Medicare
State Operations Manual
Provider Certification

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 22 **Date: DECEMBER 8, 2000**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4145.7 - 4146.7	4-44.1 - 4-44.12 (12 pp.)	4-44.1 - 4-44.12 (12 pp.)
List of Exhibits	9-xiii - 9-xiv (2 pp.)	9-xiii - 9-xiv (2 pp.)
Exhibit 259	9-733 - 9-734 (2 pp.)	9-733 - 9-734 (2 pp.)
Exhibit 260	9-735 (1 p.)	9-735 (1 p.)
Exhibit 261	9-737 - 9-738 (2 pp.)	9-737 - 9-738 (2 pp.)
Exhibit 262	9-739 (1 p.)	9-739 (1 p.)
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Exhibit 272	9-789 (1 p.)	----------
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Appendix PP	PP-73 - PP-82.2 (14 pp.)	PP-73 - PP-82.2 (12 pp.)
Appendix R	R-1 - R-41 (33 pp.) R-153 – R-165 (13 pp.)	R-1 – R-38 (42 pp.) R-153 – R-159 (7 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 9, 2001*

Facilities must implement the September 2000 update of the Resident Assessment Instrument (RAI), version 2.0, including formal attestation and the new MDS (Minimum Data Set) Correction Request Form, by September 1, 2000.

Section 4146, Minimum Data Set System, is revised to describe the MDS system as part of the Quality Improvement and Evaluation System (QIES), and omits future tense discussion of implementation of MDS automation requirements.

Section 4146.1, System Description, is revised to describe the MDS system as part of the Quality Improvement and Evaluation System (QIES), and omits future tense discussion of implementation of MDS automation requirements.

Section 4146.2, Administration Requirements, is revised to omit out-dated discussions of plans for implementation of OASIS automation for HHAs, and of plans to install hardware in each State for the MDS system.

Section 4146.3, Validation and Editing Process, is revised to provide an overview of enhanced MDS system edits that were incorporated into the system upgrade installed May 22, 2000, and that will result in rejection of MDS records by the standard MDS system at the States. Text was added that provides specific HCFA web site addresses and file names that provide additional and more detailed information about MDS system specifications and fatal record errors.

Section 4146.5, Correction of Errors in MDS Records That Have Been Accepted by the Standard MDS System at the State, was formerly titled "Key Change Requests". This brief, administrative overview section is revised to omit the obsolete discussion of manual requests for manual correction of Key MDS Items, and to include discussion of the new, electronic mechanism for facilities to submit corrections to MDS data directly to the State MDS database.

Section 4146.7, Privacy and Confidentiality, is revised to correct a typographical error in the Long Term Care (LTC) MDS System of Records, System Number.

Exhibits and the List of Exhibits, are revised to omit obsolete exhibits and to include revised and new exhibits. The revised and new exhibits reflect new policy that supports the new MDS corrections process. In addition, a new MDS 2.0 Discharge and Reentry Flowchart has been added to the series of exhibits, and the Privacy Act Statement has been revised to correct a typographical error in the LTC MDS System of Records, System Number.

Exhibit 259, Minimum Data Set Automation Contract Agreement Approval RO Checklist, is revised relative to the new MDS Correction Policy

Exhibit 260, MDS 2.0 Discharge and Reentry Flowchart, has been added to the exhibits to support the new MDS Correction Policy.

Exhibit 261, Privacy Act Statement – Health Care Records, is revised to correct an error in the systems number.

Exhibit 262, Correction Policy Flowchart, replaces Correction Policy for Locked Records to support the new MDS Correction Policy.

Exhibit 263, Submission Timeframe for MDS Records, replaces Maximum Time Frames for MDS Completion Data Entry, Editing, Locking and Transmission to support the new MDS Correction Process.

Exhibits 272 – 274, are being added to reflect new policy that supports the MDS Correction Process.

Appendix PP - Guidance to Surveyors,

F 276 Guidelines at 483.20 (c): added text regarding 92 days between Quarterly assessments.

F 286 Guidelines at 483.20 (d): omitted criteria serving as a waiver for retaining hard copies of MDS forms for facilities meeting the criteria. Given the new formal attestation requirements, and in the absence of a HCFA agency standard for electronic signature, all facilities are required to sign and retain hard copies of MDS forms. Note that facilities that truly met all the criteria are extremely rare (we are not aware of any), therefore, by far the majority of the industry will not be impacted.

F 287 Guidelines at 483.20 (f) (1 – 4), omitted obsolete references to locking MDS records *within the facility.* With the implementation of new MDS Correction Policy, the requirement to report an internal lock date has been made obsolete, and records are considered locked upon acceptance by the Standard MDS system at the State. Revised definition of monthly transmission requirement to anchor the 31 day transmission time-frame to the "final completion date", rather than to the "CARE_LCK" date.

F 278 Probes at 483.20 (g-h), added language regarding the Correction Request Form, and regarding signature requirements for RN Assessment Coordinators.

Guidelines at 483.20 (i), added language regarding formal attestation of accuracy, and signature requirements for individual assessors.

Guidelines at 483.20 (j), added guidance regarding MDS submission patterns and practices.

Appendix R – Resident Assessment Instrument for Long Term Care Facilities:

Introduction, redesignates the RAI and requires use of the September 2000 update of version 2.0 of the RAI by all States.

Part I – Utilization Guidelines for Completion of the Resident Assessment Instrument, omitted criteria serving as a waiver for retaining hard copies of MDS forms for facilities meeting the criteria. Given the new formal attestation requirements, and in the absence of a HCFA agency standard for electronic signature, all facilities are required to sign and retain hard copies of MDS forms. See above comment at F 286 in Section PP.

Clarified that the Face-Sheet information that is brought forward to the active records for a new stay is a copy. The original stays in the closed record.

Clarified requirement to use ICD-9-CM coding to code diseases and diagnoses in Section I of the RAI.

Revised Item label of R2. This item label was "Signature of Persons Completing the Assessment", and now reads "Signature of Person Coordinating the Assessment. This item label change is in accordance with other changes and form revisions made to accommodate the new formal attestation and signature requirements.

Part II – Minimum Date Set, Quarterly Review and Correction Request, Extensive changes have been made to Part II to accommodate revisions to the RAI form and coding instructions relative to the new MDS correction policy. These changes include replacing the 1/30/98 update of the RAI for version 2.0 with the September 2000 Update of the RAI for version 2.0. The September 2000 Update contains revisions including the addition of a formal attestation statement and accompanying signature lines, and the addition of the new MDS Correction Request form. In the Supplemental Coding Instructions and Common Definitions portion of Part II, the definition of Significant Correction has been clarified and redundancy in this text eliminated. Text describing signature requirements has been revised to incorporate formal attestation requirements, and to describe where signature lines are located on the September 2000 Update RAI forms. The Item label for Item R2 has been revised. A section describing items, item definitions, coding instructions, and use of the new Correction Request Form has been added.

Part IV – Minimum Data Set Automation, Electronic Transmission, and Correction Guidelines, is extensively revised. Extensive new text, including detailed scenarios, has been added describing the new, automated MDS corrections process and requirements. Text has been added that discusses new mechanisms available to facilities, including modification and inactivation, to electronically correct errors of any type in MDS records that reside in the State MDS database. Text has been added that introduces new concepts relative to correction policy, such as the concept of a "valid" record. Text has also been added to describe enhanced edits, a significant enhancement to the standard MDS system that is part of the new corrections process. Obsolete text that discussed manual and KEY item correction mechanisms has been omitted. And text describing locking and the electronic transmission time frame has been revised in keeping with changes in locking and transmission time frame policy (see text at Section PP, F 287 above), to accommodate new correction policy.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

o A plan for implementation that includes timeframes and plans for training the facilities; The name, address, phone number, and e-mail address (if known) of the State RAI coordinator (i.e., the individual responsible for liaison and training of providers and State agency staff); and

o The name, address, phone number, and e-mail address (if known) of the State agency's contact for technical questions on the proposed alternate instrument.

Please send all correspondence to:

Technical Director, Division of Nursing Homes and Continuing Care Services
Survey and Certification Group
Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Boulevard
Mail Stop S2-12-25
Baltimore, Maryland 21244

Once HCFA has received a State agency's request for use of an alternate instrument, or modifications to an existing specified instrument, HCFA will review the proposed instrument to determine whether it is an acceptable alternate, and will communicate directly with the State agency's representatives to clarify information, if necessary. HCFA will make every effort to work with the State agency to meet its needs for resident assessment information.

Once a State agency has received approval from HCFA for the alternate instrument, the State agency must implement the approved alternate. Within 60 days of receiving HCFA's approval of the alternate RAI, the State agency must notify all long term care facilities participating in the Medicare and Medicaid programs in its State of the alternate instrument. This notification must include a copy of the approved specified instrument and the procedures for using the instrument.

States that have specified the HCFA-designated RAI as their specified instrument must notify all long-term care facilities participating in the Medicare and Medicaid programs in their States of the specified instrument, and any updates issued by HCFA, with sufficient time for the facilities to meet the effective implementation date.

The State agency must ensure that all long-term care facilities participating in the Medicare and Medicaid programs in its State are using specified instrument within 90 days after a State agency has notified its providers of the specified instrument. To ensure that facilities are properly trained, each State agency must provide periodic educational programs for facility staff to assist with implementation of the specified RAI.

4146. MINIMUM DATA SET SYSTEM

The minimum data set (MDS) system in each State is the cornerstone for a comprehensive, Quality Improvement and Evaluation System (QIES) that will not only fulfill MDS administration requirements, but also support other assessment-based programs (such as the Outcome and Assessment Information Set (OASIS) for Home Health Agencies (HHAs), quality and performance indicators; and new, integrated survey and certification data systems. The State must use the MDS system for editing, storing, and processing MDS data to support HCFA's MDS operating requirements within the State and to transmit the required MDS data to the HCFA MDS repository. The State may not add additional software applications to the MDS system without a specific directive from HCFA.

The automated MDS system is a critical component of State agency and HCFA operations, and provides the means for transmission of assessment data to HCFA for validating payments under the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) for nursing homes.

The initial phase of the MDS system implementation involved a HCFA-funded installation of standardized computer hardware and data management software at each State Agency to allow electronic transfer of MDS data elements from all Medicare and Medicaid nursing homes to the State. The data management software: (1) validates the basic accuracy of the data and rejects submission files (batches) with **Fatal File Errors**, such as a missing or invalid Facility ID, incorrect record length, or missing headers or trailers; (2) validates individual assessment records and rejects those records with **Fatal Record Errors**, (3) stores and reports **Non-Fatal Errors** on records that are accepted by the database; and (4) builds a database of MDS information for all residents in each nursing home in the State.

The MDS system implemented electronic transmission of MDS data by all Medicare and Medicaid nursing homes beginning with the regulation's effective date of June 22, 1998. This provides for enhanced analytical capabilities at the State agencies; electronic transmission from the State databases to a national repository; integration with performance indicators for quality oversight and survey planning by the State Agency; use of MDS data as a basis for prospective payment of nursing homes; research directed at improving quality of care; feedback to providers; and dissemination of information to purchasers, beneficiaries, and others.

The following procedures describe MDS system operations.

4146.1 System Description.--HCFA has provided each State with an MDS system composed of standardized hardware and software platforms scaled to meet each State's anticipated processing volumes. The hardware is comprised of a communications server, database server, modems and other peripheral devices. The QIES system software includes an Oracle database, Netscape Enterprise Server, Netscape Personal Edition, Microsoft Windows NT, the MDS/OASIS Data Management Application, and all required software licenses. The MDS system deployed to each State was specifically engineered and purchased to fulfill the MDS requirements of 42 CFR Part 483.20(f) and Part 483.315(h), additional HCFA provider assessment processes as they become effective, and operational support of Medicare and Medicaid Survey and Certification pursuant to Section 1864 of the Social Security Act. The system was designed with an emphasis on flexibility and integration, so that additional software components could be easily added to provide the States with new MDS-related functionality (such as new or revised quality indicators and expanded analytical reports), as well as applications that support future assessment processes for other provider types, and new capabilities to support Survey and Certification operations or any other entity using the MDS data or system. Since each State's system was specifically sized to accommodate these planned functions, the SA or any other entity using the MDS data or system must not add other, non-HCFA prescribed, applications or databases to the MDS system.

4146.2 Administration Requirements.--The States are directly responsible for fulfilling requirements to operate the State MDS system. However, the State may enter an agreement with the State Medicaid agency, another State component, or a private contractor to perform day-to-day operations of the system.

The State must obtain RO approval prior to entering an agreement with another agency. Criteria for approval are provided at Exhibit 254. Under any such arrangement, the State must be guaranteed real-time, priority access to this system to fully support all MDS functions specified in the MDS procedures and the State Operations Manual. All HCFA privacy and confidentiality requirements must be met. Off-site operation of the MDS system will require high capacity, fault-tolerant network connections to ensure reliable support for the State's daily operations which will be affected by this system. The State also must use the MDS system for reporting MDS data to the HCFA central repository.

To promote national consistency in MDS system operations and troubleshooting, each State must designate one individual as the MDS automation project coordinator. This person is HCFA's key contact within each State for managing MDS system issues. This person must be familiar with the use of the Resident Assessment Instrument (RAI) and the MDS automation and transmission process. Technical knowledge of information systems is useful but far less critical than an understanding of the RAI and MDS processes, good communications and project management skills, and the ability to educate and work with providers and vendors to ensure successful implementation of an automated process for all providers. The State should designate additional staff, including a system administrator to manage the technical aspects of running the MDS system, and support staff to assist in answering routine user questions, assigning passwords, etc.

With respect to systems maintenance, the MDS system installed in each State is comprised of commercial off-the-shelf hardware and software components that are generally covered under typical umbrella service agreements that the State may already have in place for maintenance of data processing equipment. Those MDS software components that are developed and distributed by HCFA will be maintained and upgraded centrally by HCFA. The State will not be responsible for these software upgrades.

To the extent that the State has developed customized external applications for using information obtained from the MDS database (e.g., to support Medicaid payment), the costs of developing and maintaining these additional software applications (and any related hardware components) will not be funded through the survey and certification budget.

4146.3 Validation and Editing Process.--Each time a facility accesses the State MDS system and transmits an assessment file, the State system performs a series of three levels of validations:

1. Fatal File Errors.--The first check examines the basic structure and integrity of the submission file. If there are fatal flaws in the file (batch of records), the entire file is rejected and the facility is notified of the reason for rejection in the "Initial Feedback Report". In the event that a batch is rejected due to **Fatal File Errors**, the facility will not receive a "Final Validation Report". Rejected files must be corrected and retransmitted. **Fatal File Errors** are described in a document named spdoc110.pdf, that is posted at the HCFA Web Site, "http://www.hcfa.gov/medicaid/mds20" under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files".

2. Fatal Record Errors.--If the file structure is acceptable, then each MDS record in the file is examined individually for **Fatal Record Errors**. These errors include out of range responses (this edit applies to most, but not all fields), selected inconsistent relationships between fields, or

errors which made identifying a resident or record type difficult. Fatal Record Errors result in rejection of individual records by the State MDS database. The facility is informed of **Fatal Record Errors** on both the "Initial Feedback Report" and the "Final Validation Report." An overview of **Fatal Record Errors** is provided in a document called spdoc110.pdf, and a detailed listing of all **Fatal Record Errors** is provided in the item-by-item MDS record specifications, a document that is segmented into three files, named d_dt110a.pdf, d_dt110b.pdf and d_dt110c.pdf, "http://www.hcfa.gov/medicaid/mds20", under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files".

At this level of validation, the MDS standard system at the State is designed to reject individual records with **Fatal Record Errors** and to accept records with no **Fatal Record Errors**. An electronic "final validation report" is made available to the facility and includes error messages for individual records found to have errors, and a statement of record status (accepted or rejected), with associated error statements for any rejected records. Rejected records must be corrected and retransmitted.

3. Non-Fatal Errors.--If there are no **Fatal Record Errors**, the record is loaded into the State database and the record is further examined for **Non-Fatal Errors**. Any **Non-Fatal Errors** are reported to the facility in the "Final Validation Report." **Non-Fatal Errors** include missing or questionable data of a non-critical nature, field consistency errors of a non-critical nature, and record sequencing and timing errors.

The Initial Feedback Report is available for the facility to download immediately following the submission of a file. Since the Final Validation Report will not be available as quickly as the Initial Feedback Report, the facility may, based on experience, choose to obtain this report on a subsequent logon.

The validations and edits described above fulfill all of HCFA's editing requirements under 42 CFR Part 483.315(h)(1)(iv). Also, as specified at 42 CFR Part 483.315(h)(2)(ii), States or other data/system users may not modify any aspect of the HCFA MDS standard system, including these validations and edits, the Standard Record Layout, and the software code and specifications on which the system is based.

States who use MDS data for Medicaid payment may require additional assessment information not required by HCFA's MDS system. Section S (the State-specific section) of the MDS system was designed for this purpose. Moreover, some States may impose additional edits on Medicaid assessments. However, a State or other data system users may not interfere with, modify, or delay the transmission of records, meeting HCFA edit standards, from a Medicare or Medicaid certified facility to the HCFA MDS standard system.

Furthermore, the State or other data system users may not impose any requirements which modify the clinical accuracy of HCFA prescribed MDS records, reports, or calculations.

4146.4 Reports.--The MDS system provides the following reports to both the State and the provider. These reports, which focus on errors in MDS submissions, are key to working with facilities to ensure successful transmission of MDS data.

1. Initial Feedback Report.--During a submission session, the facility will be informed of file submission status in an Initial Feedback Report. The Initial Feedback Report may indicate that the batch was "accepted," "received" (for a test file), or that it was "rejected." Since the Initial Feedback Report is not automatically saved by the system, it must be reviewed prior to logging off after a batch submission.

The top section of this report gives general information about the entire batch of records.

- o Report Date/Time.

- o Batch Status -- Status is "Rejected" if a file had **Fatal File Errors** and the entire batch of records was rejected. Status is "Accepted" if a file had **no Fatal File Errors** and individual records were processed for loading into the State database. For **test** files only, status is "Received" if the test submission had no **Fatal File Errors**. Test records are not inserted in the data base.

- o Submission Date/Time -- Date/time that the MDS file was submitted; may be needed for troubleshooting any problems with a batch.

- o Submission Batch ID. -- Unique ID assigned to each batch used for troubleshooting problems with a batch.

- o Facility ID. -- The standard system logon ID for the facility.

- o Facility Name.

- o Number of Records Processed -- Number of data records in the file (batch)--value will be 0 if the entire file is rejected.

- o Number of Records Rejected -- Number of data records that contained **Fatal Record Errors** and were not accepted into the State database. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file.

- o Number of Records with Errors -- Number of records that were accepted into the State database but that also contained **Non-Fatal Errors**. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file.

- o Total Number of Errors -- Total number of **Non-Fatal Errors** across all records accepted into the State database. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file.

Detail concerning any file header and trailer errors will appear in the lower portion of the Initial Feedback Report, under "Report Detail." The Report Detail section includes the following information (clarification of labels is given in parentheses):

- o Record Type, Effective Date -- The record type field can contain "Header" for a header record, "Trailer" for a trailer record.

- o Field -- Field in error.

- o Invalid Data -- Data that caused the error.

- o Error Description -- Descriptive error message.

2. Final Validation Report**.--**If there are **Fatal File Errors** with the MDS submission file, the entire batch of records is rejected and the only feedback that the facility will receive during the submission session is the Initial Feedback Report. However, if there are no **Fatal File Errors**, a Final Validation Report will also be received by the facility. The Final Validation Report has exactly the same layout as the Initial Feedback Report. The "Report Detail" section of the Final Validation Report details all errors found in the data records in the batch. These errors can be **Fatal Record Errors** (resulting in record rejection) or **Non-Fatal Errors**. The following information is displayed in the record detail section:

- o SSN, Name.--Resident SSN and name.
- o Record Type, Effective Date.--The record type field can contain "Header" for a header record, "Trailer" for a trailer record. The report field can also contain the data record types as defined in definitions section (e.g., "A" for an initial admission assessment record).
- o Field.--Field in error.
- o Invalid Data.--Data that caused the error.
- o Error Description.--Descriptive error message.

