ASSESSMENT TIMING AND SCHEDULING

Chapter 2

Introduction to the Requirements for the RAI

- The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).
- These sections require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents
- The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents

Requirements for the RAI, continued

- MDS assessments are also required for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).
- We will discuss Medicare assessments later in the class when we cover PDPM

Requirements for the RAI, continued

- An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:
  - All residents of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
  - Hospice residents: When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

Requirements for the RAI, continued

- An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:
  - Short-term or respite residents: An RAI must be completed for any individual residing in the facility more than 14 days in a certified bed
    - If the respite resident is in the facility for ***fewer*** than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
      - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-")
      - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs and must initiate a plan of care to meet those needs upon admission.
      - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

Requirements for the RAI, continued

- Chapter 2 also includes instructions for completing assessments with unusual circumstances, including
  - Newly certified facilities
  - Change in ownership
  - Resident transfers

OBRA Assessment Timing

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary Team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment

OBRA Assessment Timing, Continued

- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have an Significant Change in Status (SCSA) completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA.

Item Sets

- “Item Set” refers to the MDS items that are active on a particular assessment type or tracking form. There are 9 different item subsets for nursing homes
- Comprehensive (NC) Item Set. This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, SCSA, and SCPA). This item set is used whether the OBRA Comprehensive assessment is standalone or combined with any other assessment (PPS assessment and/or Discharge assessment).
- Quarterly (NQ) Item Set. This is the set of items active on an OBRA Quarterly assessment. This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment. —
- PPS (NP) Item Set. This is the set of items active on a 5-Day PPS assessment. — Interim Payment Assessment (IPA) Item Set. This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment

Item Sets, Continued

- Discharge (ND) Item Set. This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
- Part A PPS Discharge (NPE) Item Set. This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
- Tracking (NT) Item Set. This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
- Inactivation Request (XX) Item Set. This is the set of items active on a request to inactivate a record in iQIES.

OBRA – Required Tracking Records and Assessments

- Tracking records
  - Entry
  - Death in facility
- Assessments
  - Admission (comprehensive)
  - Quarterly
  - Annual (comprehensive)
  - SCSA (comprehensive)
  - Discharge (return anticipated or return not anticipated)

Admission Assessment (A310A=1)

- What is an “admission”?
  - this is the resident’s first time in this facility, OR
  - the resident has been admitted to this facility and was discharged return not anticipated, OR
  - the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Admission Assessment (A310A=1)

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day “1” of admission.
- The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period.
  - For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).

Admission Assessment (A310A=1)

- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being.
- The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.

Admission Assessment (A310A=1)

- The MDS completion date (item Z0500B) must be no later than day 14.
- The CAA(s) completion date (item V0200B2) must be no later than day 14, and it must be on or after the MDS completion date
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2)
  - (CAA(s) completion date + 7 calendar days).

Admission Assessment (A310A=1)

- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

Quarterly Assessments (A310A=02)

- These are the only OBRA-required assessments that are non-comprehensive
- Must be completed at least every 92 days following the previous OBRA assessment of any type.
- It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored.
  - As such, not all MDS items appear on the Quarterly assessment.

Quarterly Assessments (A310A=02)

- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA SCQA, or Annual assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days)

Quarterly Assessments (A310A=02)

- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments.
- As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met.
- However, States may have more stringent restrictions

Annual Assessment (A310A=03)

- The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed.

Annual Assessment (A310A=03)

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.

Annual Assessment (A310A=03)

- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days)

Significant Change in Status (A310A = 04)

- A “significant change” is a major decline or improvement in a resident’s status that:
  - 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered “self-limiting”;
  - 2. Impacts more than one area of the resident’s health status; and
  - 3. Requires interdisciplinary review and/or revision of the care plan.

Significant Change in Status (A310A = 04)

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.
- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.

Significant Change in Status (A310A = 04)

- An SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
  - The resident's condition is not expected to return to baseline within two weeks.
- An SCSA may not be completed prior to an OBRA Admission assessment.

Significant Change in Status (A310A = 04)

- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.

Significant Change in Status (A310A = 04)

- When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

Significant Change in Status (A310A = 04)

- A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA.
- For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA.
  - In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week.
  - In this situation, staff should monitor the resident’s status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

Significant Change in Status (A310A = 04)

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement.
- In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it.
  - Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, “potential for weight loss.”
  - This situation should be documented in the resident’s clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.

Significant Change in Status (A310A = 04)

- An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- An SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

Significant Change in Status (A310A = 04)

- Decline in two or more of the following:
  - Resident's decision-making ability has changed;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©),
  - Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
  - **Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;**
  - Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and **does not reflect normal fluctuations in that individual's functioning;**

Significant Change in Status (A310A = 04)

- Decline in two or more of the following:
  - Resident's decision-making ability has changed;
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
  - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
  - Emergence of a new pressure ulcer at Stage 2 or higher, **a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;**
  - Resident begins to use a restraint of any type when it was not used before; and/or
  - Emergence of a condition/disease in which a resident is judged to be unstable.

Significant Change in Status (A310A = 04)

- Improvement in two or more of the following: —
  - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - Resident's decision making improves;
  - Resident's incontinence pattern improves.

Significant Change in Status (A310A = 04)

- An SCSA is required to be performed when a terminally ill resident **enrolls in a hospice program** (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home.
- The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than).
- **An SCSA must be performed regardless of whether an assessment was recently conducted on the resident**. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.
- A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.

Significant Change in Status (A310A = 04)

- If a resident is admitted on the hospice benefit, or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K.
  - Completing an Admission assessment followed by an SCSA is not required.
- Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required.
  - In such situations, an SCSA is not required.

