is dwelling in the community with care provided by family or non-family members, assisted living, religious communities, non-certified home health agencies or Program of All-Inclusive Care for the Elderly (PACE).

**Process:**

Review resident's discharge records as necessary. Ask resident and family members as appropriate.

**Coding instructions:**

This item will be active for all assessments including: 1) assessments where 01 Community is not the value selected for A2100 and 2) non-admission assessments. Data item S0180 will be active for non-discharge assessments that do not require completion of data items related to discharge assessments. For Discharge Assessments, items A2100 and A0310F must be

completed with valid values (a dash cannot be used in A2100 and A0310F for Discharged Assessments). For Discharge Assessments select the valid option based on the individual’s history. For other assessments, Select ‘1’ as the valid option.

**S0505 Level of care**

- 1 Nursing Facility (NF)
- 2 Skilled/Specialized Nursing Facility

**Intent:**

Code a level of care for this resident to determine if a resident is receiving custodial or skilled care from the nursing facility. This may be a provisional judgment for initial admissions, private pay residents or residents with a pending determination for a change in level of care.

**Definitions:**

***Nursing Facility (NF):***

Nursing Facility Level of Care refers to only custodial care/functional assistance to support residents in Activities of Daily Living (ADL) such as Bathing, Dressing, Toileting (Bowel and Bladder), Mobility and Transferring.

***Skilled/Specialized Nursing Facility:*** Skilled/Specialized Nursing Facility Level of Care refers to intensive care services such as ventilators, clinically complex care, extensive rehabilitation, including physical and occupational therapy, speech-language pathology services along with ADL assistance.

**Process:**

Review the patient’s pre-authorization screening form (if Medicaid). If this information is not available, make a provisional judgment.

**Coding instructions:**

Enter 1 for individuals with custodial care and 2 for those with skilled/specialized care.

**S0520 Reason for Admission Code**

- 01 Significant change in functional status
- 02 Deterioration in cognitive status
- 03 Change in the availability/status of primary caregivers
- 04 Difficulty arranging or paying for needed in-home care or support
- 05 Failed to succeed in residential care home
- 06 Short term rehabilitation or skilled care
- 99 None of the Above

**Intent:**

To capture the most important reason a nursing home stay is required rather than a continued stay in the community.

**Definition:**

The primary or most important reason for admission or readmission. The MDS definition of a significant change applies. The individual should meet the DMAS Nursing Facility Level of care requirement either in the Uniform Assessment Instrument (UAI) or have Nursing Facility Level of Care benefit assigned in the VA Medicaid system to be admitted to the nursing facility.

**Process:**

Review resident's admission records and transmittal records as necessary. Check with your facility's admission office. This item is active for admissions and readmissions.

**Coding instructions:**

Select the correct two-digit response. Note that for numeric items, signed numbers (with a leading plus or minus sign) should not be submitted. If more than one reason applies, select the option that is the primary reason for that admission or readmission based on professional judgement. If the resident is readmitted from inpatient hospital stay to nursing facility, then the reason code at the original admission is carried over. If the resident is readmitted from the community to nursing facility, select the primary reason code for this readmission.

**S1210 Mental Health Diagnoses****Mental Health Diagnoses: Check all that apply:**

- a. Schizophrenia
- b. Delusional disorder
- c. Schizoaffective disorder
- d. Psychotic disorder not otherwise specified
- e. Bipolar I mixed, manic, and depressed
- f. Bipolar disorder II
- g. Cyclothymic disorder
- h. Bipolar disorder not otherwise specified
- i. Major depression, recurrent
- j. None of the above

**Intent:**

To capture any diagnosed serious mental illness in the last 60 days and active within last 7 days.

**Definitions:**

**Active Diagnosis:** Physician documented diagnoses in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.

**Process:**

Review the medical record (progress notes, most recent history and physical, transfer documents, discharge summaries, diagnosis list, PASRR, and other resources as available) to determine if there is a serious mental illness (SMI) health diagnosis in the last 60 days and active within last 7 days.

**Coding Instructions:**

These diagnoses must meet the definition of an “active” diagnosis in accordance with Section I of the RAI Manual. Please note that psychosis is a symptom and not synonymous with Psychotic Disorder. Check all that apply.

**S2040 Behavior Management Program**

**Resident is provided a Behavior Management Program**

- 0 **Program not provided in last 7 days**
- 1 **Program provided 1 - 3 days in last 7 days**
- 2 **Program provided 4 - 6 days in last 7 days**
- 3 **Program provided daily in last 7 days**

**Intent:**

To capture Behavior Management Programs in use for a resident.

**Definitions:**

**Behavioral Management Program:** An individualized care plan for persons with behavior symptoms that is designed to support and manage behavioral health care needs. Note that a person admitting from the community to the nursing facility can have a behavioral management program in the community.

**Process:**

Code based on behavior management program in the look-back period. Do not code based on the presence of a medical diagnosis.

**Coding Instructions:**

Select the correct one-digit response based upon the number of behavioral interventions implemented in the last 7 days. A behavioral intervention is any action described in the individual’s behavioral management program and may include avoiding known triggers.

**S6202 Hospital admissions with overnight stay in last 90 days**

**Hospital Stay(s): Record number of times resident was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days). Exclude observation stays. Enter 00 if no hospital admissions.**

**Intent:**

To determine how often a resident was admitted to a hospital with an overnight stay.

**Definitions:**

**Hospital Admission:** When a resident was added to the hospital census for active patients; the admission does not refer to time spent in the emergency room or receiving other outpatient services, including observation stays.

**Process:**

Review the medical record (progress notes, most recent history and physical, transfer documents, discharge summaries, other resources as available) to determine if there is a hospital admission in the last 90 days or since the last assessment if less than 90 days.