The additional reports listed below are available to the State for the MDS system, but not directly to the provider. The State may provide copies of these reports to the facilities as they deem appropriate.

- o **Assessment Field Information.**--Displays information about each assessment field in the database including field name, start position, field length, valid values, start and end ranges (for numeric fields), field data type, field description, and which assessment section contains the field.
- o **Assessment Primary Reason**.--(MDS Item A8a or AA8a) - Displays information about primary reason for assessment.
- o **Assessment Sections**.--Displays which assessment sections are included for each combination of Primary Reason for Assessment (MDS Item A8a or AA8a) and Special Reason for Assessment (MDS Item AA8b) values.
- o **Assessment Special Reason**.**--**(MDS Item A8b or AA8b).--Displays information about these values.
- o **Case Mix Codes.--**Displays details of each CMI set that is in the database. Information includes CMI sequence, set name, ADL values, CMI codes, CMI values, and descriptions.
- o **Discharges in Previous Month**.--A list of residents who had discharge assessments (as the last assessment) submitted in the last 30 days. Report can be generated for a single facility or all facilities.
- o **Duplicate Resident Names**.--A list of residents with identical first and last names. Useful for finding duplicate residents in a facility.
- o **Duplicate Resident SSN**.--A list of residents who are listed as having the same SSN. All residents for a particular SSN are listed. This report is also useful for finding duplicate residents.

o **Error Summary**.--This report lists the errors that have occurred in submissions, the number of occurrences, and the percentage of assessments with each error. The report is for a single facility, all facilities, for a single vendor, all vendors, or for an entire State for a specified time period.

o **Error Message**.--Displays all of the error message codes and descriptions

o **Error Detail.--**List of all errors for all submissions grouped by assessment. The report can be generated for a single facility, all facilities, a single vendor, or all vendors for a specified time period.

o **Errors by Field**.--Lists, by field, the number of assessments that had an error in that field, the number of assessments successfully processed, and the percentage of assessments with each error. Can be generated for a single facility, all facilities, a single vendor, all vendors, or the entire State for a specified period of time**.**

o **Facility Accounts Report**.**--**Lists all facilities and their logon ID and password.

o **Facility List**.--Listing of all facilities in a State that submit MDS assessments.

o **Facility List, No Recent Submissions**.--Listing of all facilities in the State that have not submitted assessments since a specified date.

o **Facility List.--Non-Submitted Data**.--Listing of all facilities that have not submitted assessments.

o **Overdue Assessments**.--Listing of all residents who have not had assessments submitted within the required timeframe. Report includes which assessment type(s) is/are expected. Available for a single facility or all facilities.

o **Quarterly Assessment Fields**.--Listing of all fields that are included for each quarterly assessment type grouped by each MDS Item AA8a/AA8b combination.

o **Roster Report**.--Lists all residents who are currently in a facility. Can be generated for a single facility or all facilities.

o **Roster Timeframe Report**.--List all residents who are in a facility within a specified date range. Can be generated for a single facility or for all facilities.

o **Sequencing Report**.**–**Displays invalid sequences between assessments. Displayed by two sets of MDS Item A8a/A8b or AA8a/AA8b combinations and Record Types (current and previous).

o **State Customization**.**--**List the values for the active CMI set for the State, State optional fields (if any), and the validation engine options set by the State.

o **Summary Statistics**.**--**List the number of files received, number of records processed (by record type), number of records rejected, and number of records received with errors (by record type). Available for a single facility or all facilities for a specified time period.

o **Validation Codes**.--A reference report that lists valid codes for various fields in the assessment.

o **Vendor List**--A list of facilities that have used a particular vendor. This report can be generated for a single vendor or multiple vendors.

o **Ad Hoc Reports**.--Various user-defined reports can also be generated using structured query language within the Data Management Application.

In addition, the MDS system has made, other reports available to both the States and providers, based on the deployment of analytical and quality indicator software.

4146.5 Correction of Errors in MDS Records That Have Been Accepted by the Standard MDS System at the State.--The standard MDS system in each State includes a mechanism by which facilities can electronically submit corrections to MDS data that have already been accepted into the State MDS database. Depending on the circumstances surrounding the error, corrections may include modification or inactivation of MDS records (assessments, Discharge Tracking forms and Reentry tracking forms). The MDS system provides management reports to the State that analyze the type, nature and frequency of corrections submitted by facilities to the MDS database at the State. For information about the process of correcting errors in MDS records in the State database, refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV.

4146.6 Replication to the HCFA Repository.--Each State's MDS database will be transmitted to HCFA's Central Repository at least monthly using a data replication process initiated by HCFA. Since the process will be managed by HCFA through an automatic polling process, the States will not actually have to transmit the data. However, the State must ensure that the HCFA data-line established for this purpose is accessible to HCFA at all times for testing and monitoring purposes. Actual replication access to the Oracle assessment data tables may be controlled by the States but, in such cases, a fixed schedule must be established with HCFA Central Office.

The MDS system and HCFA data line meet all industry security standards. However, if the State is concerned about security, it may establish a firewall (an electronic block) to restrict access to the State's portion of the network. Access must not be restricted to the HCFA-supplied MDS System.

4146.7 Privacy and Confidentiality.--

A. System of Records.--The MDS database is operated and maintained by States as a Federal database and, as such, is subject to the requirements of the Federal Privacy Act. The text of the System of Records notice for the MDS which follows describes the legal requirements regarding privacy and disclosure of information by HCFA or the State.

> "The purpose of the Long Term Care Minimum Data Set (LTC MDS) System NO. 09-70-1517 is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system supports regulatory, reimbursement, policy and research functions. In addition, this system will enable Federal and State regulators to provide long term care facility staff with outcome data for provider's internal quality improvement activities.

This system shall contain clinical information found in the comprehensive assessments of persons residing in long term care facilities that are certified to participate in the Medicare and/or Medicaid programs (including private pay individuals). This information is found in the Long Term Care Minimum Data Set for Nursing Home Resident Assessment."

HCFA established this system in accordance with the principles and requirements of the Privacy Act. The Privacy Act allows the disclosure of information from this system without an individual's consent if the information is to be used for a purpose that is compatible with the purposes for which the information was collected. Any such compatible use of data is known as a "routine use." The proposed routine uses for this system meet the compatibility requirement of the Privacy Act since they are consistent with the purpose of analyzing data on the physical, mental, functional, and psychosocial status of nursing facility residents living in the State.

The routine uses specify the circumstances under which HCFA and the State in their roles as contractors representing HCFA may release information from the long-term care MDS system without the consent of the individual to whom such information pertains. Each proposed disclosure of information under the routine uses must be evaluated by the HCFA System Manager and/or an individual authorized by HCFA. The authority to release data is limited to the System Manager or authorized designee.

B. Procedures for Disclosure of Information Pursuant to Data Use Agreement.--Releases of information **must be** evaluated to determine if disclosure is **legally permissible** by the HCFA System Manager or authorized designee, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. Releases are generally only made for the routine uses specified in the system notice. The HCFA System Manager or authorized designee **must require** each prospective recipient of LTC MDS system information to agree in writing to certain conditions to ensure the continuing confidentiality and to physically safeguard of the information. For each disclosure it is necessary for the System Manager or authorized designee to, as necessary and appropriate:

1. Determine that no other Federal statute specifically prohibits disclosure of the information;

2. Determine that the use or disclosure does not violate legal limitations under which the information was provided, collected, or obtained;

3. Determine the purpose for which the disclosure is to be made;

a. Cannot reasonably be accomplished unless the information is provided in individually identifiable form;

b. Is of sufficient importance to warrant the effect on or the risk to the privacy of the individual(s) that additional exposure of the record(s) might bring;

c. There is a reasonable probability that the purpose of the disclosure will be accomplished; and

d. The purpose is within the scope of a routine use.

4. Require the recipient of the information to:

a. Establish reasonable administrative, technical, and physical safeguards to prevent unauthorized access, use, or disclosure of the record or any part thereof. The physical safeguards shall provide a level of security that is at least equivalent to the level of security contemplated in OMB Circular No. A-130 (revised), Appendix III, Security of Federal Automated Information Systems, which sets forth guidelines for security plans for automated information systems in Federal agencies; contemplated in OMB Circular No. A-130 (revised), Appendix III, Security of Federal Automated Information Systems, which sets forth guidelines for security plans for automated information systems in Federal agencies;

b. Remove or destroy the information that allows subject individual(s) to be identified at the earliest time at which removal or destruction can be accomplished, consistent with the purpose of the request;

c. Refrain from using or disclosing the information for any purpose other than the stated purpose under which the information was disclosed; and

d. Make no further use or disclosure of the information except:

- To prevent or address an emergency directly affecting the health or safety of an individual;

- For use on another project under the same conditions, provided the System Manager or authorized designee has authorized the additional use(s) in writing; or

- When required by law

5. Secure a written statement or agreement from the prospective recipient of the information whereby the prospective recipient attests to an understanding of, and willingness to abide by the foregoing provisions and any additional provisions that the System Manager deems appropriate in the particular circumstance. The System Manager or authorized designee must use a HCFA-approved Data Release Agreement that cannot be modified; and

6. Determine whether the disclosure constitutes a computer "matching program" as defined in 5 U.S.C. §552a(a)(8). If the disclosure is determined to be a computer "matching program" the instructions regarding preparation and transmission of a matching agreement as stated in 5 U.S.C. §552a(o) must be followed.

C. Routine Uses.--The following lists the routine uses published in the LTC MDS System NO. 09-70-1517 (current as of May 1998).

Disclosure may be made:

1. To a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual.

2. To the Bureau of Census for use in processing research and statistical data directly related to the administration of Agency programs.

3. To the Department of Justice, to a court or other tribunal, or to another party before such tribunal, when:

a. HHS, or any component thereof;

b. Any HHS employee in his or her official capacity;

c. Any HHS employee in his or her individual capacity where the Department of Justice (or HHS, where it is authorized to do so) has agreed to represent the employee; or

d. The United States or any agency thereof where HHS determines that the litigation is likely to affect HHS or any of its components; is party to litigation or has an interest to such litigation, and HHS determines that the use of such records by the Department of Justice, the tribunal, or the other party is relevant and necessary to the litigation and would help in the effective presentation of the governmental party or interest, provided, however, that in each case HHS determines that such disclosure is compatible with the purpose for which the records were collected.

4. To an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

5. To a HCFA contractor for the purpose of collating, analyzing, aggregating, or otherwise refining or processing records in this system or for developing, modifying, and/or manipulating automated data processing (ADP) software. Data could also be disclosed to contractors incidental to consultation, programming, operation, user assistance, or maintenance for ADP or telecommunications systems containing or supporting records in the system.

6. To an agency of a State Government, or established by State law, for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; or for the purpose of administration of Federal-State health care programs within the State. Data will be released to the State only on those individuals who are either residents in long term care facilities within the State or are legal residents of the State, irrespective of the location of the LTC facility wherein they are residents. In effect, only data collected by the State for HCFA may be released for this purpose.

7. To another Federal agency: (1) to contribute to the accuracy of HCFA's proper payment of Medicare health benefits, and/or (2) to enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds.

8. To a HCFA contractor to perform Title XI or Title XVIII (of the Social Security Act) functions. Records from the LTC MDS may be released to a Peer Review Organization (PRO), or other HCFA contractors, respectively, for performing medical review functions under these provisions of the law.

9. To a HCFA contractor, including but not limited to, fiscal intermediaries and carriers under Title XVIII of the Social Security Act, to administer some aspect of a HCFA-administered health benefits program, or to a grantee of a HCFA-administered grant program, which program is or could be affected by fraud or abuse, for the purpose of preventing, deterring, discovering, detecting, investigating, examining, prosecuting, suing with respect to, defending against, correcting, remedying, or otherwise combating such fraud or abuse in such programs.

10. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States, including any State or local Government agency, for the purpose of preventing, deterring, discovering, detecting, investigating, examining, prosecuting, suing with respect to, defending against, correcting, remedying, or otherwise combating such fraud or abuse in such programs.

11. To any entity that makes payment for or oversees the administration of health care services, for the purpose of preventing, deterring, discovering, detecting, investigating, examining, prosecuting, suing with respect to, defending against, correcting, remedying, or otherwise combating fraud or abuse against such entity or the program or services administered by such entity, provided:

a. Such entity enters into an agreement with HCFA to share knowledge and information regarding actual or potential fraudulent or abusive practices or activities regarding the delivery or receipt of health care services, or regarding securing payment or reimbursement for health care services, or any practice or activity that, if directed toward a HCFA-administered program, might reasonably be construed as actually or potentially fraudulent or abusive;

b. Such entity does, on a regular basis, or at such times as HCFA may request, fully and freely share such knowledge and information with HCFA, or as directed by HCFA, with HCFA's contractors; and

LIST OF EXHIBITS

Exhibit 259

MINIMUM DATA SET AUTOMATION CONTRACT/AGREEMENT APPROVAL RO CHECKLIST

Background: All certified nursing homes are required to encode and transmit MDS records to a repository maintained by the State in accordance with HCFA-established record specifications and time frames. Provider costs will be compensated through the Medicare and Medicaid programs according to the rules for such reimbursement effective in each State. It is expected that overall responsibility for fulfilling requirements to operate the State MDS data system will rest with the State survey agency. However, the State survey agency may enter an agreement with the State Medicaid agency, another State component or a private contractor to perform day-to-day operations of the system. **Before entering an agreement with a subcontractor, i.e., if the State MDS system is operated by an entity other than the survey agency, the survey agency must receive HCFA RO approval. Such agreements must include the following provisions:**
****

1. Meets confidentiality requirements: Federal Privacy Act, 5 U.S.C. Section 522a; HIPAA of 1996; other applicable Federal data acts; Section 1902 (a)(7) of the Social Security Act; applicable State standards; and industry security standards.

2. Gives State survey agency real-time access to the system to fully support all MDS-driven functions which will be required of the survey agency (e.g., quality indicator reporting, survey targeting), or if contractor is performing analysis for State agency details how.

3. Complies with need for high capacity, fault-tolerant network connections to ensure reliable support for the State survey agencies, HCFA's national database and any other daily operations (e.g., FI Medical Case Review, OIG or DOJ Fraud and Abuse activities), which will be affected by this system. Assures hardware will be properly maintained and upgraded as necessary to meet any future HCFA or State survey agency requirements. Assures adequate backup of all data.

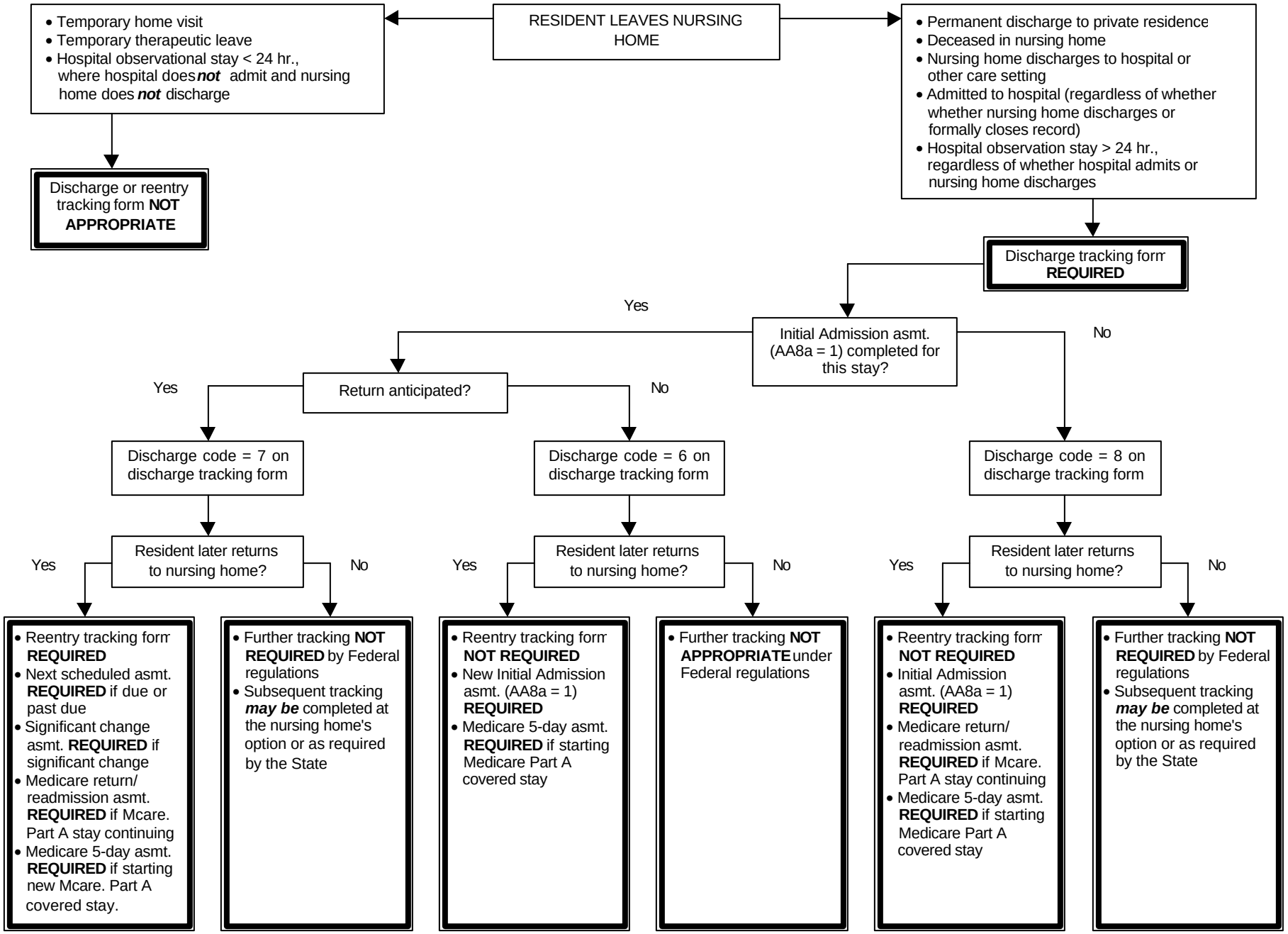
4. Covers State survey agency responsibilities for reporting MDS data to a central repository at HCFA. Designates responsibilities for edits and "cleanness" of data. Designates responsibilities for generating and communicating facility error reports. Describes what kinds of communication will be established, e.g., a State-specific Internet and/or Intranet web pages, newsletters, their content, and who will produce/maintain/distribute these communications. If there is a separate database, designates who is responsible for operating and maintaining the HCFA-provided equipment and who will assure the viability of the HCFA database.

5. Covers responsibilities of contractor and/or State for training and support operations: Including at least who will provide facility and MDS software vendor startup training, and on-going customer/facility support/troubleshooting; provide internal training and daily user support within the State agency; work with program staff to integrate the MDS system into State survey agency functions; train State survey agency staff on aspects of analytical system (e.g., ASPEN upgrades and performance measure/"quality indicator" linked reports); handle System Operations -- functions associated with transmission logging, error tracking and resolution, system archival and process reporting; designates who is responsible for determining facility transmission schedules.

6. Delineates how State will fund the monthly line charges associated with installation, maintenance, and transmission of the MDS data from the facilities to the contractor and between the contractor and State, e.g., built into contract costs or is an outside ongoing cost to the State survey agency.