Significant Change in Status (A310A = 04)

- An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care).
- The ARD must be within 14 days from one of the following:
  - 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than);
  - 2) the expiration date of the certification of terminal illness; or
  - 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

Significant Change in Status (A310A = 04)

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K.
  - Completing an Admission assessment followed by an SCSA is not required.
- Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required.
  - In such situations, an SCSA is not required.

Significant Change in Status (A310A = 04)

- Guidelines for When a Change in Resident Status Is Not Significant: (Note: this is not an exhaustive list)
  - Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require an SCSA).
  - Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.

Significant Change in Status (A310A = 04)

- Guidelines for When a Change in Resident Status Is Not Significant: (Note: this is not an exhaustive list)
  - Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate an SCSA).
  - Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
  - Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

Significant Change in Status (A310A = 04)

- Guidelines for Determining the Need for an SCSA for Residents with Terminal Conditions: Note: this is not an exhaustive list
  - The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.
  - If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required.

Entry Tracking Record (A310F = 01)

There are two types of entries – admission and reentry.

- Admission (Item A1700 = 1)
  - Entry tracking record is coded an Admission every time a resident:
    - is admitted for the first time to this facility; or
    - is readmitted after a discharge return not anticipated; or
    - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.
- Reentry (Item A1700 = 2)
  - Entry tracking record is coded Reentry every time a person:
    - is readmitted to this facility, and was discharged return anticipated from this facility, and returned within 30 days of discharge.

Entry Tracking Record (A310F = 01)

- The Entry tracking record is the first item set completed for all residents.
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.

Death in Facility Tracking Record (A0310F = 12)

- Must be completed when the resident dies in the facility or when on LOA.
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).

OBRA Discharge Assessments (A0310F)

- OBRA Discharge Assessment–Return Not Anticipated (A0310F = 10)
  - Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
  - Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
  - Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
  - If the resident returns, the Entry tracking record will be coded A1700 = 1, Admission. The OBRA schedule for assessments will start with a new Admission assessment.

OBRA Discharge Assessments (A0310F)

- OBRA Discharge Assessment–Return Anticipated (A0310F = 11)
  - Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
  - Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days)
  - Must be submitted within 14 days after the MDS completion date (item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).

OBRA Discharge Assessments (A0310F)

- OBRA Discharge Assessment–Return Anticipated (A0310F = 11)
  - When the resident returns to the nursing home, the IDT must determine if criteria are met for an SCSA
    - If criteria are met, complete an SCSA.
    - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge
  - For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.

OBRA Discharge Assessments (A0310F)

- OBRA Discharge Assessment–Return Anticipated (A0310F = 11)
  - If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
  - When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

OBRA Discharge Assessments (A0310F)

- Must be completed when the resident is discharged from the facility
  - Resident is discharged home or to a lower level of care
  - Resident is admitted to an acute care hospital.
  - Resident has a hospital observation stay greater than 24 hours.
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.

OBRA Discharge Assessments (A0310F)

- For an OBRA Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments.
  - The ARD (item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, “-”, is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment.

OBRA Discharge Assessments (A0310F)

- For unplanned discharges, the facility should complete the OBRA Discharge assessment to the best of its abilities.
- An unplanned discharge includes, for example:
  - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
  - Resident unexpectedly leaving the facility against medical advice; or
  - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

5.1 Transmitting MDS Data

- All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES).
- Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS.
  - Assessments that are completed for purposes other than OBRA or SNF PPS reasons are not to be submitted to iQIES, examples include, but are not limited to, private insurance and Medicare Advantage Plans (i.e., Medicare Part C).

5.1 Transmitting MDS Data

- After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications
- When the transmission file is received by iQIES, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by iQIES for the same resident.
  - The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the Error Messages guide.

5.3 Validation Edits

- Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES. This confirmation information includes the file submission identification number (ID), the date and time the file was received for processing as well as the file name

5.3 Validation Edits

- Validation and Editing Process. Each time a user accesses iQIES and transmits an MDS file, iQIES performs three types of validation:
- 1. Fatal File Errors. If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.

5.3 Validation Edits

- 2. Fatal Record Errors. If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:
  - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).
  - Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600)

5.3 Validation Edits

- Fatal Record Errors result in rejection of individual records by iQIES. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted, unless the Fatal Error is due to submission of a duplicate assessmen

5.3 Validation Edits

- 3. Non-Fatal Errors (Warnings). The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature.
- Examples are timing errors. Timing errors for a Quarterly assessment include
  - (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or
  - (b) the assessment completion is more than 14 days after the ARD (A2300).
- Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening Discharge assessment (A0310F = 10 or 11).
- Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions

5.3 Validation Edits

- Storage to iQIES. If there are any Fatal Record Errors, the record will be rejected and not stored in iQIES. If there are no Fatal Record Errors, the record is saved into iQIES, even if the record has Non-Fatal Errors (Warnings).
- Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 website and in the Error Messages guide

5.5 MDS Correction Policy

- Several processes have been put into place to assure that the MDS data are accurate both at the provider and in iQIES:
  - If an error is discovered within 7 days of the completion of an MDS and before submission to iQIES, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
  - If an error is discovered in a record that has been accepted by iQIES, Modification or Inactivation procedures must be implemented by the provider to assure that iQIES information is corrected.

Things to Think About

- Failing to comply with the assessment timing requirements can result in survey deficiencies
- Assessment scheduling requirements are minimum requirements, assessments can be done earlier/more often than required
- Assessment schedulers should understand the relationship of the Assessment Reference Date to the data that will be captured, and be alert to opportunities to increase reimbursement or improve quality measures with an early/extra assessment