MDS Assessment Cheat Sheet

This cheat sheet contains the codes for completing a Minimum Data Set (MDS) Assessment (version 3.0).

Section title	Intent	Subsection	Codes	
A - Identification information	Obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident, potential care needs, including access to transportation and the home in which they reside.	A0050: Type of record	Code 1: Add new record	
			Code 2: Modify existing record	
		A0100: Facility provider numbers	A. National Provider Identifier (NPI). B. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank. C. State Provider Number (optional).	
			Code 1: Nursing home (SNF/NF)	
		A0200: Type of provider	Code 2: Swing bed	
		A0310: Type of assessment	A0310A	O1. Admission assessment (required by day 1- 02. Quarterly review assessment O3. Annual assessment O4. Significant change in status assessment O5. Significant correction to prior comprehensive assessment O6. Significant correction to prior quarterly assessment 99. None of the above
			A0310B	01. 5-day scheduled assessment 08. IPA-Interim Payment Assessment 99. None of the above
			A0310E	Code 0: No
				Code 1: Yes
			A0310F	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
			A0310G	Code 1: Planned discharge
				Code 2: Unplanned discharge
				Code 0: No
			A0310G1	Code 1: Yes (did resume SNF care in the sam SNF within the interruption window)
		A0410: Unit certification or licensure designation	Code 1: Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State	
			Code 2: Unit is neither Medicare nor Medicaid certified but MDS data is required by the State	
			Code 3: Unit is Medicare and/or Medicaid certified	
		A0500: Legal name of resident	A. First Name B. Middle Initial (if the resident has no middle initial, leave item A05008 blank; if the resident has two or more middle names, use the initial of the first middle name) C. Last Name D. Suffex (e.g., Jr/Sr.)	
		A0600: Social security and Medicare numbers	A. Social security number	
			B. Medicare number	
		A0700: Medicaid number	"+" if connection	g, "N" if not a Medicaid recipient

Mds Documentation Guidelines

Wendy D Bircher

Mds Documentation Guidelines:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

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<u>Nursing Home Federal Requirements</u> James E. Allen MSPH, PhD, CNHA,2010-11-24 The book lists all the federal requirements that are evaluated by state surveyors during the annual survey visit to nursing homes and for complaint visits

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