7. Specifies whether it is the contractor's or the State survey agency's responsibility for systems maintenance for commercial "off-the-shelf" MDS hardware and software components. For example, are these covered under typical umbrella service agreements that the State or contractor may already have in place for maintenance of data processing equipment? If not, what is the process?

Exhibit 260
MDS 2.0 DISCHARGE AND REENTRY FLOWCHART



PRIVACY ACT STATEMENT - HEALTH CARE RECORDS 8/9/2000

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating long term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Health Care Financing Administration (HCFA) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing homes to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

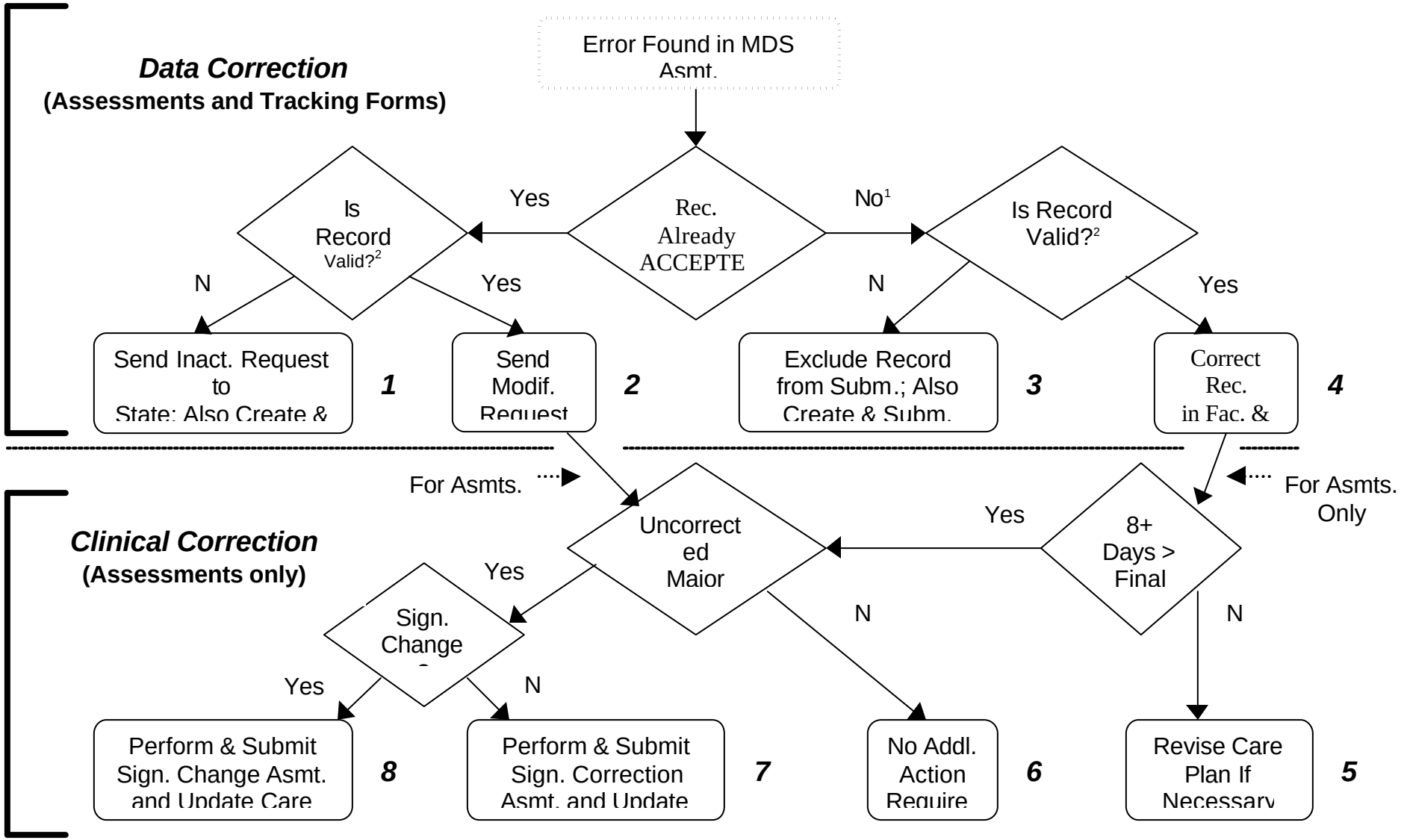
The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

Exhibit 262: CORRECTION POLICY FLOWCHART



[1]Record has not been data entered, has not been submitted, or has been submitted and rejected.
[2]The record is ***valid*** if ***event occurred***, ***resident*** and ***reasons for asmt.*** are correct, and ***submission is required***.
[3]The asmt. in error contains a Major error which has not been corrected by a subsequent assessment.

[4]Final completion is Item VB4 for a comprehensive and R2b for all other assessments.

Exhibit 263

SUBMISSION TIMEFRAME FOR MDS RECORDS

Type of Record	Primary Reason (AA8a)	Secondary Reason (AA8b)	Final Completion Or Event Date	Submit By
Admission Asmt.	01	all values	VB4	VB4 + 31
Annual Asmt.	02	all values	VB4	VB4 + 31
Sign. Change Asmt.	03	all values	VB4	VB4 + 31
Sign. Correction Full Asmt.	04	all values	VB4	VB4 + 31
Quarterly Asmt.	05	all values	R2b	R2b + 31
Sign. Correction Quarterly Asmt.	10	all values	R2b	R2b + 31
Asmt. for Medicare PPS only (with AA8a = 00)	00	1 thru 5, 7, 8	R2b	R2b + 31
Discharge Tracking	06, 07, 08	blank	R4	R4 + 31
Reentry Tracking	09	blank	A4a	A4a + 31
Correction Request	all values	all values	AT6	AT6 + 31

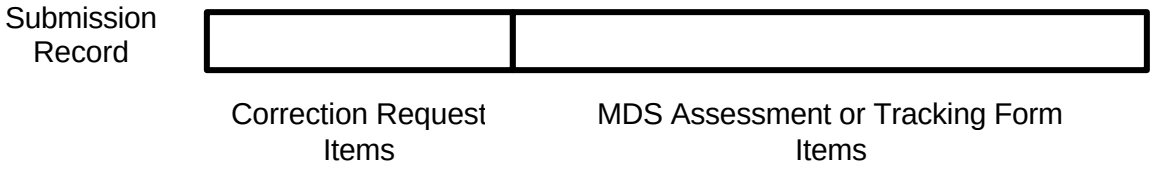
Exhibit 263 MDS Item Legend:

ITEM	DESCRIPTION
VB4	Date of the signature of the person completing the care planning decision on the RAP summary sheet (section V), indicating which RAPs are addressed in the care plan.
R2b	Date of the RN assessment coordinator's signature, indicating that the MDS is complete.
R4	Date of death or discharge.
A4a	Date of reentry.
AT6	Date of the RN coordinator's signature on the Correction Request Form certifying completion of the correction request information and the corrected assessment or tracking form information.

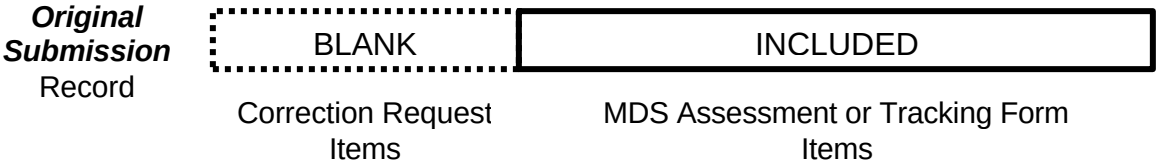
Exhibit 272

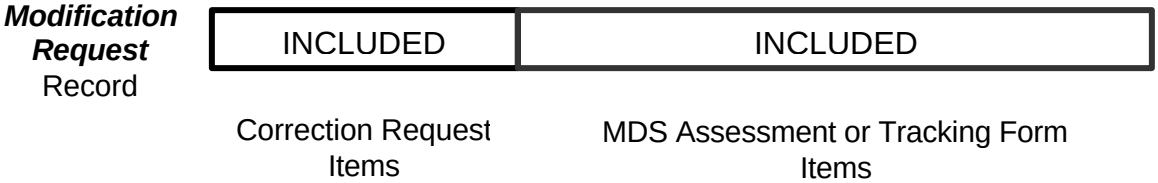
OVERVIEW OF MDS SUBMISSION RECORD
(Version 1.10 of the MDS Data Specifications)

With the new MDS 2.0 Correction Policy, previously unused space in the submission record has been assigned to accommodate information on the Correction Request Form. A submission record now consists of areas devoted to MDS Assessment or Tracking Form items ***and*** areas devoted to Correction Request Form information as follows:



The contents of a submission record vary depending upon whether the record is an original submission, a modification request, or an inactivation request, as displayed below:





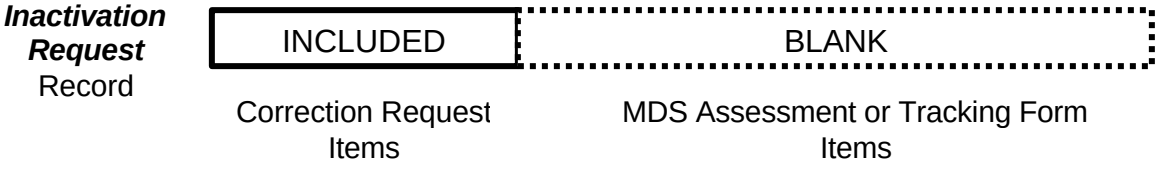


Exhibit 273
Correction Policy Summary Matrix

SCENARIO	ACTIONS BY FACILITY							
	1 Inactivate Record in State Database	2 Modify Record in State Database	3 Exclude Record from Submission	4 Correct Orig. Record In-House and Submit	5 Revise Care Plan if Necessary	6 No Sign. Change or Correct. Required	7 Perform and Submit Sign. Correction Assessment and Update Care Plan	8 Perform and Submit Sign. Change Assessment and Update Care Plan
1 Invalid asmt. (assessment) or tracking form record at State	✔							
2 Tracking form error at State		✔						
2/6 Minor assessment error at State		✔				✔		
2/7 Uncorr. Major assessment error at State, no sign. change		✔					✔	
2/8 Uncorr. Major assessment error at State, sign. change		✔						✔
3 Invalid assessment or tracking form record in-house			✔					
4 Tracking form error in-house				✔				
4/5 Major or minor error in asmt. in edit phase in-house				✔	✔			
4/6 Minor error in assessment in-house				✔		✔		
4/7 Uncorr. Major assessment error in-house, no sign. change				✔			✔	
4/8 Uncorr. Major assessment error in-house, sign. change				✔				✔

Exhibit 274

DEFINITION OF SELECTED DATES IN THE RAI PROCESS

TYPE OF RECORD	TARGET (OR EVENT) DATE	FINAL COMPLETION DATE
Assessment not Comprehensive (quarterly or full assessment without Section V)	A3a	R2b (all required assessment items complete)
Comprehensive Asmt. (includes Section V)	A3a	VB4 (final completion of comprehensive assessment and care plan)
Discharge Tracking Form	R4	R4
Reentry Tracking Form	A4a	A4a
Correction Request Form	----	AT6

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F274	(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	§483.20(b)(2)(ii) Guidelines: The following are the criteria for significant changes: A significant change reassessment is generally indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement: Decline: o Any decline in activities of daily living (ADL) physical functioning where a resident is newly coded as 3, 4 or 8 Extensive Assistance, Total Dependency, activity did not occur (note that even if coding in both columns A and B of an ADL category changes, this is considered 1 ADL change); o Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (e.g., an increase in the use of code 1's for E4B); o Resident's decision-making changes from 0 or 1, to 2 or 3; o Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter; o Emergence of sad or anxious mood as a problem that is not easily altered; o Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); o Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before; o Emergence of a condition/disease in which a resident is judged to be unstable;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F274 (Cont.)		o Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or o Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision making). Improvement: o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered;" o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports. If the resident experiences a significant change in status, the next annual assessment is not due until 366 days after the significant change reassessment has been completed.
F275	(iii) Not less than once every 12 months.	§483.20(b)(2)(iii) Guidelines: The annual resident assessment must be completed within 366 days after final completion of the most recent comprehensive resident assessment. §483.20(b)(2) Probes: o Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F275 (Cont.)		o Has the facility identified, in a timely manner, those residents who have experienced a change? o Has the facility reassessed residents using the State-specific RAI who had a significant change in status within 14 days after determining the change was significant. o Has the facility gathered supplemental assessment information based on triggered RAPs prior to establishing the care plan? o Does information in the RAI correspond with information obtained during observations of and interviews with the resident, facility staff and resident's family?
F276	(c) *Quarterly review assessment*. A facility must assess a resident using the quarterly review instrument specified by the State and approved by HCFA not less frequently than once every 3 months.	§483.20(c) Intent: To assure that the resident's assessment is updated on at least a quarterly basis. §483.20(c) Guidelines: At least each quarter, the facility shall review each resident with respect to those MDS items specified under the State's quarterly review requirement. At a minimum, this would include all items contained in HCFA's standard quarterly review form. A Quarterly review assessment must be completed within 92 days of the date at MDS Item R2b of the most recent, clinical assessment (AA8a=1,2,3,4,5 or 10). If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the significant change reassessment. §483.20(c) Probes: o Is the facility assessing and acting, no less than once every 3 months, on the results of resident's functional and cognitive status examinations? o Is the quarterly review of the resident's condition consistent with information in the progress notes, the plan of care and your resident observations and interviews?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F286	(d) *Use*. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	§483.20(d) Intent: Facilities are required to maintain 15 months of assessment data in the resident's active clinical record. §483.20(d) Guidelines: The requirement to maintain 15 months of data in the resident's active clinical record applies regardless of form of storage to all MDS forms, RAP Summary forms, Quarterly Assessment forms, Face Sheet Information and Discharge and Reentry Tracking Forms and MDS Correction Request Forms (including signed attestation). MDS assessments must be kept in the resident's active clinical record for 15 months following the final completion date, tracking forms for discharge and reentry must be kept for 15 months following the date of the event, Correction Request Forms must be kept for 15 months following the final completion date of the MDS Correction Request form. The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, the State agency, or HCFA. Whether or not the facility's clinical record system is entirely electronic, a hard copy of all MDS forms, including the signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
Refer to F279	And use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	For guidance regarding the use of the results of the assessment (other than storage), see guidance at F279.
Refer to F285	(e) *Coordination*. A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	§483.20(e) Guidelines: With respect to the responsibilities under the Pre-Admission Screening and Resident Review (PASRR) program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.
F287	(f) *Automated data processing requirement*. (1) *Encoding Data*. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii)Significant change in status assessments.	§483.20(f)(1-4) Intent: The intent is to enable a facility to better monitor a resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data. The primary purpose of maintaining the assessment data is so a facility can monitor resident progress over time. The information should be readily available at all times. §483.20(f)(1-4) Guidelines: "Encoding" means entering MDS information into a computer. "Transmitting data" refers to electronically sending encoded MDS information, from the facility to the State database, using a modem and communications software.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F287 (Cont.)	(iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) *Transmitting data*. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. (3) *Monthly transmittal requirements*. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:	"Capable of transmitting" means that the facility has encoded and edited according to HCFA specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission. "Passing standard edits" means that the encoded responses to MDS items are consistent and within range, in accordance with HCFA specified standards. In general, inconsistent responses are either not plausible or ignore a skip pattern on the MDS. An example of inconsistency would be if one or more MDS items on a list were checked as present, and the "None of the Above" response was also checked for the same list. Out of range responses are invalid responses, such as using a response code of 2 for an MDS item for which the valid responses are zero or 1. "Monthly Transmittal" means electronically transmitting to the State, an MDS record that passes HCFA's standard edits, within 31 days of the final completion date of the record. "Accurate" means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at §483.20(g), and the information accurately reflects the resident's status as of the Assessment Reference Date at MDS Item A3a. "Complete" means that all items required according to the record type, and in accordance with HCFA's record specifications and State required edits are in effect at the time the record is completed. In accordance with the final rule, facilities will be responsible to edit the encoded MDS data to ensure that it meets the standard edit specifications.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F287 (Cont.)	(i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) *Data format*. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.	We encourage facilities to use software that has a programmed capability to automatically edit MDS records according to HCFA's edit specifications. For §483.20(f)(1)(v), the subset of items required upon a resident's transfer, discharge, and death are contained in the Discharge Tracking form and the items required for reentry are contained in the Reentry Tracking form. Refer to Appendix R for further information about the Discharge Tracking and Reentry Tracking forms. All nursing homes must computerize MDS information. The facility must edit MDS information using standard HCFA-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the State system within 7 days of: o completing a comprehensive assessment (the date at MDS item VB4); o completing an assessment that is not comprehensive (the date at MDS item R2b); o a discharge event (the date at MDS item R4); o a reentry event (the date at MDS item A4a); or o completing a correction request form (the date at MDS item AT6). Submission must be according to State and Federal time frames. Therefore the facility must: o Encode the MDS and RAP Summary (where applicable) in machine readable format;

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F287 (Cont.)		o Edit the MDS and RAP Summary (where applicable) according to edits specified by HCFA. Within the 7 day time period specified above for editing, the facility must revise any information on the encoded MDS and RAP Summary (if applicable) that does not pass HCFA-specified edits, revise any otherwise inaccurate information, and make the information ready for submission. The MDS Vendor software used at the facility should have an automated editing process that alerts the user to entries in an MDS record that do not conform with the HCFA-specified edits and that prompts the facility to complete revisions within the 7 day editing and revision period. After editing and revision, MDS information and RAP summary information (if applicable) must always accurately reflect the resident's overall clinical status as of the original Assessment Reference date for an assessment or the original event date for a discharge or reentry; o Print the edited and revised MDS and RAP summary form (where applicable). Discharge or Reentry Tracking form or Correction Request form, and place it in the resident's record. The hard copy of the MDS record must match the record that the facility transmits to the State, and it must accurately reflect the resident's status as of the Assessment Reference date or event date. If a hard copy exists prior to data entry, the facility must correct the hard copy to reflect the changes associated with the editing and revision process. o Electronically submit MDS information to the State MDS database within 31 days of: o the date the Care Planning Decision process was complete (the date at MDS Item VB4) for comprehensive assessments; o the date the RN Coordinator certified that the MDS was complete (the date at MDS Item R2b) for assessments that are not comprehensive; o the date of death or discharge (the date at MDS Item R4) for Discharge Tracking forms; o the date of reentry (the date at MDS Item A4a) for Reentry Tracking forms; and o the date of completion of a correction request (the date at MDS Item AT6)

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F287 (Cont.)		For a discussion of the process that a facility should follow in the event an error is discovered in an MDS record after editing and revision but before it is transmitted to the State, refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV. The facility must maintain RAI assessments and Discharge and Reentry Tracking forms, as well as correction information, including Correction Request forms as a part of the resident's clinical record. Whether or not the facility's system is entirely electronic, a hard copy of completed MDS forms, including the signature of the facility staff attesting to the accuracy and completion of the corrected record, must be maintained in the resident's clinical record. A facility must complete and submit to the State a subset of items when the resident is discharged from the facility (discharge tracking form), or readmitted to the facility (reentry tracking form.
Refer to F516	(5) *Resident-identifiable information.* (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	§483.20(f)(5) Guidelines Automated RAI data are part of a resident's clinical record and as such are protected from improper disclosure by facilities under current law. Facilities are required by §§1819(c)(1)(A)(iv) and 1919(c)(1)(A)(iv) of the Act and 42 CFR Part 483.75(l)(3) and (l)(4), to keep confidential all information contained in the resident's record and to maintain safeguards against the unauthorized use of a resident's clinical record information, regardless of the storage method of the records.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F278	(g) Accuracy of assessment. The assessment must accurately reflect the resident's status. (h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification. (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for falsification. (1) Under Medicare and Medicaid, an individual who willfully and knowingly-- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	§483.20(g) Intent: To assure that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline. §483.20(g) Guidelines: "The accuracy of the assessment" means that the appropriate, qualified health professional correctly documents the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. The initial comprehensive assessment provides baseline data for ongoing assessment of resident progress. §483.20(h) Intent: The registered nurse will conduct and/or coordinate the assessment, as appropriate. Whether conducted or coordinated by the registered nurse, he or she is responsible for certifying that the assessment has been completed. §483.20(h) Guidelines: According to the Utilization Guidelines for each State's RAI, the physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs. §483.20(g)(h) Probes: o Have appropriate health professionals assessed the resident? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident? o If the resident's medical status, functional abilities, or psychosocial status declined and the decline was not clinically unavoidable, were the appropriate health professionals involved in assessing the resident?

