CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Long-term care nursing facilities are required to submit MDS records for all residents in Medicare or Medicaid certified beds regardless of the pay source. Skilled nursing facilities are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF PPS.

5.1   Transmitting MDS Data

Every State agency is equipped with the standardized computer hardware and data management software system to electronically receive MDS data from all Medicare and Medicaid nursing facilities. After completion of the required assessments and/or tracking forms, each nursing facility must create an electronic transmission file that meets the requirements detailed in the current MDS Data Specifications available at **http://www.cms.hhs.gov/medicaid/mds20/mdssoftw.asp**.

In addition, nursing facilities must be certain they are submitting MDS assessments under the appropriate authority. There must be a Federal and/or State authority to submit MDS assessment data to the standard MDS system. The software used by nursing facilities should have a prompt for confirming the authority to submit that record.

The facility indicates the submission authority for a record in a field labeled SUB_REQ.

- **Value = 3**   Indicates that the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.
- **Value = 2**   Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or Medicaid requirements, to collect MDS information for residents on this unit.
- **Value = 1**   Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for all residents on this unit. Note that if a record is submitted with SUB_REQ = 1, then that record will be rejected and all information concerning the record will be purged.

Nursing facilities must establish communication with the State MDS database in order to submit a file. This is accomplished by using specialized communications software and hardware and the Medicare Data Communication Network (MDCN). Details about these processes are available at the following web site: **http://www.qtso.com/mdsdownload.html**.

Once communication is established, the nursing facility can access the State's CMS MDS Welcome Page in the MDS system. This site allows nursing facilities to submit MDS assessment data, receive various reports, including the validation reports for the submitted MDS data, and access various

information sources such as Bulletins and Questions and Answers. The <u>Minimum Data Set (MDS)</u> <u>Long-Term Care Facility User's Manual</u> provides more detailed information about the MDS system. It is available at: **http://www.qtso.com/mdsdownload.html**.

When the transmission file is received by the State MDS database, the State system performs a series of validations or edits to evaluate whether or not the data submitted meets the required standards. MDS assessments are edited to verify that clinical responses are within valid ranges, dates are reasonable, and assessments are consistent with previous assessments completed for the same resident. The facility is notified of the results of this evaluation on the Initial Feedback Report or the Final Validation Report. All edit messages are detailed and explained in the <u>Validation Report</u> <u>Messages and Descriptions Manual</u> available at: **http://www.qtso.com/mdsdownload.html**.

5.2   Timeliness Criteria

In accordance with the requirements at 42 CFR § 483.20 (f) (1), (2), and (3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**

  - For the Admission assessment, the RAPs Completion Date (VB2) can be no more that 14 days from the date of admission or reentry, whichever is later.
  - For all other comprehensive MDS assessments, the RAPs Completion Date (VB2) may be no later than 14 days from the Assessment Reference Date (A3a).
  - For Quarterly or MPAF assessments, the MDS Completion Date (R2b) may be no later than 14 days from the Assessment Reference Date (A3a).
  - Discharge and Reentry records must be completed within 7 days of the Event Date (R4 for Discharge records; A4a for Reentry records).

- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)

- **Encoding Data:** Within 7 days after a facility completes a resident's MDS assessment or tracking form, a facility must encode the MDS data. The MDS data must be in a record format that conforms to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. When this process is completed, the facility is ready to transmit the MDS assessment to the State MDS database.

- **Transmitting Data:** Facilities must transmit all sections of the MDS 2.0 required for their State-specific instrument, including the Resident Assessment Protocol Summary (Section V) and all tracking or correction forms. Transmission requirements apply to all MDS 2.0 assessments or MPAF assessments when used to meet both OBRA and Medicare requirements. Care plans are not required to be transmitted.

- **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 31 days of the Care Plan Completion Date (VB4). All other MDS or MPAF assessments must be submitted within 31 days of the MDS Completion Date (R2b).
- **Tracking Form Transmission:** Tracking forms must be transmitted within 31 days of the Event Date (R4 for Discharge records; A4 for Reentry records).
- **Monthly Transmission Requirements:** A facility must, at least on a monthly basis, electronically transmit to the State MDS database encoded, accurate and complete MDS assessments conducted during the previous month.

SUBMISSION TIME FRAME FOR MDS RECORDS

Type of Record	Primary Reason (AA8a)	Secondary Reason (AA8b)	Final Completion or Event Date	Submit By
Admission Assmt.	01	All values	VB4	VB4 + 31
Annual Assmt.	02	All values	VB4	VB4 + 31
Sign. Change Assmt.	03	All values	VB4	VB4 + 31
Sign. Correction Full Assmt.	04	All values	VB4	VB4 + 31
Quarterly Assmt.	05	All values	R2b	R2b + 31
Sign. Correction Quarterly Assmt.	10	All values	R2b	R2b + 31
Assmt. for Medicare (with AA8a = 00)	00	1, 2, 3, 4, 5, 7 or 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

Table 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 (Care Plan Completion Date).
R2b...................Date of the RN assessment coordinator's signature, indicating that the MDS is complete (MDS Completion Date).
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.