**Coding instructions:**

Enter the number of times the resident was considered to be an inpatient of the hospital for at least one overnight in the last 90 days or since the last assessment if less than 90 days. Exclude observation stays and/or time spent in the emergency room or receiving other outpatient services. Enter a two-digit number between 00 and 99.

**S6212 ER visits without overnight stay in last 90 days**

**Emergency Room (ER) visit(s): Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). Exclude observation stays. Enter 00 if no ER visits.**

**Intent:**

To gather information about the number of times a resident was evaluated or treated in the emergency room (ER) without being admitted to the hospital.

**Definitions:**

**Emergency Room Visit:** Time spent at the ER for evaluation or treatment without being admitted to the inpatient hospital as a patient. Also includes when patient is at the emergency department during the night but was not admitted to the facility. Does not include observation stays.

**Process:**

Review the medical record (progress notes, most recent history and physical, transfer documents, discharge summaries, other resources as available) to determine the number of emergency room visits in the last 90 days or since the last assessment if less than 90 days.

**Coding instructions:**

Enter the number of times the resident was at the ER without being admitted (not days) as a two-digit number between 00 and 99.

**S9100 Virginia Room & Board**

**A. Virginia Room & Board Payment Assessment Reference Date**

**Code for the primary source of per diem room and board reimbursement for the resident on the date indicated - Assessment Reference Date (A2300)**

- 1 Virginia Medicaid per diem**
- 2 Virginia Commonwealth Coordinated Care (CCC) Plus**
- 3 Other reimbursement source**

**Intent:**

To identify individuals that are reimbursed by VA Medicaid or VA Medicaid Managed Care Plans.

**Definitions:**

**Virginia Medicaid Per Diem:** Resident’s nursing facility reimbursement method wherein the nursing facility submits a claim directly to the Virginia Department of Medical Assistance Services for payment for the resident’s care.

**Virginia Commonwealth Coordinated Care (CCC) Plus:** Resident’s nursing facility reimbursement method wherein the resident is enrolled with CCC/CCC Plus managed care health plans and the nursing facility submits a claim to managed care plans for the resident’s care.

**Other Reimbursement Source:** Member’s nursing facility reimbursement that is neither Virginia Medicaid Per Diem nor Virginia Commonwealth Coordinated Care (CCC) Plus or CCC managed care health plans.

**Process:**

The facility must check with their billing office to review current payment sources. Do **not** rely exclusively on the information recorded in the resident’s clinical record, including whether or not the resident is enrolled in hospice. Hospice enrollment cannot be used as a proxy for payment source. The facility business office should have the most up to date information for the source of resident reimbursement.

**Coding instructions:**

Check the primary payer source that is covering the resident’s stay on the Assessment Reference Date (A2300).

**B. VA Room & Board Payment Entry Date**

Code for the primary source of per diem room and board reimbursement for the resident on the date indicated) Date of Entry (A1600)

- 1 Virginia Medicaid per diem
- 2 Virginia Medicaid Specialized Care per diem
- 3 Managed Care Organization reimbursement
- 4 Other reimbursement source

**Intent:**

To identify individuals that are reimbursed by VA Medicaid or VA Medicaid Managed Care Plans.

**Definitions:**

**Virginia Medicaid Per Diem:** Resident’s nursing facility reimbursement method wherein the nursing facility submits a claim directly to the Virginia Department of Medical Assistance Services for payment using Resource Utilization Group (RUG) methodology.

**Virginia Medicaid Specialized Care Per Diem:** Resident’s nursing facility reimbursement method wherein the nursing facility submits a claim directly to the Virginia Department of Medical Assistance Services for payment and the individual is determined to be eligible for a specialized care (e.g., ventilator) per diem payment (i.e., not a RUG payment).

**Managed Care Organization Reimbursement:** Resident’s Medicaid nursing facility reimbursement method wherein the resident is enrolled with CCC/CCC Plus managed care health plans (Medicaid) and the nursing facility submits a claim to managed care plans for the resident’s care. Does not include commercial/private managed care plans.

**Other Reimbursement Source:** Member’s nursing facility reimbursement that is not: Virginia Medicaid Per Diem, Virginia Medicaid Specialized Care Per Diem or Virginia Medicaid Managed Care Organization Reimbursement.

**Process:**

The facility must check with their billing office to review current payment sources. Do not rely exclusively on the information recorded in the resident’s clinical record, including whether or not the resident is enrolled in hospice. Hospice enrollment cannot be used as a proxy for payment source. The facility business office should have the most up to date information for the source of resident reimbursement.

**Coding instructions:**

Enter the code of the payer source that is covering the resident’s stay on the Date of Entry (A1600).

**C. VA Medicaid Room & Board initial date**

**Initial Date Medicaid Per Diem: Initial date Virginia Medicaid is the primary source of per diem room and board reimbursement.**

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**Intent:**

To capture the initial date that VA Medicaid became the primary source of reimbursement for the resident.

**Definitions:**

Initial date Virginia Medicaid became primary source for room and board reimbursement for this resident. The date should reflect when the individual became eligible for VA Medicaid while a nursing facility resident

**Process:**

If S9100B is equal to 1, 2 or 3 complete this item. The facility must check with their billing office to review current payment sources. Do not rely exclusively on the information recorded in the resident’s clinical record. The facility business office should have the most up to date information for the source of resident reimbursement.

**Coding instructions:**

Enter the Initial VA Medicaid date as YYYYMMDD when VA Medicaid became the primary source of reimbursement.

If VA Medicaid is not the primary source of reimbursement, please leave these fields blank.

When VA Medicaid reimbursement initial date is unknown, please enter the date the resident originally entered the facility.