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F278 (Cont.)		o Based on your total review of the resident, is each portion of the assessment accurate? o Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an assessment or Correction Request form, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment, tracking form or face sheet they completed or corrected. On an assessment or correction request, the RN Assessment Coordinator is responsible for certifying overall completion once all individual assessors have completed and signed their portion(s) of the MDS forms. When MDS forms are completed directly on the facility's computer, (e.g., no paper form has been manually completed), the RN Coordinator signs and dates the computer generated hard copy after reviewing it for completeness, including the signatures of all individual assessors. Backdating a completion date is not acceptable. §483.20(i) Guidelines: o Whether the MDS forms are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses on the forms relative to the resident's condition and discharge or reentry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the MDS record. When MDS forms are completed directly on the facility's computer (e.g., no paper form has been manually completed), then each individual assessor signs and dates a computer generated hard copy, after they review it for accuracy of the portion(s) they completed. Backdating completion dates is not acceptable. §483.20(j) Guidelines: o MDS information serves as the clinical basis for care planning and delivery. With the introduction of additional uses of MDS information such as for payment rate setting and quality monitoring, MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher RUG scores, untriggering RAP(s), or unflagging QI(s), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or avoidance of the quality monitoring process. Such practices may include but are not limited to a pattern or high prevalence of the following:

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F278 (Cont.)		- Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Reentry Tracking forms, where the information does not accurately reflect the resident's status as of the Assessment Reference date, or the Discharge or Reentry date, as applicable; - Submitting correction(s) to information in the State MDS database where the corrected information does not accurately reflect the resident's status as of the original Assessment Reference date, or the original Discharge or Reentry date, as applicable, or where the record it claims to correct does not appear to have been in error; - Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error; - Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met; - Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Reentry Tracking information, or correction(s) to information in the State MDS database. When such patterns or practices are noticed, they should be reported by the State Agency to the proper authority.
F279	k) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:	§483.20(k) Guidelines: An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the RAP summary or clinical record of the following: o The resident's status in triggered RAP areas; o The facility's rationale for deciding whether to proceed with care planning; and o Evidence that the facility considered the development of care planning interventions for all RAPs triggered by the MDS.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F279 (Cont.)	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan or care. The requirements reflect the facility's responsibilities to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment). §483.20(k)(1) Probes: o Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment? o Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths? o Does the care plan reflect standards of current professional practice? o Do treatment objectives have measurable outcomes? o Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment. o Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment. o If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? For implementation of care plan, see §483.20(k)(3).

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F280	(2) A comprehensive care plan must be-- (i) Developed within 7 days after the completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	§483.20(k)(2) Guidelines: As used in this requirement, "Interdisciplinary" means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. The physician must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-on-one discussions and conference calls. The resident's right to participate in choosing treatment options, decisions in care planning and the right to refuse treatment are addressed at §483.20(k)(2)(ii) and 483.10(b)(4), respectively, and include the right to accept or refuse treatment. The facility has a responsibility to assist residents to participate, e.g., helping residents, and families, legal surrogates or representatives understand the assessment and care planning process; when feasible, holding care planning meetings at the time of day when a resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's advocate to attend (e.g. family member, friend) if desired by a resident. The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. (See §483.20(k)(2)(ii) and 483.10(b)(4).) The facility should encourage residents, legal surrogates and representatives to participate in care planning, including attending care planning conferences if they so desire. While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions. §483.20(k)(2) Probes: 1. Was interdisciplinary expertise utilized to develop a plan to improve the resident's functional abilities? a. For example, did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability? b. Do the dietitian and speech therapist determine, for example, the optimum textures and consistency for the resident's food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident? c. Is there evidence of physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls)? 2. In what ways do staff involve residents and families, surrogates, and/or representatives in care planning?

APPENDIX R

RESIDENT ASSESSMENT INSTRUMENT FOR LONG TERM CARE FACILITIES

INTRODUCTION

PART I
Utilization Guidelines for Completion of the Resident Assessment Instrument

PART II
Minimum Data Set, Quarterly Review and Correction Request

PART III
Utilization Guidelines Pertaining to The Resident Assessment Protocols

PART IV
Minimum Data Set
Automation, Electronic Transmission, and Correction Guidelines

INTRODUCTION

Sections 1819(f)(6) and 1919(f)(6) of the Social Security Act (the Act) require that the Secretary specify a minimum data set (MDS) of core elements and common definitions for use by long term care facilities in conducting comprehensive assessments of residents residing in long term care facilities. These sections also require the Secretary to establish guidelines for the use of these data elements. These utilization guidelines consist of instructions for using the Resident Assessment Instrument (RAI) and include the resident assessment protocols (RAPs). Furthermore, the Secretary is required to designate one or more RAIs which are consistent with the MDS and common definitions. A State may specify the RAI designated by the Secretary for use in conducting assessments, or it may develop an alternate RAI provided it is approved by the Secretary as being consistent with the MDS of core elements, common definitions and utilization guidelines.

HCFA's original RAI was published in 1990 and implemented in all States by 1991. HCFA subsequently undertook a collaborative process to revise the RAI, which culminated in the release of version 2.0 of the RAI.

This transmittal serves as HCFA's means of redesignating the RAI and requiring the use of the September, 2000 update of version 2.0 of the RAI (or an approved alternate) by all States. As such, each State's RAI must consist of at least HCFA's September, 2000 RAI. Any State-specific items are included in an optional Section S. States may also specify the standardized, optional sections T and U as part of their RAI.

Version 2.0 of the RAI is comprised of the utilization guidelines included in Part I of this appendix; the MDS, Quarterly review, and Correction Request Form in Part II; and the utilization guidelines pertaining to the RAPs in Part III. Corresponding instructional materials are included in each part. The guidelines for encoding, correcting and electronically transmitting RAI information to the State are included in Part IV.

Under the SNF PPS requirements, facilities must complete Section T for residents in a Medicare Part A covered stay each time an MDS is required for Medicare payment purposes.

PART I UTILIZATION GUIDELINES FOR COMPLETION OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

Include the following guidelines with any assessment instrument provided to long term care facilities.

A. General Guidelines.--

1. Use of The Assessment.--

a. Clinical.--Use the RAI to comprehensively assess all residents, regardless of payor source, in long term care facilities certified to participate in Medicare or Medicaid. The RAI gathers information on the resident's condition, helps develop an individualized care plan, and enables a facility to track changes in resident status.

Adhere to the MDS definitions specified in Part I. In addition to direct observation and communication with the resident, use a variety of information sources to complete the assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

Other sources of information may include, but are not limited to:

- o Discussion of the resident's status with an attending physician;
- o Discussion of the resident's status with family members;
- o Discussion of the resident's status with appropriate licensed health professionals who have observed, evaluated, and/or treated the resident; and/or
- o The resident's record, including the admission record, physician's orders, plan of care, documentation of services provided to the resident, reports of any diagnostic testing, consultation, or other services, medications administration record, copies of any transfer data provided by another health care facility, and summaries of previous discharges.

While the MDS is primarily a tool for clinicians to use in care planning, many MDS items are also used to determine the Resource Utilization Group (RUG III) for residents in a Part A Medicare stay.

2. Coordination of the Assessment.--A registered nurse is responsible for conducting or coordinating each resident assessment. This person's responsibilities may include:

- o Using instructional materials, including the utilization guidelines prepared by HCFA, to train other facility staff to gather information, and to instruct them of circumstances which require that an assessment be completed;
- o Delegating responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, social workers, activities specialists, physical, occupational, or speech therapists, attending physicians, dietitians, and pharmacists;
- o Establishing facility policies and procedures to assure that key clinical personnel on all shifts are knowledgeable about the information found in the resident's most current assessment, and report changes in resident's status that may affect the accuracy of this information; or
- o Establishing facility policies and procedures that instruct staff how to integrate MDS information with existing facility resident assessment and care planning practices.

3. Certification of Completion and Accuracy.--Have the registered nurse coordinating the assessment sign, date and certify the completion of the MDS and RAPs. Each individual who completes a portion of the MDS assessment must indicate which portions he or she completed and must certify the accuracy of that portion of the assessment. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties. Clinical disagreement does not constitute a material and false statement. Civil and criminal statutes impose liability on persons or entities for knowingly submitting false or for knowingly and willfully making false statements. They do not impose liability for innocent acts or for mistakes. For the purpose of the Federal Civil False Claims Act, Congress defined the term "knowingly" to include not only acting with "actual knowledge" of the truth or falsity of information, but also acting with "reckless disregard" or "deliberate ignorance" of the truth or falsity of information.

4. Guidelines for Maintaining Assessment Information.--Place all completed resident assessments (i.e., all full MDS forms, all quarterly review forms, all RAP Summary Forms and RAP documentation, Face Sheet information, and Discharge and Reentry Tracking forms) in the resident's record. Maintain all resident assessments completed within the last 15 months on each resident's record. The one exception is for Face Sheet information, which is a permanent part of the clinical record, and as such, is to remain in the active record for all current residents, for the duration of their stay. A copy of the Face Sheet information is to be brought forward from the closed to the active record when a resident returns from a discharge. If a resident is permanently discharged, (without expectation of return), and then comes back to the facility, a new Face Sheet must be completed. Assessment data need not be stored in one binder. For example, facilities may choose to maintain assessment and care planning information in a separate binder or kardex system, as long as the information is kept in a centralized location and is accessible to all staff who need to review the information in order to provide care to the resident.

B. Frequency of Assessment.--Federal requirements mandate that long term care facilities perform a comprehensive assessment of residents using the RAI specified by the State:

- Within 14 days of admission to the facility;
- Promptly after a significant change in the resident's physical or mental condition; and
- In no case, less often than once every 12 months.

In addition, the facility must assess each resident no less frequently than once every 3 months and, as appropriate, revise the resident's care plan. In doing so, the facility must use the quarterly review specified by the State and approved by HCFA.

Following are specific utilization guidelines for conducting comprehensive assessments and quarterly reviews:

1. At Admission.--Conduct an assessment within 14 days of admission if this is the resident's first stay in the facility or if the resident returns to the facility after he or she was discharged with no expectation of return.

Facilities are not required to reassess the resident if he or she is readmitted unless a significant change has occurred. A readmission is defined as a return to the facility following a temporary absence for hospitalization or for therapeutic leave. If a significant change in status has occurred, use the procedures which follow for conducting a significant change reassessment.

2. At a Significant Change in a Resident's Status.--A "significant change" is defined as a major decline or improvement in the resident's status that:

- Will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions;
- Impacts on more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan.

For example, normally a five percent weight loss would trigger a significant change reassessment. However, if a resident had the flu and experienced nausea and diarrhea for a week, a 5 percent weight loss may be an expected outcome. In this case, staff should monitor the resident's status. If the resident did not become dehydrated and started to regain weight after the symptoms subsided,

a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment. This timeframe is not meant to be prescriptive but rather, should be driven by clinical judgment and the resident's needs.

A comprehensive significant change reassessment is required if decline or improvement are consistently noted in two or more areas of decline, or two or more areas of improvement.

3. Decline.--

o Any decline in Activities of Daily Living (ADL) physical functioning where a resident is newly coded as 3, 4 or 8 (Extensive Assistance, Total Dependency, Activity Did Not Occur);

o Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1's" for E4B);

o Resident's decision-making changes from 0 or 1 to 2 or 3;

o Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter;

o Emergence of sad or anxious mood as a problem that is not easily altered;

o Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

o Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before;

o Emergence of a condition/disease in which a resident is judged to be unstable;

o Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or

o Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making).

4. Improvement.--

o Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8;

o Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered";

o Resident's decision-making changes from 2 or 3 to 0 or 1;

o Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or

o Overall improvement of resident's condition; resident receives fewer supports.

This list is not exhaustive, as other situations may also meet the significant change definition. In an end-stage disease status, a significant change reassessment is optional, depending on a clinical determination of whether the resident would benefit from it.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes.

Complete a comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case later than 14 days after determining a significant change has occurred.

It is not necessary to complete a significant change assessment if declines in a resident's physical, mental, or psychosocial well-being are attributable to:

o Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action, e.g., an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a significant change reassessment;

o Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect the resident to fully recover; or

o Well-established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a significant change reassessment.

5. At Least Annually.--Each resident must have a comprehensive assessment no later than 12 months following the last comprehensive assessment. Whenever a comprehensive assessment is performed due to a significant change or significant correction of prior full assessment, the 12-month "clock" starts over.

6. Quarterly Reviews.--To track resident status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status, assess the following key MDS elements for all residents quarterly using the State-specified form. In conducting quarterly reviews, facilities must also assess any additional items required for use by the State. The facility must complete Section AA, Identification Information, in addition to the items listed below:

- o Section A: Identification and Background Information:
  - Item 1 (Resident Name);
  - Item 2 (Room Number);
  - Item 3 (Assessment Reference Date);
  - Item 4 (Date of Readmission); and
  - Item 6 (Medical Record Number).
- o Section B: Cognitive Patterns:
  - Item 1 (Comatose);
  - Item 2 (Memory);

- Item 4 (Cognitive Skills for Daily Decision-making); and
- Item 5 (Indicators of Delirium--Periodic Disordered Thinking/Awareness).

o Section C: Communication/Hearing Patterns:

- Item 4 (Making Self Understood); and
- Item 6 (Ability to Understand Others).

o Section E: Mood and Behavior Patterns:

- Item 1 (Indicators of Depression, Anxiety, Sad Mood);
- Item 2 (Mood Persistence); and
- Item 4 (Behavioral Symptoms).

o Section G: Physical Functioning and Structural Problems:

- Item 1 (ADL Self-Performance);
- Item 2 (Bathing);
- Item 4 (Functional Limitation in Range of Motion); and
- Items 6a, b, and f (Modes of Transfer).

o Section H: Continence in Last 14 Days:

- Item 1 (Continence Self-Control);
- Items 2d and e (Bowel Elimination Pattern); and
- Items 3a, b, c, d, i and j (Appliances and Programs).

o Section I: Disease Diagnoses:

- Items 2j and m (Infections); and
- Item 3 Disease Diagnoses.

Using the ICD-9-CM coding system, note only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

o Section J: Health Conditions:

- Items 1c, i, and p (Problem Conditions);
- Item 2 (Pain Symptoms);

- Item 4 (Accidents); and
- Item 5 (Stability of Conditions).

o Section K: Oral/Nutritional Status:

- Item 3 (Weight Change); and
- Items 5b, h and i (Nutritional Approaches).

o Section M: Skin Condition:

- Item 1 (Ulcers); and
- Item 2 (Type of Ulcer).

o Section N: Activity Pursuit Patterns:

- Item 1 (Time Awake); and
- Item 2 (Average Time Involved in Activities).

o Section O: Medications:

- Item 1 (Number of Medications); and
- Item 4 (Days Received the Following Medications).

o Section P:

- Item 4 (Devices and Restraints).

o Section Q: Discharge Potential:

- Item 2 (Overall Change in Care Needs)

o Section R: Assessment/Discharge Information:

- Item 2 (Signature of Person Coordinating the Assessment).

Based on the quarterly review, revise the care plan if indicated.

PART II - MINIMUM DATA SET (MDS)

The following rules apply to HCFA's RAI, Version 2.0, as used by all long-term care facilities certified to participate in Medicare or Medicaid.

1. Content of the Minimum Data Set (MDS) Version 2.0 for Nursing Home Resident Assessment and Care Screening is Recorded on the Following Mandated Forms.--In addition to the forms for identification (Section AA) and background information (Sections AB, AC and AD), 19 sections, lettered from A to R and V, comprise the MDS. Each section contains one or more items labeled sequentially and corresponding definitions. For instance, the third item in Section B is labeled "B3", the fifth item in Section P is "P5".

Answer boxes differ by the type of response required for the MDS item. Annotate those items with a letter in the answer box with a check mark. For items which have a blank box, enter either a number, such as height or weight, or a pre-assigned code. Leave darkly shaded boxes blank. Answer all items unless the instructions tell you to skip over the next item (or several items). Leave skipped items blank. When responding to these items, follow the sequence as closely as possible. In cases where information is unavailable and despite continued investigation, the information WILL REMAIN UNAVAILABLE OR UNKNOWN, enter the code "NA" or a circled dash. When the MDS is entered into the computer the "NA" or a circled dash will be entered as a dash ("-").

A. The Basic Assessment Tracking Form.--This form contains Section AA (Identification Information) Items 1-9, which consists of identifying information needed to uniquely identify each resident, the home in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of The Assessment or Tracking form, Sections AA and A - V, (including Sections T and U). It is particularly important that identifying information is complete and accurate. Refer to Correction Policy (Part IV of Appendix R) for information concerning the process of correcting erroneous key information in a locked record.

The information contained on this form must accompany each Comprehensive, Full or Quarterly Assessment submitted electronically to the State MDS database. This includes Federally-required assessment records (e.g., *Admission, Annual, Significant Change in Status, and Quarterly Assessments)*, as well as assessments required for Medicare PPS or by the State. The Discharge and Reentry Tracking Forms have been developed to also contain the identifying information found on the Basic Assessment Tracking Form, as well as signatures of Persons Completing a Portion of the Assessment or Tracking Form. This information is required to be submitted with either the Discharge or Reentry Tracking Form.

B. Background (Face Sheet) Information at Admission Form.--This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the time of the resident's initial admission to the nursing home. A new Face Sheet is also required to be completed, along with an Initial Admission assessment, for an individual who returns to the facility after a discharge in which return was not anticipated. HCFA's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally-required records (those indicated by the codes under AA8a) or the assessments required for Medicare PPS (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

If Face Sheet information was completed for residents admitted prior to implementation of version 2.0 use the information from the original Face Sheet to complete the version 2.0 Face Sheet. Three new items appear on the version 2.0 Face Sheet, including items AB2 "Admitted From (At Entry)", AB4 "Zip Code of Prior Primary Residence," and AB7 "Education". These items should be completed prior to submission, if the information is obtainable. Use the standard "no information" code (circled dash or "NA") where, despite exhaustive probing, the information is not available.

If there is no Face Sheet information for a resident, complete as many version 2.0 Face Sheet items as can be completed. Some information, such as customary routine, may not be known or obtainable. Use the standard "no information" code (circled dash or "NA") where information is unobtainable.

C. Full Assessment Form.--This form contains Sections A (Identification and Background Information) through Section R (Assessment Information). Completion of the *Full Assessment* form is required more frequently for those residents whose stay is being paid by Medicare Part A. Section T (Therapy Supplement for Medicare PPS) is required for residents whose stay is covered by Medicare Part A any time completion of a Medicare PPS assessment is required.

Some States may also require assessments to be conducted outside of the schedule of Federally-required assessments for payment or quality monitoring purposes. Contact your State RAI representative if you have any questions about when assessments are required. Additional MDS items (if any) required by your State appear in Section S. States may also require facilities to complete Sections T (Therapy Supplement) or U (Medication Information) for all residents.

D. Comprehensive Assessment.--By statute, a comprehensive assessment (the full MDS assessment form, RAPs, and care plan review) must be completed on admission, annually, and at the time of significant change in resident status. Facilities are required to complete the RAI within 14 days of admission, no later than within 14 days of a significant change in a resident's status and at least annually. The RAI must also be completed within 14 days of the identification of a major, uncorrected error in a prior, comprehensive assessment. In this case, the primary reason for assessment (MDS Item AA 8a) is coded 4, "Significant Correction of Prior Full Assessment". The registered nurse must sign and date the RAP Summary Form to signify that the assessment is complete. The dates on the MDS and RAP Summary Form must be within required timeframes (i.e., within 14 days of admission and annually) or within 14 days of determining a significant change in status or identifying a major, uncorrected error in a prior, comprehensive assessment. Facilities remain responsible for providing necessary care and services while completing the assessment documentation.

E. MDS Version 2.0 Quarterly Assessment Form--This two page form contains a mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for quarterly assessment within each State's RAI. The Quarterly Assessment is to be completed no less frequently than once every 3 months between comprehensive assessments. The quarterly assessment must also be completed within 14 days of the identification of a major, uncorrected error in a prior quarterly assessment. In this case, the primary reason for assessment (MDS Item AA8a) is coded 10, "Significant Correction of Prior Quarterly Assessment".

Some States have mandated an expanded *Optional Quarterly Assessment Form.* HCFA has published two optional versions that States may require: the three page MDS Quarterly Assessment Form (Optional Version for RUG III) or the three page MDS Quarterly Assessment Form (Optional Version for Resource Utilization Groups (RUGs) (RUG III 1997 Update). A State may also specify

a full assessment on a quarterly basis (or any set of MDS items that, as a minimum, include those on the standard 2 page quarterly assessment form, with the addition of other MDS items up to and including the full assessment, with or without RAPs or with or without sections S, T and/or U.)

F. RAP Summary Form.--Considered Section V of the MDS, this form is used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A *RAP Summary Form* must be completed each time a comprehensive RAI is required under the Federal schedule.

Some States require completion of the full MDS each quarter or more frequently for payment or quality monitoring purposes. Generally, the RAP Summary Form does not need to be completed on these occasions, unless specifically directed by the State. Check with your State to determine if RAPs are required for any State-required assessments.

G. MDS Correction Request Form.--This form is part of Correction Policy, which provides a mechanism for facility-driven electronic corrections to erroneous information that has been previously submitted and accepted into the MDS database at the State. This form must be completed by the facility, in accordance with the guidelines for Correction Policy in Part IV of Appendix R, within 14 days of detecting an inaccuracy in an MDS record (assessment, Discharge or Reentry Tracking Form) that resides in the MDS database at the State. This form should only be used to request corrections to records that actually have been accepted and reside in the State database. The standard MDS system at the State will not recognize and will reject a correction request for a record that has not yet been submitted, or for a record that has been submitted, but rejected. The MDS Correction Request Form contains a Prior Record Section and a Correction Attestation Section. The Prior Record Section contains Items Prior AA1 - Prior AA3, Prior AA5, Prior AA8, Prior A3, Prior R4, and Prior A4a. Information in this Section is reproduced exactly as it appeared in the corresponding items on the prior, erroneous record, and is necessary in order to locate the erroneous record in the State database. The Correction Attestation Section contains Items AT1-AT7. This Section provides a mechanism to describe the reason for the correction request; identify the action required (modification or inactivation); and attest to the accuracy of the Correction Request Form, as well as the corrected information.

2. Discharge and Reentry Tracking Forms.--Facilities are required to submit the information contained on two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the *Discharge Tracking Form* and the *Reentry Tracking Form* contain Section AA (Identification Information) Items 1 through 7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The *Discharge Tracking Form* also contains items from Section R related to discharge status and date, along with two items that are required only for individuals whose stay is less than 14 days. The *Reentry Tracking Form* contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms.

A. The Discharge Tracking Form.--This form includes Section AA (Identification Information) Items 1-9, but *only the 3 discharge codes from Item 8, Reason for Assessment*. It also contains Items AB1-2, A6, and R3-4. This form must be completed when the resident dies or leaves the facility and is actually admitted to another health care facility, regardless of whether the long-term care facility formally discharges the resident. For example, a resident may be admitted to the hospital for a 3-day stay, but never discharged from the facility. In that case, the D*ischarge Tracking Form* must be completed. An exception to this requirement is when the resident is on a temporary visit home or another type of therapeutic or social leave. This requirement also does not apply to observational stays of less than 24 hours when the resident is not admitted to the hospital.

The requirement for completing the *Discharge Tracking Form* applies regardless of a facility's policy and procedure for discharge or opening and closing records, and regardless of how long the individual was a resident of the facility. Note that HCFA's definition of discharge may differ from your facility's own definition of discharge. Because there is so much variation in bed hold policies across States and facilities, HCFA was compelled to create a uniform way of defining discharge for the national assessment system.

The Discharge Tracking Form must be completed within 7 days of the date at MDS Item R4 (Discharge Date).

The Discharge Tracking Form must always be completed whenever the resident is formally discharged from the facility. There are two separate codes that differentiate whether or not the resident is expected to return to the facility. There is not a requirement to track the resident's status once a discharge form has been completed (whether or not return was anticipated) so there is not a Federal requirement for submission of additional information to the State, unless the resident returns to the facility.

Facilities must complete and submit to the State database, information on the Discharge Tracking Form for all individuals that have been admitted to the facility and then die, or are discharged for reasons other than a temporary visit home, regardless of how short the stay is. For individuals who have been discharged prior to the 14th day of their stay, and for whom an admission assessment was not completed, the facility must complete the two additional items on the Discharge Tracking Form, and use the code "8" at AA8a indicating "Discharged prior to completing initial assessment". The Discharge Tracking Form is the only form that must always be completed at the time of any discharge from the nursing home. Most of the items on the form are not clinical in nature, and can be completed by clerical staff. However, clinical staff should note the appropriate "Reason for Assessment" by entering a code of either "6. Discharged-return not anticipated;" "7. Discharged-return anticipated;" or "8. Discharged prior to completing initial assessment," for Item AA8a on the *Discharge Tracking Form*.

Refer to the "MDS 2.0 Discharge and Reentry Flowchart" (Exhibit 260) for more detailed guidance regarding when Discharge Tracking forms are required.

B. The Reentry Tracking Form.--This form includes Section AA (Identification Information) Items 1-9, but only one code (designating "Reentry") from Item 8, Reason for Assessment. It also contains Items A4a and b, and A6. This form is completed whenever a resident reenters the nursing home following temporary admission to a hospital or other health care setting, even if the resident's clinical record was not formally closed, and regardless of whether the resident was formally discharged from the facility. In this case, the facility should have submitted a Discharge Tracking Form when the individual was admitted to the other care setting. The State system must receive the Reentry tracking information in order to enter the resident back into the State database. The Reentry Tracking Form is the only form that must always be completed at the time of reentry to the facility following a temporary admission to a hospital or other health care setting. If the resident is discharged with return not anticipated, and then returns to the facility, a Reentry Tracking Form is not required. In this scenario, the resident is treated as a new admission and a new admission assessment is required.

The Reentry Tracking Form must be completed within 7 days of the date at MDS Item A4a (date of reentry).

There is one condition under which other forms shall accompany a *Reentry Tracking Form*. If the resident reenters the nursing home following a temporary admission to a hospital or other health care setting AND also meets significant change criteria, a comprehensive assessment must be completed,

which includes the MDS and RAPS. In this case, the facility should complete and submit a record for a *Reentry Tracking Form*, and a second record including a *Basic Assessment Tracking Form*, and a comprehensive assessment (with MDS Item AA8a coded as 3, significant change). In this scenario, enter a code of "9," Reentry for MDS Item AA8a (Reason for Assessment) on the Reentry Tracking Form; enter a code of "3," Significant Form; enter a code of "3," Significant Change Assessment for MDS Item AA8a (Reason for Assessment) on both the *Basic Assessment Tracking Form* and the *Full Assessment* Form. Completion of a Full Assessment may also be required by the State for payment purposes at times other than those required by Federal regulations at CFR Part 483.20.

Refer to the "MDS 2.0 Discharge and Reentry Flowchart" (Exhibit 260) for more detailed guidance regarding when Discharge Tracking forms are required.

3. The "Reason for Assessment" codes under MDS Items AA8a and A8a designate assessments required by Federal regulations related to comprehensive assessment. The codes under AA8b and A8b designate assessments required under Medicare PPS for patients whose stay is covered by Medicare, or by the State. Please note that there is no relationship between the codes in 8a and 8b, and that it is possible to select a code from both A8a or AA8a (Primary Reason for Assessment) and A8b or AA8b (Codes for Assessments Required for Medicare PPS or the State). For example, an individual receiving rehabilitation covered by Medicare may develop an acute condition, and be hospitalized. Upon return to the facility, a significant change in status assessment (A8a or AA8a=3) may be required if the individual meets the HCFA clinical criteria for a significant change. If a Medicare readmission/return assessment is also required (A8b or AA8b=5), a single assessment (with AA8a=3 and AA8b=5) can fulfill both requirements. The types of assessments and their corresponding reason for assessment codes are defined as follows:

o Admission Assessment, (Code 1).--In order to be in compliance with the requirements for Medicare or Medicaid certification, facilities must complete an Initial Admission Assessment, which is a comprehensive assessment including the MDS and the RAPs, within 14 days of a resident's admission to the facility. The facility may use either the Medicare 5-day or the Medicare 14-day assessment to meet the clinical requirement for completing and transmitting an Admission assessment provided it was completed as a comprehensive assessment (including MDS, RAPs and care plan). For example, if the Medicare 5-day assessment includes the RAPs, the "Primary Reason for Assessment" MDS item AA8a would be coded as an Admission assessment, and the MDS item AA8b would be coded as a Medicare 5 day assessment. If a facility is using the Medicare 14-day assessment to meet the Federal requirement for the Admission assessment, the assessment must be completed by day 14 of the resident's stay, regardless of the grace period that PPS rules permit.

o Annual Assessment, (Code 2).--A comprehensive reassessment required within 12 months of the most recent comprehensive assessment. If a resident is noted as having a significant change in status at the time of the annual assessment, use code "A8a=3" (significant change in status assessment); DO NOT code as an Annual Assessment.

o Significant Change in Status Assessment, (Code 3).--A comprehensive reassessment prompted by a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on the resident's health status, and requires interdisciplinary review or revision of the care plan, or both. When a resident experiences a significant change in status, the assessment must be completed by the end of the 14th calendar day following the date of determining that a significant change has occurred. The assessment clock is reset based on the completion date of the significant change in status assessment.

If, while completing a quarterly review assessment, it is noted that a significant change in status has occurred, facility staff should document the findings regarding significant change in the resident's clinical record, and proceed directly to completing a comprehensive assessment, rather than the quarterly review. The primary reason for assessment is to be coded as a significant change in status. In this case the comprehensive assessment satisfies the requirement for a quarterly review and the quarterly review does not need to be completed. The date of the significant change assessment may be later than the scheduled completion date of the quarterly review, because facility staff have until the end of the 14th calendar day following the date of determining that a significant change has occurred to complete the assessment.

o Significant Correction of Prior Full Assessment, (Code 4).--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an *uncorrected major error* is discovered in a prior comprehensive assessment (MDS Item AA8a=1,2,3 or 4). An error is *major* when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A *major error is uncorrected* when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of Prior Full assessment that has already been accepted into the State MDS database, or in a comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). It is not necessary to complete a new Significant Correction of Prior Full assessment if an assessment is already due or in progress that contains and will correct the item(s) in error.

A significant correction assessment uses a new observation period (as defined by a new Assessment Reference date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, in addition to completing a new assessment, (the Significant Correction assessment), the facility should also correct the assessment that was in error, by completing and submitting a correction request for the erroneous assessment. Refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

The significant correction of prior full assessment differs from a significant change in status assessment, in which there has been an actual significant change in the resident's health status. In any instance in which a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, the primary reason for assessment should be coded as a significant change in status. In the event of a significant change in status where there are also errors in a prior assessment already accepted into the State database, in addition to completing a significant change in status assessment, the facility should also correct the assessment that was in error by completing and submitting a correction request for that erroneous assessment.

o Quarterly Review Assessment, (Code 5).--The subset of MDS items required by the State which must be completed no less frequently than once every 3 months between comprehensive assessments. This assessment ensures that changes in the resident's status are noted, and can be incorporated into the care plan so that it remains current and meets the needs of the resident. If a significant change in status is noted at the time of a resident's quarterly review assessment, perform a comprehensive significant change in status assessment rather than a quarterly. Use code "A8a=3" (Significant Change in Status Assessment). DO NOT code as a Quarterly review assessment. In this case, a quarterly assessment need not be completed.

To minimize burden on facility staff, a full assessment that is completed to meet PPS requirements, may also be used to meet the clinical requirements at CFR Part 483.20 for completion of a Quarterly Review Assessment, as long as the Quarterly Review Assessment is completed no later than 92 days from the date at MDS Item R2b of the prior assessment, and the assessment includes at least the MDS items in the State-specified quarterly assessment. In this case, the "Primary Reason for Assessment" item on the assessment would be coded as a Quarterly Review Assessment (AA8a=5), and the Medicare reason for assessment at MDS Item AA8b would be coded appropriately.

o Discharged - Return Not Anticipated, (Code 6).--Use this code when a resident dies or is permanently discharged from a nursing home without the expectation that the resident will return. The following exception to HCFA's requirements for Discharge is allowable according to HCFA's standard edit specifications, but is not Federally required: A Discharge Tracking form that used code 7 (return anticipated) can be followed by an additional, subsequent Discharge tracking form using code 6 (return not specifications, but is not Federally required: A Discharge Tracking form that used code 7 (return anticipated) can be followed by an additional, subsequent Discharge tracking form using code 6 (return not anticipated), at the facility's option. This option can be used if, after the temporary discharge (with return anticipated), the facility gains knowledge that the resident will not return. Submission of a subsequent Discharge Tracking form may be required in some States for Medicaid program purposes.

o Discharged - Return Anticipated, (Code 7).--Use this code when a resident is temporarily discharged to a hospital (or other therapeutic setting). There is no federal requirement for a facility to track a resident following discharge, or to complete or submit an additional Discharge Tracking form when the likelihood of a resident's return changes after discharge. The facility is responsible for accurate coding of the Discharge Tracking form, including whether or not return is anticipated, based on what the facility knows to be true on the date of discharge. When the likelihood of return changes, subsequent to the discharge, the facility may at their option or per a State requirement, complete and submit an additional, subsequent Discharge Tracking form including current information regarding anticipation of return.

Inactivation of the original Discharge Tracking form and resubmission of the corrected information regarding anticipation of return is only appropriate when the facility can demonstrate that anticipation of return was, in fact, erroneously coded.

o Discharged Prior to Completing Initial Assessment, (Code 8).--Use this code when a resident dies or is discharged during the first 14 days of residency AND a comprehensive, Initial Admission assessment (including the full MDS form, RAPs and care plan review) has not been completed. In this case, the items in section AB on the discharge tracking form must also be completed.

o Reentry, (Code 9).--Use this code when a resident is readmitted after a temporary discharge to a hospital or other therapeutic setting.

o Significant Correction of Prior Quarterly Assessment, (Code 10).--A new Quarterly assessment is completed when an *uncorrected major error* is discovered in a prior Quarterly assessment. An error is *major* when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A *major error is uncorrected* when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of Prior Quarterly assessment is appropriate when an *uncorrected major error* is present in a Quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State

MDS database, or in a Quarterly assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). It is not necessary to complete a new Significant Correction of Prior Quarterly assessment if an assessment is already due or in progress that contains and will correct the item(s) in error.

A significant correction assessment uses a new observation period (as defined by a new Assessment Reference date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, in addition to completing a new assessment, (the Significant Correction assessment), the facility should also correct the assessment that was in error, by completing and submitting a correction request for the erroneous assessment. Refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

- NONE OF ABOVE, (Code 0).--Use this code when none of the codes in A8a or AA8a apply, but the facility is required to complete an assessment for Medicare PPS or by the State (i.e., for the assessment types referenced in Item A8b or AA8b). If "0" is entered at A8a or AA8a, a code must be selected from the list of types of assessments at A8b or AA8b.

4. Assessments Required for Medicare PPS or the State.--All Medicare assessments require at least the full MDS form and Section T. The following codes under MDS Items AA8b and A8b, with the exception of code "6", designate assessments required under Medicare PPS for residents whose stay is covered by Medicare. The "Other State Required Assessment" (code "6") is for State required, off-cycle assessments. Some States require additional detail regarding the type of State required assessment, which is included in the State's Section S.

- Medicare 5-day assessment, (Code 1)
- Medicare 30-day assessment, (Code 2)
- Medicare 60-day assessment, (Code 3)
- Medicare 90-day assessment, (Code 4)
- Medicare Readmission/return assessment, (Code 5)
- Other State required assessment, (Code 6)
- Medicare 14-day assessment, (Code 7)
- Other Medicare required assessment, (Code 8)

Note that it is possible to select a code from both MDS Items A8a or AA8a and A8b or AA8b (e.g., Item A8a or AA8a coded "3" for a Significant Change in Status Assessment, and MDS Item A8b or AA8b coded "3" for a Medicare 60-day assessment).

In addition to the forms for identification (Section AA) and background information (Sections AB, AC and AD), 19 sections, lettered from A to R and V, comprise the MDS. Each section contains one or more items labeled sequentially and corresponding definitions. For instance, the third item in Section B is labeled "B3", the fifth item in Section P is "P5".

Answer boxes differ by the type of response required for the MDS item. Annotate those items with a letter in the answer box with a check mark. For items which have a blank box, enter either a number, such as height or weight, or a pre-assigned code. Leave darkly shaded boxes blank. Answer all items unless the instructions tell you to skip over the next item (or several items). Leave skipped items blank. When responding to these items, follow the sequence as closely as possible. In cases where information is unavailable and despite continued investigation, the information WILL REMAIN UNAVAILABLE OR UNKNOWN, enter the code "NA" or a circled dash. When the MDS is entered into the computer the "NA" or a circled dash will be entered as a dash ("-").

Facilities are required to complete the RAI within 14 days of admission, no later than within 14 days of a significant change in a resident's status and at least annually. The registered nurse must sign and date the RAP Summary Form to signify that the assessment is complete. The dates on the MDS and RAP Summary Form must be within required timeframes (i.e., within 14 days of admission and annually) or within 14 days of determining a significant change in status. Facilities remain responsible for providing necessary care and services while completing the assessment documentation.

The next 23 pages (pages R-15 through R-15.22) are reserved for the September 2000 Update of the RAI, version 2.0.

An electronic copy of the September 2000 RAI forms, a detailed description of the revisions to the forms, and implementation instructions are posted at the HCFA website at "http://www.hcfa.gov/medicaid/mds 20", under "Manuals and Forms", then under "MDS 2.0 RAI", then under "Forms:" then "September 2000 Update to the MDS Resident Assessment Form. There are several download files in this section, including a file named MDS0900b.pdf. This file includes an electronic copy of all the September 2000 RAI forms. There is another file named MDSC900b.pdf, that contains a summary of the revisions to the September 2000 update forms, compared to the 1/30/98 update version. Another download file named mdsimple.pdf includes the implementation and transition rules for the September 2000 Update RAI.

CHANGES WITH THE SEPTEMBER 2000 UPDATE OF THE RAI

This document is named MdsC0900.pdf and is available on the HCFA world wide web site at:

http://www.hcfa.gov/medicaid/mds20/man-form.htm

This document describes (1) MDS Form Changes Implemented in the September 2000 Update and (2) Minor Revisions in the September 2000 Update (from the Draft August 2000 update).

A Draft, August 2000 update of the MDS 2.0 had previously been posted on the HCFA world wide web site. This draft version will not implemented. Instead, the September 2000 update will be implemented on September 1, 2000. The September 2000 update includes a few revisions to the Draft, August 2000 update.

MDS Form Changes Implemented in the September 2000 Update

The September 2000 update of the MDS Version 2.0 includes several form changes from the prior 1/30/98 Version of the MDS 2.0. These form changes are in keeping with the new MDS Correction Policy, and with the federal requirements, 42 CFR (h) (i) (1) and (2), for individual staff completing any portion of the RAI to sign and certify the accuracy of the portion(s) they completed. The revised forms will be implemented on September 1, 2000. At that time, facilities must adopt the revised forms and instructions for use. RAI form revisions include the following:

- The label of MDS Item AA9 is revised, and formal attestation language has been added above the signature lines. The identical change was made to Item AA9 as it appears on all tracking forms (The Basic Assessment Tracking form, the Discharge Tracking form and the Reentry Tracking form). Upon implementation of the revised forms, Item AA9 will be used to record signatures and dates of completion, as well as attestation of accuracy, for all parts of MDS full assessments, quarterly assessments, and tracking forms, from section AA and A through V. With implementation of the revised forms, signatures should be included at Item AA9 for these sections of the MDS, including sections T, U and V. States that have specified a Section S for use by facilities in the State may opt to require signatures for Section S at Item AA9. To accommodate the increased number of signatures that will likely be recorded at this Item, additional signature lines were added to Item AA9 on all tracking forms. With this revision, all signatures attesting to the accuracy of all MDS sections AA and A through V are consolidated at Item AA9.

- With consolidation of signatures for accuracy at Item AA9, section R has been simplified by removal of Items R2 c - h. That is, signatures for individual assessors (MDS Items R2 c - h) on the full MDS, and all federal standard Quarterly MDS assessment forms, have been omitted. Note that Items R2 a - b remain on the assessment forms. Items R2 a - b require the signature and date that the RN

Assessment Coordinator certifies overall completion of all portions of the MDS Sections A - R included in the record. The RN Assessment Coordinator signs and dates at Items R2 a - b when all other assessors have finished their portions of MDS Sections A - R. In Items R2 a - b, the RN Assessment Coordinator is not attesting to the accuracy of the portions of the assessment that were completed by other health professionals. Upon implementation of the revised forms, signatures and dates of individual staff certifying completion and accuracy of Items in Sections A - R should be recorded at Items AA9 a - l on the Basic Assessment Tracking form. Completion dates in AA9 a - l for sections A - R should be earlier than or the same as the overall completion date for these sections at R2 b.

- Section AD on the Background (Facesheet) Information form has been revised to also include the formal attestation language certifying the accuracy of the information on this form.

- A new, one-page MDS Correction Request Form is being implemented as part of the federally mandated RAI, to accommodate new MDS Correction Policy. The MDS Correction Request Form contains the minimum amount of information necessary to locate erroneous MDS records that reside in the MDS database at the State. Due to enhanced MDS record edits and rejections implemented with Correction Policy, the need for corrections, and for the use of the MDS Correction Request Form, should be rare. A temporary version of the Correction Request Form, labeled "Washington Pilot 10/14/1999", was implemented with the new MDS Correction Policy on May 22, 2000. Upon implementation of the September 2000 update of the MDS Version 2.0, facilities must switch from the temporary "Washington Pilot 10/14/1999" version of the MDS Correction Request Form to the September 2000 version, which includes formal attestation language and accompanying signature lines.

- The date at the bottom of all forms included in the federally mandated RAI is revised to reflect the current September 2000 update of the MDS version 2.0.

Minor Revisions in the September 2000 Update (from the Draft August 2000 Update)

The following minor revisions were made:

- Two revisions (highlighted below) were made in the attestation language in MDS Item AA9 on the Basic Assessment Tracking Form, the Discharge Tracking Form, and the Reentry Tracking Form; also in MDS Section AD on the Background (Facesheet) Information form; and also in MDS Item AT7 on the Correction Request Form:

Draft August 2000 Update language:

"…this information was collected in accordance with **all** Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that **patients** receive appropriate and quality care,…"

September 2000 Update revised language:

"…this information was collected in accordance with **applicable** Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that **residents** receive appropriate and quality care,…"

- The label for MDS Item R2 on the Full Assessment Form, the MDS Quarterly Assessment Form, the MDS Quarterly Assessment Form (Optional Version for RUG-III), and the MDS Quarterly Assessment Form (Optional Version for RUG-III 1997 Update) was revised as follows:

  Draft August 2000 Update label:

  "SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:"

  September 2000 Update revised label:

  "SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:"

- The date at the bottom of all forms included in the federally mandated RAI is revised to reflect the current September 2000 update of the MDS version 2.0.

SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident **received** during the last 7 days. Include scheduled medications that are used regularly, but less than weekly .

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
2. **Route of Administration (RA).** Code the Route of Administration using the following list:

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily (includes every 12 hrs)	QO=every other day
1H=(QH) every hour		4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other

4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) **per dose** administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength , and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes

B. Supplemental Coding Instructions and Common Definitions.--These instructions and additional explanations supplement the instructions and definitions found within the sections of the MDS. Some MDS items are self-explanatory and therefore do not include definitions in this section. The numbering and lettering correspond to the elements of the MDS.

AA. IDENTIFICATION INFORMATION

1. Resident Name.--Legal name. Print using the following format: first name, middle initial, last name.

2. Gender.--Enter "1" for Male or "2" for Female.

3. Birthdate.--Use all boxes to record date. For months and days with only one digit, place a zero in the first box. For example, March 3, 1918 should be recorded **0 3 - 0 3 - 1 9 1 8**

4. Race/Ethnicity.--Enter the race or ethnic category the resident uses to identify him/herself.

5. Social Security and Medicare Numbers.--Record resident identifier numbers. Begin writing one number per box starting with the left most box.

6. Social Security Number: If no Social Security number for the resident is available (e.g., if the resident is a recent immigrant or a child), enter the standard "no information" code, "NA," or a circled dash.

7. Medicare Number (or comparable railroad insurance number).--Enter the resident's Medicare number. This number occasionally changes with marital status. In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, a "C" is placed in the left most Medicare Number box, and the remaining numbers are entered, one digit per box, beginning with the second box.

8. Facility Provider Numbers.--Record the facility identification numbers assigned to the nursing home by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. Medicaid only facilities have a Federal as well as a State number. The Medicaid Federal number has a "letter" in the third box. The facility's Medicare and Medicaid numbers can be obtained from the facility's business office. Once you have these numbers, they apply to all residents of that facility. Begin writing in the left-hand box. Enter one digit per box.

9. Medicaid Number (if applicable).--This number is entered if the resident is a Medicaid recipient. Write one number per box, beginning in the left hand box. A "+" is entered in the left most box if the number is pending. If not applicable, enter "N" in the left most box.

10. Reasons for Assessment.--

11. Primary Reason for Assessment.--Document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. Most of the types of listed assessments require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI.

NOTE: Assessment type 5 (Quarterly Review Assessment) requires the assessor to complete only a limited number of MDS items.) Please note that it is possible to select a code from both A8a or AA8a (Primary Reason for Assessment) and A8b or AA8b (Special Medicare or State Codes).

12. Admission Assessment.--A comprehensive assessment using the MDS and RAPs required by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.

13. Annual Assessment.--A comprehensive reassessment required within 12 months of the most recent full assessment. If a significant change is noted during the course of conducting an annual assessment, code "3" (significant change in status assessment) and DO NOT code as an annual assessment.

14. Significant Change in Status Assessment.--A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.

15. Significant Correction of Prior Full Assessment.--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an uncorrected major error is discovered in a comprehensive assessment (MDS Item AA8a=1,2,3 or 4) that has already been accepted into the State MDS database, or in a prior comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Full Assessment, (Code 4)", earlier in Part II of this State Operations Manual.

16. Quarterly Review Assessment.--The subset of MDS items specified on the State-specified Quarterly Review Form, which must be completed no less frequently than once every 3 months (i.e., between required full assessments). Additionally, Section AA must be completed as part of the quarterly review requirement.

17. None Of Above.--This code is used to indicate that the assessment has been completed to comply with Medicare or State-specific requirements (e.g., case-mix payment).

18. Significant Correction of Prior Quarterly Assessment.--A new quarterly assessment is completed when an uncorrected major error is discovered in a prior quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State MDS database, or in a quarterly assessment that was completed 8 or more days ago (date at MDS item R2b) but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Quarterly Assessment, (Code 10)," earlier in Part II of this State Operations Manual.

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

a. Medicare 5 day assessment (Code 1)

b. Medicare 30 day assessment (Code 2)

c. Medicare 60 day assessment (Code 3)

d. Medicare 90 day assessment (Code 4)

e. Medicare readmission/return assessment (Code 5)

f. Other State required assessment (Code 6).--

g. Medicare 14 day assessment (Code 7).--

h. Other Medicare required assessment (Code 8).--

20. Signatures of Persons Who Completed a Portion of the Accompanying Assessment or Tracking Form.--Upon implementation of the September, 2000 update of the RAI, version 2.0, individual staff members who complete any portion of an MDS assessment or tracking form (Sections AA, and A - V (including Sections T and U)) must sign and date at Items AA9 a - l, and indicate beside their signature the portion(s) they completed. Two or more staff members can complete Items within the same section of the MDS. In that case, the individual assessors must indicate the range of Items that they completed in that section. Signature at Items AA9 a - l certifies the accuracy of the portion of the assessment or tracking form completed by the individual assessor. States that have specified Section S for use by facilities in the State may opt to require signatures for Section S at Item AA9.

SECTION AB.--DEMOGRAPHIC INFORMATION

1. Date of Entry.--Normally, the MDS Face Sheet is completed once, when an individual first enters the facility. This is the date the person first became a resident in this facility. However, the face sheet is also required if the person is reentering this facility after a discharge where return had not previously been expected. It is not completed following temporary discharges to hospitals or after therapeutic leaves/ home visits. The date of entry is the date the resident entered the facility for care, regardless of how the facility chooses to "open" or "close" its medical records during the course of the stay.

2. Date the Stay Began.--The date the resident was most recently admitted to this facility.

3. Admitted From (At Entry).--The place from which the resident was admitted to the nursing home on the date given in item AB1.

4. 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.

5. Home Health Services.--Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

6. Assisted Living.--A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

7. Other.--Includes psychiatric facilities, hospices, rehabilitation and chronic disease hospitals.

8. Lived Alone (Prior to Entry).--To document the resident's living arrangements prior to admission.

9. In Other Facility.--Any institutional/supportive setting, such as a nursing home, group home, sheltered care, board and care home.

10. Zip Code of Prior Primary Residence.--A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to the facility from another nursing home or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing home, etc.

11. Residential History 5 Years Prior to Entry.--Document the resident's previous experience living in institutional or group settings. Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1.). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to. If the resident has not lived in any of these settings in the past five years, check "NONE OF ABOVE".

12. Prior Stay at This Nursing Home.--Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

13. Stay in Other Nursing Home.--Prior stay in one or more nursing homes other than current facility.

14. Other Residential Facility.----Examples include board and care home, group home, and assisted living.

15. Mental Health/Psychiatric Setting.--Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

16. Mental Retardation/Developmental Disabilities (MR/DD) Setting.--Examples include mental retardation or developmental disabilities facility (including MR/DD institutions), intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

17. Lifetime Occupation.--Identify the resident's role or past role in life and to establish familiarity in how staff should address the resident. Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box. When two occupations are identified, place a slash (/) between each occupation.

18. Education (Highest Level Completed).--Record the highest level of education the resident attained.

19. Technical or Trade School.--Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

20. Some College.--Includes completion of some college courses, junior (community) college, or associate's degree.

21. Bachelor's Degree.--Includes any undergraduate bachelor's level college degree.

22. Graduate Degree.--Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

23. Language - Primary Language.--The language the resident primarily speaks or understands.

24. Mental Health History.--To document a primary or secondary diagnosis of psychiatric illness or developmental disability. Review the resident's record only. There must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient). Resident has one of the following:

- o A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- o Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;
- o The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;
- o The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

25. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities).--Document conditions associated with mental retardation or developmental disabilities.

26. Other Organic Condition Related to MR/DD.--Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.

27. Date Background Information Completed.--Enter date that background information sheet is originally completed. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item should then reflect the date that new information is recorded or existing information is revised.

AC.--CUSTOMARY ROUTINE

Goes out 1+ days a week - Went outside for any reason (e.g., socialization, fresh air, clinic visit).

Use of tobacco products at least daily - Smoked any type of tobacco (e.g., cigarettes, cigars, pipe) at least once daily. This item also includes sniffing or chewing tobacco.

Distinct food preferences - This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread). Do not check this item for simple likes and dislikes.

Use of alcoholic beverage(s) at least weekly - Drank at least one alcoholic drink per week.

Wakens to toilet all or most nights - Awoke to use the toilet at least once during the night all or most of the time.

Has irregular bowel movement pattern - Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

Bathing in PM - Took shower or bath in the evening.

Daily contact with relatives/close friends - Includes visits and telephone calls. Does not include exchange of letters only.

Usually attends church, temple, synagogue (etc.) - Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

Daily animal companion/presence - Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

Unknown - If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, the last box in the category ("UNKNOWN"), is checked. All other boxes in Section AC are blank.

AD.--FACE SHEET SIGNATURES

a. Signature of RN Assessment Coordinator: The RN Assessment Coordinator who worked on the Background (Face Sheet) Information at Admission sections of the MDS enters his or her signature on the day this part of the MDS form is complete. Also, to the right of the name, the date the form was signed is entered.

b-g Signature of Others Who Completed Part of Background Assessment Sections AB and AC: Other staff who completed parts of the Background sections of the MDS enter their signatures, the sections they completed, and the day they completed their assigned sections. Signature at Items AD b-g certifies the accuracy of the portion of the Face Sheet completed by the individual assessor.

SECTION A.--IDENTIFICATION AND BACKGROUND INFORMATION

1. Resident Name: Legal name in record.

2. Room Number: Number of resident's room in facility.

3. Assessment Reference Date: To establish a common temporal reference point for all staff participating in the resident's assessment. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period (i.e., "starting the clock" so that all assessment items refer to the resident's objective performance and health status during the same period of time).

a. Last Day of MDS Observation Period: This date refers to a specific end-point in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period, most frequently the seven day period ending on this date. The date sets the designated endpoint of the common observation period, and all MDS items refer back in time from this point. Some cover the seven days ending on this day, some 14 days prior, some 30 days prior, and so forth. The first coding task is to enter the observation reference date (i.e., the end point date of the observation period). For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for completing the admission assessment). For a follow-up assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all MDS items must refer.

b. Original (0) or Corrected Copy of Form (enter number of corrections): This item is inactive in the MDS system at the State.

4. Date of Reentry: To track the date of the resident's readmission to the facility following a temporary discharge. The date the resident was most recently readmitted to the facility after being temporarily discharged for hospital stay in last 90 days (or since last assessment or admission if less than 90 days).

5. Marital Status: Choose the answer that describes the current marital status of the resident.

6. Medical Record Number: This number is the unique identifier assigned by the facility for the resident.

7. Per diem - Room, board, nursing care, activities, and services included in the routine daily charge.

8. Current Payment Source(s) for Nursing Home Stay: To determine payment source(s) that cover the daily per diem and ancillary services for the resident's stay in the nursing facility over the last 30 days.

9. Ancillary: Services such as medications, equipment for treatments or supplies billed outside of the daily routine per diem charge.

10. Self (or family) Pays - Full: Includes full private pay by resident or family.

11. Self (or family) Pays - Co-Pay: The resident is responsible for a co-payment.

12. Private Insurance: The resident's private insurance company is covering daily charges.

13. Other: Examples include Commission for the Blind, Alzheimer's Association.

14. Reasons for Assessment:

A. Primary Reason for Assessment.--Document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. Most of the types of listed assessments require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI. [Note -- assessment type 5 (quarterly review assessment) requires the assessor to complete only a limited number of MDS items.] Note that it is possible to select a code from both MDS Item AA8a (Primary Reason for Assessment) and MDS Item AA8b (Special Medicare or State Codes).

1. Admission Assessment.--A comprehensive assessment using the MDS and RAPs required by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.

2. Annual Assessment.--A comprehensive reassessment required within 12 months of the most recent full assessment. If a significant change is noted during the course of conducting an annual assessment, code "3" (significant change in status assessment) and DO NOT code as an annual assessment.

3. Significant Change in Status Assessment.--A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.

4. Significant Correction of Prior Full Assessment.--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an uncorrected major error is discovered in a prior comprehensive assessment (MDS Item AA8a=1,2,3 or 4) that has already been accepted into the State MDS database, or in a comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Full Assessment, (Code 4)," earlier in Part II of this State Operations Manual.

5. Quarterly Review Assessment.--The subset of MDS items specified on the State-specified Quarterly Review form, which must be completed no less frequently than once every 3 months (i.e., between required full assessments). Additionally, Section AA must be completed as part of the quarterly review requirement.

6. Discharged - Return Not Anticipated.--This code is used whenever a resident is permanently discharged from a nursing facility. This is a means of "closing" the record of any resident at the point of discharge from the facility (without an anticipated return).

7. Discharged - Return Anticipated.--This code is used when a resident is temporarily discharged to a hospital or other therapeutic setting

8. Discharged Prior to Completing Initial Assessment.--This code is used when the resident is discharged during the first 14 days of residency and the comprehensive, Initial Admission assessment (MDS Item AA8a=1), including the RAPs, has not been completed. A subset of information is entered for all residents regardless of length of stay in the long-term care facility.

9. Reentry.--A subset of MDS items must be completed for residents "reentering" the facility after a temporary absence (other than a therapeutic leave) in order to reenter the resident into the State database.

10. Significant Correction of Prior Quarterly Assessment.-- A new quarterly assessment is completed when an uncorrected major error is discovered in a prior quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State MDS database, or in a quarterly assessment that was completed 8 or more days ago (date at MDS item R2b) but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Quarterly Assessment (Code 10)," earlier in Part II of this State Operations Manual.

11. None Of Above.--This code is used for Section A to indicate that the assessment has been completed to comply with Medicare or State-specific requirements (e.g., case-mix payment).

B. MDS item codes for assessments required for Medicare PPS or the State.--

Medicare 5 day assessment, (Code 1)

Medicare 30 day assessment, (Code 2)

Medicare 60 day assessment, (Code 3)

Medicare 90 day assessment, (Code 4)

Readmission/return assessment, (Code 5)

Other State required assessment, (Code 6).

Medicare 14 day assessment, (Code 7)

Other Medicare required assessment, (Code 8)

Note that it is possible to select a code from both MDS Items A8a and A8b (e.g., Item A8a coded "3" for a Significant Change in Status assessment, and MDS Item A8b coded "3" for a Medicare 60-day assessment).

1. Responsibility/Legal Guardian.--Record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending on the resident's condition, multiple options may apply. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification. Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

SECTION R.--SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT

2. Signatures of Persons Coordinating the Assessment.--The RN Assessment Coordinator signs and dates at Items R2a-b, certifying completion of all portions of the MDS Sections A-R included in the MDS record. The RN Assessment Coordinator must not sign and attest to completion of the assessment until after all other assessors have completed their portions of the MDS, and signed, certifying completion and accuracy. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

THE MDS CORRECTION REQUEST FORM

The federal requirements for use of the MDS Correction Request Form, as part of MDS Correction Policy, are specified in Part IV of Appendix R. The Correction Request Form includes two sections; the Prior Record Section (Prior AA), and the Correction Attestation Section (AT).

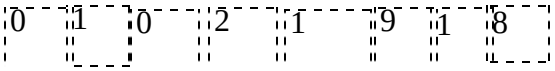
PRIOR_AA. PRIOR RECORD SECTION

The Prior Record Section is used to locate the erroneous assessment or tracking form record in the State database. Obtain the information for this section from the previously submitted, erroneous assessment or tracking form. Record the information ***exactly as submitted and accepted into the State database***, **even if it was wrong**. For example: The MDS assessment was submitted and accepted for Joan L. Smith. When the encoder "key entered" the assessment, he typed "John" by mistake. To correct this error, the facility should complete a Correction Request Form and a corrected assessment form. When completing the Resident's Name Item in the Prior Record Section of the Correction Request Form, "John" should be entered. This will permit the State system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" were entered, the State system would not be able to locate the prior assessment.

Prior_AA1. Resident Name: Enter the resident's name exactly as submitted in MDS item AA1on the prior, erroneous record.

Prior_AA2. Gender: Enter the gender code exactly as submitted in MDS item AA2 on the prior, erroneous record.

Prior_AA3. Birthdate: Fill in the boxes with the appropriate date exactly as submitted in MDS item AA3 on the prior, erroneous record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, January 2, 1918, should be entered as:

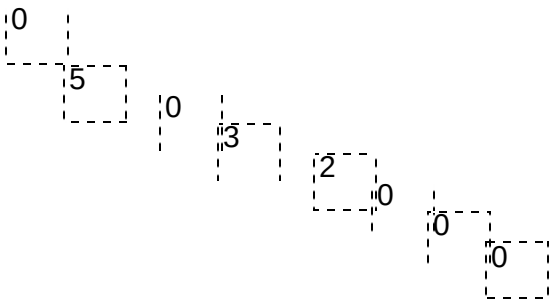


Prior_AA5a. Social Security Number: Fill in the boxes with the resident's social security number exactly as submitted in MDS item AA3 on the prior, erroneous record. Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

Prior_AA8a. Primary Reason for Assessment: Enter the two digit code corresponding to the primary reason for assessment exactly as submitted in MDS item AA8a on the prior, erroneous record.

Prior_AA8b. Codes for Assessments Required for Medicare PPS or the State: Enter the one digit code corresponding to the special Medicare PPS or State reason for assessment exactly as submitted in MDS item AA8b on the prior, erroneous record. If this item was blank on the prior, erroneous assessment, then it should be blank on this item on the Correction Request.

PRIOR_DATE. (Complete one *ONLY*) -- This section is used to document the reference date for the prior record. If the prior, erroneous record is an assessment, complete the PRIOR_A3a Assessment Reference Date only. If the prior record is a discharge tracking form, complete the PRIOR_R4 Discharge Date only. If the prior record is a reentry tracking form, complete the PRIOR_A4a date of reentry only. Fill in the boxes with the appropriate date exactly as submitted on the prior, erroneous assessment or tracking form record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, May 3, 2000 should be entered as:



Prior_A3a. Assessment Reference Date: If the prior, erroneous record was an assessment (PRIOR_AA8a equals 01, 02, 03, 04, 05, 10, or 00), enter the Assessment Reference Date exactly as submitted in the prior MDS item A3a. Leave blank if the prior record was a discharge or reentry (PRIOR_AA8a is equal to 06, 07, 08, or 09).

Prior_R4. Discharge Date: If the prior, erroneous record was a Discharge Tracking Form (Prior_AA8a equals 06, 07, or 08), enter the Discharge Date exactly as submitted in the prior MDS item R4. Leave blank if the prior record was an assessment or reentry (PRIOR_AA8a equals 01, 02, 03, 04, 05, 09, 10, or 00).

Prior_A4a. Date of Reentry: If the prior, erroneous record was a Reentry Tracking form (PRIOR_A4a equals 09), enter the date of reentry exactly as submitted in the prior MDS item A4a. Leave blank if the prior record was an assessment or discharge (PRIOR_AA8a equals 01, 02, 03, 04, 05, 06, 07, 08, 10, or 00).

AT. CORRECTION ATTESTATION SECTION

The Correction Attestation Section is used to collect attestation information; and to describe the reason for the correction request and whether the request is to modify or to inactivate an MDS assessment or tracking form record that has been previously submitted and accepted by the State database.

AT1.Attestation Sequence Number: Item AT1 identifies the total number of correction requests following the original assessment or tracking record, including the present request. This item is used to track successive correction requests. Note that prior to implementation of the Correction Request Form, MDS Item A3b was intended for this purpose. With the inclusion of Item AT1 on the Correction Request Form, MDS Item A3b will not be needed and has been made inactive in the standard system at the State. For the first correction request for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, AT1 is incremented by one. For values between one and nine, a leading zero should be used in the first box.

AT2.Action Requested: This Item is used to identify whether the correction request is being submitted to modify or to inactivate a prior, erroneous assessment or tracking form. Enter "1" if the action requested is to MODIFY an assessment or tracking form. Enter "2" if the requested action is to INACTIVATE an assessment or tracking form.

AT3.Reasons for Modification: This Item is used to identify the reason(s) for the error(s) that require modification of the prior, erroneous assessment or tracking form record that has been previously submitted and accepted by the State database. If the Action Requested at Item AT2 was "1" (Modify), then check all that apply at Item AT3. Leave all of AT3 blank and proceed to Item AT4, if Item AT2 was coded "2" (Inactivate). Definitions and examples of Reasons for Modification are as follows:

a. Transcription Error.--Includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the patient's weight (e.g., recording "191" rather than the correct weight of "119" that appears in the medical record).

b. Data Entry Error.--Includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is a "key punching" error where the response to a minutes of therapy item (P1b) is incorrectly encoded as "3000" minutes rather than the correct number of "0030" minutes recorded on the MDS form.

c. Software Product Error.--Includes any error created by the encoding software, such as, "storing" an item with the wrong format (e.g., misplacing the decimal point in an ICD-9 code in item I3) or "storing" an item in the wrong position in an electronic MDS record.

d. Item Coding Error.--Includes any error made coding an MDS item, such as choosing an incorrect code for an ADL self-performance item in G1 (e.g., choosing a code of "4" in G1aA for a resident who requires limited assistance and should be coded as "2"). Item coding errors may result when an assessor makes an incorrect judgement or misunderstands the RAI coding instructions.

e. Other Error.--Includes any other reason for error that causes a prior assessment or tracking form record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided on the form.

AT4. Reasons for Inactivation: This item is used to identify the reason(s) requiring inactivation of an invalid assessment or tracking form record that has been previously submitted and accepted into the MDS database at the State. If the Action Requested at Item AT2 was "2" (Inactivate), then check all that apply at Item AT4. Leave all of AT4 blank and complete Item AT3, if Item AT2 was coded "1" (Modify). Definitions and examples of Reasons for Inactivation are as follows:

a. Test Record Submitted as a Production Record.--An example is a fictitious assessment or tracking form record which was fabricated to test a software product and then inadvertently submitted to the State as a production record.

b. Event Did Not Occur.--Includes submission of an assessment or tracking form record describing an event that did not occur. The event did not occur if *any* of the following conditions apply:

1) The record submitted does not correspond to an actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was *no event*.

2) The record submitted identifies the *wrong resident*. For example, a discharge tracking form was completed and submitted for the wrong person.

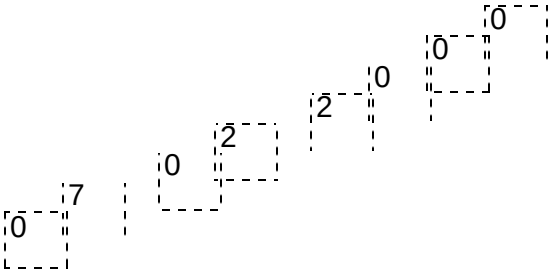
3) The record submitted identifies the *wrong reasons for assessment*. For example, a Reentry Tracking Form was submitted when the resident was discharged.

c. Inadvertent Submission of Inappropriate Record.--An example would be submission of a *non-required* assessment performed for an "in-house" quality improvement or quality assurance program being conducted by the facility.

d. Other Reason Requiring Inactivation.--Includes any other reason for error that causes a prior assessment or tracking form record to require inactivation under the Correction Policy. Facility staff should describe the "other error" in the space provided on the form.

AT5. Name: Enter the name of the RN Assessment Coordinator attesting to the completion of the MDS Correction Request Form, and corrected information. Begin with the first name (at Item AT5a), followed by the last name (at Item AT5b), and then their title (at Item AT5c). In addition, when the form is complete, the RN Assessment Coordinator must sign a hard copy of the Correction Request Form, certifying completion.

AT6. Date: Enter the date the facility staff certified the completion and accuracy. Do not leave any boxes blank. For a one digit month or day, place a zero in the first box. For example, July 2, 2000, should be entered as:



AT7 Attestation of Accuracy and Signatures of Persons Who Correct a Portion of Assessment or Tracking Information: Individuals who correct any portion of an MDS record or complete any portion of the MDS Correction Request Form must sign and date a hard copy of the MDS Correction Request form, indicating their title beside their signature. Signature certifies the completion and accuracy of information they corrected, and the portion(s) of the MDS Correction Request Form they completed.

PART IV. LONG TERM CARE MINIMUM DATA SET (MDS) AUTOMATION REQUIREMENTS

The Final Rule, HCFA-2180-F, "Medicare and Medicaid; Resident Assessment in Long Term Care Facilities", sets forth new conditions of participation that, as of June 22, 1998 require all Medicare or Medicaid-certified facilities, as defined in CFR 483.5, to establish a database of resident assessment information for every resident in the facility, regardless of their payor source, and then electronically send that information to the State.

A. Definitions.--

Encoding means entering MDS information into a computer.

Passing standard edits means that the responses to MDS and RAP summary (where applicable) items are encoded in accordance with HCFA specified standards. The Standard MDS system at the State will reject (not accept into the State database) an MDS record (assessment, Discharge or Reentry Tracking Form or correction Request Form) that contains any out of range values (e.g., item coded 5 when valid responses are 1, 2, 3 or 4); that contains selected inconsistencies between item responses (e.g., skip pattern ignored); that omits critical information (e.g., information that identifies the facility, the resident, or the type of record); that contains impossible date relationships (e.g., admission earlier than birthdate); that involve miscalculations for selected items (e.g., a miscalculated RAP trigger); or that violates selected formatting requirements (e.g., a misplaced decimal in an ICD-9 diagnosis code); or that is a duplicate of a record that already exists in the State MDS database. The fatal record edit for out of range values applies to most, but not all MDS Items. Other edits will result in non-fatal record errors, (the record will not be rejected), for example: errors involving timing between assessments and assessments out of sequence; errors involving certain formatting requirements, such as text entries that are not upper case; and certain calculated items, such as RUGs. In accordance with the final rule, facilities are responsible to edit the encoded MDS data to ensure that it meets HCFA's standard edit specifications.

Within the time period specified for editing and revision as detailed below, and in Exhibit 263, "Maximum Time Frames for MDS Completion, Data Entry, Editing and Transmission", the facility must edit MDS information using standard HCFA-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the State system. After editing and revision, MDS information and RAP summary information (if applicable) must always accurately reflect the resident's status as of the original Assessment Reference Date for an assessment or the event date for a discharge or reentry.

The time frames for editing and revision of MDS records are within 7 days of completing a comprehensive assessment (the date at MDS item VB4), within 7 days of completing an assessment that is not comprehensive (the date at MDS item R2b), within 7 days of a discharge event (the date at MDS item R4), within 7 days of a reentry event (the date at MDS item A4a), or within 7 days of completing a Correction Request Form (the date at MDS item AT6).

After the end of the editing and revision process (7 days after final completion of an assessment or 7 days after the event for a discharge or reentry), MDS records found to be in error should be corrected using the correction policy for MDS Records below. The MDS vendor software used at standard edit specifications are published on our website at www.hcfa.gov/medicaid/mds20, under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files". We encourage facilities to use software that has a programmed capability to automatically edit MDS records according to HCFA's edit specifications.

Capable of transmitting means that the facility has encoded and edited according to HCFA specifications and the record is ready for electronic transmission.

Electronic transmission refers to electronically sending encoded MDS information, from the facility to the State database, using a modem and communications software.

Monthly means no more than 31 days.

B. Required MDS Records.--The requirement to encode and electronically transmit MDS data from the facility to the State MDS database applies to all Federally required resident assessments, including MDS forms (Sections AA through R, and V - the RAP Summary Form), Quarterly Review Forms, and Discharge and Reentry Tracking Forms. Facilities are responsible to electronically transmit to the State all required assessments as they become due (regardless of assessment type) as well as any Discharge and Reentry Tracking Forms. Version 2.0 Face Sheet information must also be transmitted. On an ongoing basis, Background (Face Sheet) information is completed and transmitted with every admission assessment. There is an additional Background (Face Sheet) requirement when the facility first begins transmissions to the State. For residents already in the facility when transmissions to the State begin, background (Face Sheet) information must also be included and transmitted with the first MDS assessment of any type (not including Discharge or Reentry Tracking Forms). States may have additional specifications regarding completion and submission of assessments. There is not a Federal requirement for transmission of historic assessments (e.g., completed prior to the effective date of requirement to encode and transmit data.

The MDS system at the State checks records against HCFA data specifications and against prior records submitted, and makes a determination regarding whether the sequence of assessment types received for each resident is valid. For example, following a comprehensive assessment, the system would expect a series of three Quarterly assessments, no later than 92 days apart, followed by an annual assessment, no later than 366 days from the completion date of the last comprehensive assessment (based on the date at MDS item VB4), unless the system is notified otherwise, (e.g., via receipt of a Significant Change Assessment or a Discharge Tracking Form).

C. Correction Policy for MDS Records.--On May 22, 2000, HCFA implemented, by incorporation into the MDS standard system, two separate system enhancements designed to improve the accuracy of information in the State MDS databases. The first system enhancement involves the refinement of the MDS record editing process in the standard MDS system to include stricter enforcement of existing edits. The second enhancement involves a new mechanism to enable facilities to submit electronic requests to correct any type of errors in MDS records that reside in the State database. This new correction mechanism involves the use of an MDS Correction Request Form to allow either modification or inactivation of a record that has actually been accepted into the State database. As a direct result of the enhanced editing and record rejection process, very few records with errors will be accepted by the State MDS system, and the need for corrections should be rare.

Prior to implementation of Correction Policy, facilities had no easy mechanism of making corrections to erroneous data in their MDS records in the State database. However, State Agency staff had the capability to change data in facility MDS records at the State, at the facility's request. The new mechanism enabling facilities to make electronic corrections to their MDS records in the State MDS database eliminates the need for States to make corrections to facilities' records. This new, facility-driven correction mechanism (incorporated into the standard MDS system May 22, 2000), along with the formal attestation requirements (implemented September 1, 2000, along with the accompanying) make facilities solely accountable for any changes to their MDS records in the State database. Therefore, upon the introduction of Correction Policy and formal attestation requirements, States' ability to change information in facility records in the State database will be phased-out. States may not accept or act on requests for manual corrections from facilities that are dated after May 21, 2000; and States must clear any back-log of requests for manual corrections by September 1, 2000.

The Correction Policy Flowchart (Exhibit 262) depicts the sequential decision-making and action steps for facility staff to follow when an error is detected in an MDS assessment, Discharge Tracking form, or Reentry Tracking form. In this flowchart, the diamond shapes represent decisions that facility staff must make about the type of error(s), and the solid rectangles represent the corrective action a facility should take. There is a code number to the right of each solid rectangle to allow reference to that corrective action. For example, the corrective action "Send Inact. [Inactivation] Request to State" is labeled as corrective action "***1***". The flowchart can be thought of as a "decision tree", and in that sense, it is a useful tool for determining appropriate corrective actions. There are nine different paths through the decision tree, each path being associated with a scenario involving specific facility actions. Each path involves one or two corrective actions. These paths or scenarios are labeled with the code numbers of the actions involved. For example, the left most path (involving action "1" only) is referred to as "Scenario 1". Similarly, the right most path (involving both actions "4" and "5") is referred to as "Scenario 4/5".

1. Errors in MDS Records in the State MDS Database.--When an error is detected in an MDS record that has already been submitted and accepted into the MDS database at the State, facility staff should submit a request to correct the error(s) to the State, using an electronic MDS record which includes Correction Request Form information. The Correction Request Form information is used primarily to locate the erroneous record in the State database. It is also used to indicate whether the record in error requires Inactivation or Modification.

For a modification, both the information on the Correction Request Form and the corrected assessment or tracking form is encoded into a single, electronic submission record according to HCFA's standard MDS Data Specifications. This submission record includes data from the entire, corrected MDS assessment or tracking form, not just the corrected values for the items that were in error.

For an inactivation, the facility encodes the information from the Correction Request Form into an electronic submission record according to HCFA's standard MDS Data Specifications. In this case, the submission record contains the correction request information only, and assessment or tracking form information must be blank. Exhibit 272, "Overview of MDS Submission Record", depicts the required contents of a submission record, depending on whether the record is an original record, an inactivation request, or a modification request.

a. Inactivating an Invalid MDS Record in the State MDS Database, Scenario 1.--A facility should inactivate a record in the State database when the record is invalid and should not actually have been submitted. Even if an invalid record in the State database contains other errors, this invalid record should not be modified. Any invalid record should be inactivated. A record is considered to be invalid in any of the following cases:

1) It was a test record inadvertently submitted as a production record.

2) The event did not occur.

a) The record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was no event.

b) The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.

c) The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking Form was submitted when the resident was discharged.

3) Inadvertent submission of an inappropriate, non-required record.

a) Modifying a Valid MDS Record in the State MDS Database.--A facility performs a Data Correction to modify a valid record that resides in the State database when the record is known to have data errors. Because a record is valid, it does not mean that it is error-free. One or more MDS Items in a valid record may have data errors. A record is considered to be valid if it meets all of the following conditions:

- It is not a test record.
- The record corresponds to an actual event.
- The record identifies the correct resident.
- The record identifies the correct reasons for assessment.
- The record is required to be submitted.

2. Tracking Form Error, Scenario 2.--For a tracking form error, the facility corrects a copy of the tracking form and also completes a Correction Request Form, indicating that the required action is modification. The facility transmits a submission record to the State.

3. Assessment Error: Determine Whether the Error Was Major and Uncorrected.--Modification of an MDS assessment does not necessarily insure a current, accurate view of the resident's overall clinical status, or the appropriateness of the current care plan. Even though an assessment is modified, a new Significant Correction or Significant Change assessment and an update to the care plan may also be required. A data correction cannot simply substitute for a "Significant Correction of Prior" or a "Significant Change in Status" assessment. To do so would jeopardize the clinical integrity of the MDS process.

One complication that can occur with the modification of a comprehensive assessment record is the possibility that RAPs will trigger differently (newly trigger, untrigger, or trigger for different reasons) as a result of changes made to the assessment record. Facilities should establish a procedure whereby RAPs are recalculated and submitted anytime corrections involving RAP trigger items are made to a comprehensive assessment record.

Whenever it is determined that an MDS assessment record in the State database requires modification, facility staff must make an additional determination regarding whether the error was major and was not corrected with a subsequent assessment. An error is major if the resident's

overall clinical status has been miscoded on the MDS assessment or if the care plan derived from the assessment does not suit the resident's needs. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan.

a. When the Assessment Error Was Not a Major Error or Has Been Corrected, Scenario 2/6.--If an assessment error was not major or if a major error has been corrected by a subsequent assessment, then the facility need only make a data correction and submit a correction request to modify the erroneous record in the database. There is no need for a new assessment to be performed.

b. When a Major Assessment Error Has Not Been Corrected on a Subsequent Assessment.--If the assessment error is major, and it has not been corrected on a subsequent assessment, the facility should complete and transmit both the correction request to modify the erroneous record in the database, and a new significant change or significant correction assessment, whichever is appropriate. Significant change in status assessments and significant correction of prior assessments are entirely new assessments of the resident, based upon a new Assessment Reference Date (MDS Item A3a).

4. No Significant Change in Status Has Occurred, Scenario 2/7.--The facility must also determine whether the resident's status has actually changed since the erroneous assessment was completed. If the resident has not experienced a significant change in status, in addition to submitting the modification request, the facility must also perform and transmit a significant correction of prior full or quarterly assessment, whichever is appropriate. If the assessment in error was a comprehensive assessment, requiring RAPs, Triggers and care plan review, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an admission, annual, significant change in status, significant correction of prior full), then a new significant correction of a prior full assessment must be completed, including RAPs, Triggers and care plan review. If the assessment in error was not a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a quarterly or significant correction of prior quarterly assessment), then a new significant correction of a prior quarterly assessment must be performed and submitted.

5. Significant Change in Status Has Occurred, Scenario 2/8.-If the assessment error is major, and it has not been corrected on a subsequent assessment, and the resident has experienced a significant change in status since the Assessment Reference Date (MDS Item A3a) of the original, erroneous assessment, then in addition to submitting a request to modify the erroneous assessment, the facility must also perform and transmit a significant change in status assessment. In any instance in which a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a significant change in status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred.

6. Errors in MDS Records That Are Not In the State MDS Database.--Records that are not in the State MDS database include those that have not been data entered, have not been transmitted, or have been transmitted and rejected. The automated mechanism for correcting records in the MDS database at the State and the use of the MDS Correction Request Form is not appropriate for records that have not been accepted. When an error occurs in an MDS record (assessment, or discharge or reentry tracking form) that has not been accepted into the State database, facility staff should determine whether the record should be excluded from submission or corrected and then submitted.

a. Excluding an Invalid MDS Record Not in the State MDS Database, Scenario 3.--The facility should exclude (not submit) an invalid record that should not actually have been submitted. A record is considered to be invalid in any of the following cases:

1) It was a test record inadvertently created as a production record.

2) The event did not occur.

a) The record created does not correspond to any actual event. For example, a discharge tracking form was created for a resident, but there was no actual discharge. There was no event.

b) The record created identifies the wrong resident. For example, a discharge tracking form was completed for the wrong person.

c) The record created identifies the wrong reasons for assessment. For example, a Reentry Tracking Form was created when the resident was discharged.

b. Correcting a Valid MDS Record Not in the State MDS Database.--A facility should perform an in-house correction when a valid record has not been accepted and is known to have data errors. A record is considered to be valid if it meets all of the following conditions:

- It is not a test record.
- The record corresponds to an actual event.
- The record identifies the correct resident.
- The record identifies the correct reasons for assessment.
- The record is required to be submitted

Since the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in the facility and use of the MDS Correction Request Form does not apply. Paper records should be corrected using standard medical records procedures. That is, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry.

1) Tracking Form Error, Scenario 4.--Whenever a valid Discharge or Reentry Tracking Form record is found to be in error but has not been accepted by the standard MDS system at the State, then the facility need only correct that record in-house and submit it.

2) Assessment Error: Determine Whether it Has Been Eight or More Days since Assessment Completion.--Whenever a valid MDS assessment record is found to be in error but has not been accepted by the standard MDS system at the State, the facility should correct and submit that assessment record. The facility should take additional action if the error was detected outside of the standard MDS editing time frame of seven days after the final assessment completion date. Final assessment completion is defined as the date the care planning decision process was completed (MDS Item VB4) for comprehensive assessments, or the date the RN Coordinator certified that the MDS was complete (MDS Item R2b) for non-comprehensive assessments. In accordance with the clinical process, the facility must use the information contained in the Resident Assessment Instrument as the basis for the resident's care plan, and the care plan must be developed, or revised if appropriate, within seven days after final completion of an assessment.

a) Assessment Error Detected During Seven Day Editing Period, Scenario 4/5.--If an assessment error is detected within the seven day editing time frame, the facility should correct the record and ensure its accuracy relative to the resident's status as of the event date (MDS Item A3a for assessments); edit the record using HCFA specified edits; and then submit the corrected record to the State. It may also be appropriate to update the resident's care plan, based on

the revised assessment record. When the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in-house, and the MDS Correction Request Form should not be used.

b) Assessment Error Detected Eight or More Days Since Completion.--If the error is detected eight or more days after the assessment was completed (i.e., after the editing phase), the assessment record should be corrected and submitted. Additional action may also be required, depending on whether the error was major. Whenever an MDS assessment record that resides only in the facility is found to be in error, and the error was detected eight or more days after the assessment final completion date (MDS Item VB4 for comprehensive assessments or Item R2b for other assessments), the facility must correct and submit that record and update the care plan if necessary. In addition, the facility must determine whether the assessment error was major and not corrected with a subsequent assessment. An error is major if the resident's overall clinical status has been miscoded on the assessment or the care plan derived from the assessment does not suit the resident's needs. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's status and an appropriate care plan.

3) When the Assessment Error Was Not a Major Error or Has Been Corrected, Scenario 4/6.--If the assessment error was not major or if a major error has been corrected by a subsequent assessment, then the facility need only correct and submit the record. There is no need for a new assessment to be performed as a clinical correction step.

4) When a Major Assessment Error Has Not Been Corrected on a Subsequent Assessment.--If the error is major, and it has not been corrected on a subsequent assessment, the facility should correct and transmit the assessment to the State. In addition, facility staff must also determine whether the resident's status has actually changed since the erroneous assessment was completed, and if it has, whether this was a significant change in status. The facility must then perform and transmit a new significant change or significant correction assessment, whichever is appropriate.

a) No Significant Change in Status Has Occurred, Scenario 4/7.--If the error is major, and it has not been corrected on a subsequent assessment, and the resident has not experienced a significant change in status, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a significant correction of prior assessment. If the assessment in error was a comprehensive assessment, requiring RAPs, Triggers and care plan review, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an admission, annual, significant change in status, significant correction of prior full), then a new significant correction of a prior full assessment must be completed, including RAPs, Triggers and care plan review. If the assessment in error was not a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a quarterly or significant correction of prior quarterly assessment), then a new significant correction of a prior quarterly assessment must be performed and submitted.

b) A Significant Change in Status Has Occurred, Scenario 4/8.--If the assessment error is major, and it has not been corrected on a subsequent assessment, and the resident has experienced a significant change in status since the assessment reference date (MDS Item A3a) of the original, erroneous assessment, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a significant change in status assessment.

Whenever a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a significant change in status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred.

Significant change in status assessments and significant correction of prior assessments are entirely new assessments of the resident, based upon a new assessment reference date (MDS Item A3a).

The Correction Policy Summary matrix, Exhibit 273, provides a quick reference to all the correction policy scenarios. This matrix provides a summary checklist of all the actions required for each scenario.

3) Parameters for Correcting (Modifying or Inactivating) MDS Information in the State Database.--

a) Types of Corrections That Should be Made.--Facilities should correct any errors necessary to insure that the information in the State MDS database accurately reflects the resident's identification, discharge or reentry status, overall clinical status, or the resident's Medicare, Medicaid or Social Security Number. It is not HCFA's intent that a record be corrected when the only errors are trivial (e.g., the lifetime occupation in MDS item A6 has been misspelled). States have the option to require more extensive correction. However, States may not impose requirements that interfere with the federal MDS requirements or system specifications. If there is uncertainty about the correction requirements in a particular State, the State RAI coordinator should be contacted for clarification.

b) Time Length Between Error Detection and Correction.--It is expected that a Correction Request Form will be completed within 14 days of error detection. If circumstances have precluded timely completion, corrections should be made as soon as possible. Documentation must be included in the resident's clinical record indicating the date(s) that error(s) were detected.

c) Time Length Between Acceptance and Correction.--A correction may be submitted for any accepted record, regardless of the age of the original record. For example, a record accepted 2 years ago can still be modified. However, certain limitations might apply for specific system applications. For example, a time has been placed on using corrections for making payment adjustments.

d) Correction of Non-Current Records.--A record may be corrected even if subsequent records have been accepted for the resident. For example, an admission assessment may be corrected after one or more subsequent quarterly assessments have been accepted.

e) Regarding Changing Dates on the MDS.--In most cases, a correction to an MDS assessment will not involve changing any of the dates in the record. The only time any date on an MDS record should be modified is when the facility can substantiate that the date itself was in error. The facility should not update the assessment completion dates (MDS Items R2b, VB2, and VB4) to the date the correction is being made. Even when an assessment is corrected, the completion dates should usually remain unchanged from the original completion times.

f) Number of Items Changed in a Modification Request.--There is no limit to the number of items that can be changed in one assessment or tracking form record with a single modification request.

g) Number of Modification Requests for a Record.--There is no practical limit to the number of sequential modifications that may be requested for a record (up to 99 sequential changes are allowed). If a record has been previously modified and additional errors are detected, then an additional correction should be submitted. Similarly, if a modification itself is in error, then a subsequent correction should be submitted.

h) Transition Rule With Implementation of Correction Policy.--For records accepted before implementation of correction policy, the facility may optionally make corrections, however correction of these records is not a federal requirement. It is not HCFA's intent that facilities review and correct all historic records submitted before implementation of correction policy. For MDS records accepted after implementation of correction policy, facilities should correct any errors that misrepresent the resident's identification, location, overall clinical status, or payment status.

7. Retention of Correction Request Forms and Substantiating Documentation.--

o There must be documentation in the resident's clinical record that clearly substantiates the accuracy of the corrected information, relative to the resident's actual status as of the event date of the erroneous record (MDS item A3a for an assessment, MDS Item R4 for a discharge, or MDS Item A4a for a reentry).

o Documentation must be included in the resident's clinical record indicating the date(s) that error(s) were detected.

o A hard copy of the completed MDS Correction Request Form, including the signatures of the facility staff attesting to the completion and accuracy of the corrected record, must be attached to the appropriate MDS form and retained in the active clinical record for 15 months from the date the correction request was completed, at Item AT7 on the MDS Correction Request Form.

o In the case of a modification, a facility must correct the original MDS form, using standard medical record procedure, clearly indicating and initialing all items that have been changed, the date of the change, and the corrected values. The modification request and attached corrected MDS form must be maintained in the resident's active clinical record for 15 months as noted above.

o When more than one modification is performed, a facility must document the sequence of corrections on the original MDS form. For each set of corrections, an MDS Correction Request Form must be attached to the corrected MDS form documenting the associated corrections. It is acceptable to have multiple MDS Correction Request Forms attached to a single MDS form, as long as that MDS form documents all corrections made. This documentation must be legible.

o When more than one modification is performed, a facility must document the sequence of corrections on the original MDS form. For each set of corrections, an MDS Correction Request Form must be attached to the corrected MDS form documenting the associated corrections. It is acceptable to have multiple MDS Correction Request Forms attached to a single MDS form, as long as that MDS form documents all corrections made. This documentation must be legible.

o In the case of an inactivation, a facility must simply attach the MDS Correction Request Form to the erroneous MDS form to be inactivated. The inactivation request and erroneous form should then be maintained in the resident's active clinical record for 15 months as noted above. Retention of information in a resident's clinical record is obviously not an option in the event that the resident did not actually exist (e.g., fabricated test record). In this case, the inactivated record must still be retained for 15 months, however it may be kept in a common file.

o For corrections to records that had not been previously accepted into the MDS database at the State, the electronic and paper records are corrected in the facility and use of the MDS Correction Request Form does not apply. Paper records should be corrected using standard medical records procedures. That is, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry.

D. Facility Requirements for Automating and Transmitting MDS Data, and Database Management.--

1. Process of Data Flow From Facility to State.--

a. Encode, Edit, and Lock the MDS Records.--Final completion of a comprehensive resident assessment (including RAPs and care plan decisions), is represented by the date at MDS Item VB4. Completion of any noncomprehensive assessment, or of a full assessment without RAPs, is represented by the date at MDS Item R2b.

After a facility completes a resident assessment, Discharge or Reentry Tracking form, the facility must encode and edit according to HCFA specifications. Each record must be transmitted to the State no later than 31 days after its final completion date. Refer to Exhibit 263, Submission Timeframe for MDS Records, encoding, editing and transmission. Also refer to Exhibit 274, Definition of Important Dates in the RAI Process, for a description of critical dates in the MDS process.

An MDS record (assessment or tracking form) is considered locked when accepted into the MDS database at the State. This locking policy does not extend the MDS editing period beyond 7 days. The 7 day editing period following assessment or tracking form completion plays an important role in the MDS process. The end of the 7 day time period is the point at which the care plan is established or updated based on information in a completed assessment. If the record is not submitted and accepted by the end of the 7 day editing period, then a formal, paper audit trail must be maintained in the facility for any subsequent changes, until the record is accepted by the State. Any corrections after the editing period must reflect resident status and condition as of the original Assessment Reference Date.

Discharge and Reentry Tracking Forms must be encoded and edited within 7 days of the *event*. The date of the event is represented by the date at MDS Item A4a for a Reentry, and the date at MDS Item R4 for a Discharge.

Each facility is ultimately responsible for submitting accurate data. Once assessments are performed, facility staff must validate that the information on the MDS accurately reflects the resident's condition and clinical record. Once the data are encoded, they must be both verified to assure that the information entered into the facility's computer system matches the information on the MDS form, and edited, to assure that the data conform to the Standard MDS Record Layout and HCFA's MDS edits posted as on HCFA's wed site: http://www.hcfa.gov/medicaid/mds20, under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files". Editing can be accomplished manually (that is visually), although HCFA strongly encourages use of software that has a programmed edit capability that uses HCFA's edit specifications.

b. Export MDS Records /MDS Export File.--MDS vendor software creates the export file by gathering one or more records to be transmitted, putting the data into HCFA standard format, and adding standard Header and Trailer records.

c. Communications Software (Netscape) and the MDS Submission File.--The export file is then electronically transmitted to the State MDS system via communications software (e.g., Netscape.) The export file, also known as a submission file, is electronically transmitted to the State database.

2. Initial Feedback and Final Validation Reports.--After the export *file* (batch of MDS records) is submitted to the standard MDS system at the State, the system examines the integrity and structure of the file. The entire file will be rejected if it has "fatal *file* errors". If there are no fatal

file errors, the file will be accepted and loaded into the State MDS database. An Initial Feedback Report is sent electronically from the State to the facility, indicating whether the file was accepted or rejected. If the file was rejected, the Initial Feedback Report includes an error statement indicating the reason(s) for rejection. Rejected files must be corrected and re-transmitted.

If the file is accepted, the standard MDS system at the State performs more extensive edits on each individual MDS *record* in the file, using HCFA's standard edit specifications, to determine whether there are errors. The system will reject individual records with "critical errors" (also referred to as fatal *record* errors), and accept records with no critical errors. A Final Validation Report is sent electronically from the State to the facility that includes error statements for individual records found to have errors, and record rejection statements (with associated error statements) for any records rejected. Rejected records must be corrected and re-transmitted within the original 31day submission timeframe, (see Correction Policy for MDS Records) in part IV of Appendix R. For more detailed information regarding the Validation and Editing Process, refer to §4146.

3. Timing and Frequency of Transmissions of MDS Data to the State.--A facility must transmit MDS data at least monthly to the States. "Monthly" means submitting a record no later than 31 days from its *final completion date* (as defined above). The final completion date counts as day 0 (zero) in the 31 day count.

Transmissions must be no more than 1 month apart. The time interval between the final completion date and transmission date could be between 0 days to 31 days.

It is recommended that transmission files (batches) include all MDS records completed since the last transmission, including rejected records that are being retransmitted.

4. Preservation of Data .--HCFA strongly recommends that facilities establish a back-up capability and routine that preserves both data and programs. Automatic back-up routines ensure that back-ups are performed consistently. Back-up routines should include validation. Facilities should periodically test their ability to restore their system from backups on a test system.

Facilities may wish to consider periodically backing up their entire hard drive, as well as their data. It may also be useful to periodically store a back-up off site, and update that back-up at specified intervals. Facilities may also wish to consider virus protection (such as virus checking software and policy regarding handling of diskettes brought in from the outside), as well as protecting data in the event of a power surge (such as the use of Uninterruptible Power Supply (UPS) systems).

5. System Access and Passwords.--It is recommended that facilities consider software that will allow the use of individual passwords that, for security reasons, can limit access to specified portions of the system. For example, for a facility considering software that will automate clinical records beyond the MDS, such as progress notes, nursing staff should be permitted to read and write nursing progress notes, and only read and not write therapy progress notes. There may also be areas of the system that only the facility system administrator should have access to, such as areas where passwords are assigned and disabled. Facilities might wish to consider that staff not responsible for system administration tasks have no access to those areas. Also, in order to provide an audit trail, it is important that an individual staff member's password links their name with their work. We advise that facility staff also be cautioned against "posting" passwords. Finally, it is recommended that facilities consider policy regarding disabling passwords in the event of staff termination.

6. Maintaining a Submission Log.--To provide an audit trail, facilities may wish to consider keeping data submission logs of submission file (batch) lists, Initial Feedback and Final Validation Reports, as well as actions taken on errors and rejected records or files.

E. Privacy, Confidentiality and Resident's Rights.--

1. Facility Release of Information.--MDS data are considered to be a part of the resident's clinical record, and as such, are protected from improper disclosure by facilities under the requirements of 42 CFR Part 483.10(e). Facilities must keep confidential all information contained in the resident's record and maintain safeguards against the unauthorized use of resident clinical information, regardless of storage method. Circumstances that may necessitate the release of information from the resident's clinical record are limited by regulation (42 CFR Part 483.10 (e) to circumstances required:

(1) By transfer to another health care institution;
(2) By law; or
(3) By the resident.

A facility may not release resident identifiable information to the public. Providers who are part of a chain may release data to their corporate office or parent company but not to other providers within their chain. The parent company is required to "act" in the same manner as the facility and permitted to use data only to the extent the facility is permitted to do so.

The release of data by facilities to other agents who are under contract and have a need to know the MDS information (including but not limited to physicians, physical therapists, occupational therapists, or other specialists) in order to develop plans of care and/or agents who are under contract to handle the data for administrative reasons, such as for transmission to the State repository or to develop quality indicator reports, are required to "act" in the same manner as the facility and permitted to use data only to the extent the facility is permitted to do so.

2. Residents' Rights.--

a. Notification of Residents.--Nursing Homes must inform each resident about the electronic transmission of the MDS to the State and HCFA. This is done because the data will be part of the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517, and therefore are ultimately subject to the Federal Privacy Act of 1974.

To properly inform the residents of their rights under the Privacy Act, the provider must furnish each resident with information required by the Privacy Act. Under the requirements of the Privacy Act, notices must contain the following information: (1) the authority for collection of information, including social security number; (2) the principal purposes for which the information is intended to be used; (3) the routine uses for which the information may be disclosed, and (4) the effect on the individual of not providing information. The Exhibit provides one example of the required information for a Privacy Act Notification for the Long Term Care Minimum Data Set System of Records. This required information includes:

b. Authority for Collection of Information, Including Social Security Number, and Whether Disclosure is Mandatory or Voluntary.--**Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.**

Medicare and Medicaid participating long term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by HCFA to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

c. Principal Purposes for Which Information is Intended to Be Used.--The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information is also necessary for the nursing homes to receive reimbursement for Medicare services.

d. Routine Uses.--The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1) a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

e. Effect on Individual of Not Providing Information.--The information contained in the Long Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare/Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

This information must be provided in writing to each current and future resident (or his/her representative) under the requirements of 42 CFR Part 483.10 (b) and the Federal Privacy Act of 1974. For residents who have legal representatives, providers can provide a copy of the notice in person or by mail. For new under the requirements of 42 CFR Part 483.10 (b) and the Federal Privacy Act of 1974. For residents who have legal representatives, providers can provide a copy of the notice in person or by mail. For new admissions, a copy of the Privacy Act Notification can be a part of the admission packet that is given to and reviewed with the resident or representative at the time of admission.

Providers may or may not elect to have residents or their representatives sign a copy of the notification as a matter of record that the notice was provided. The signature of a resident or representative merely indicates that notification was provided.