5.3   Validation Edits

The MDS system has edits designed to monitor the timeliness and accuracy of MDS assessment record submissions. If transmitted MDS assessment records do not meet the edit requirements, the system will post error messages on the nursing facility's validation report.

Validation and Editing Process: Each time a facility accesses the State MDS system and transmits an assessment file, the State MDS system performs three types of validations:

1. **Fatal File Errors** - The first validation examines the basic structure and integrity of the submission file. The facility will be informed of the file submission status in the Initial Feedback Report indicating that the batch was "accepted," "received" (for a test file), or that it was "rejected." If there are fatal flaws in the file (batch of records), the entire file is rejected; the facility will not receive a Final Validation Report. Rejected files must be corrected and retransmitted.

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:

    - out of range responses, e.g., for G1aA Bed Mobility Self Performance, a 5 is submitted when the only allowable answers are 0 – 4;

    - selected inconsistent relationships between fields, e.g., dates submitted must be reasonable. As an example, it is not possible that the resident's Birthdate (Item AA3) would be later than the Date of Entry (Item AB1);

    - errors which may prevent accurate identification of the resident or record type.

    Fatal Record Errors result in rejection of individual records by the State MDS system. The facility is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.

3. **Non-Fatal Errors** - If there are no Fatal Record Errors, the record is loaded into the State MDS database and the record is further validated for Non-Fatal Errors. Non-Fatal Errors include missing or questionable data of a non-critical nature or field consistency errors of a non-critical nature. These might be timing errors, e.g., the date submitted at R2b is more than 14 days after the date at A3a, or record sequencing errors, e.g., a Reentry record (AA8a = 09) is submitted after a Quarterly record (AA8a = 05). Any Non-Fatal Errors are reported to the facility in the Final Validation Report as warnings. The facility must evaluate each error to identify necessary corrective actions.

The edits are structured to match the timeliness criteria outlined in Section 5.2. Detailed information on the timeliness edits may be found in the Validation Report Messages and Descriptions Manual available at: **http://www.qtso.com/mdsdownload.html**.

5.4   Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR § 413.343 (a) and (b), nursing facilities reimbursed under the SNF PPS "are required to submit the resident assessment data described at § 483.20…. in the manner necessary to administer the payment rate methodology described in § 413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in § 413.337 (c) related to the adjustment of the Federal rates for case-mix. SNFs must submit assessments according to an assessment schedule. This schedule must include performance of resident assessments on the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

RUG-III Codes: Every Medicare assessment (AA8b = 1, 2, 3, 4, 5, 7 or 8) submitted must include a RUG-III case mix code (T3a). The first three characters are the RUG-III group code and the last two characters are a valid RUG-III version code, e.g., RMC07. The RAVEN software calculates and inserts the correct RUG-III case mix code for each Medicare assessment. Every Medicare assessment that is submitted to the State MDS database must include a RUG-III case mix code. The version code is used solely for electronic submission purposes. The version code is included on all MDS files electronically submitted to the State MDS database. The version code is different from the HIPPS code, and is not used when filing Medicare Part A claims.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting claims to the fiscal intermediary (FI). The HIPPS codes contain a three-position alpha code to represent the RUG-III case mix code of the SNF resident, plus a two-position assessment indicator to indicate which assessment was completed. SNFs are **<u>not</u>** currently required to transmit the HIPPS code as part of the MDS data record. The HIPPS code is calculated manually or by nursing facilities' proprietary software. Once the MDS record has been accepted into the State MDS database, clinical staff should give the HIPPS code to the billing office. The HIPPS code must appear on the claim and the claim cannot be filed until the MDS has been accepted into the State MDS database.

It is important to remember that the record will be accepted into the State MDS database, even if the calculated RUG-III code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG-III code. When such discrepancies occur, the RUG-III code reported on the Final Validation Report should always be used for billing.

5.5   Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the State MDS Database

Facilities may not "change" a previously completed MDS assessment when the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is part of the facility's responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident's status is not required, unless a significant change in status has occurred.

A flow chart is provided at the end of this chapter to graphically present the decision processes necessary to identify the proper correction steps.

MDS assessments that have not yet been accepted in the State MDS database include records that have been submitted and rejected, production records that were inadvertently submitted as test records, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the State MDS database. The paper copy should be corrected according to standard procedures detailed below.

ERRORS IDENTIFIED DURING THE ENCODING PERIOD

Facilities have up to 7 days to encode and edit an MDS assessment after the MDS has been completed. Amendments may be made to the electronic record for any item during the encoding period, provided the amended response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data is encoded into the facility's MDS system, the facility is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the facility is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 2.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a nursing facility may "correct" item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For "corrected" items, the facility must use the same "period of observation" as that used for the original item completion (i.e., the same Assessment Reference Date – A3a). Any corrections must be accurately reflected in both the electronic and paper copies of the MDS (i.e., the paper version of the MDS must be corrected.)

ERRORS IDENTIFIED AFTER THE ENCODING PERIOD

The corrections process is more complex if errors are identified after the end of the encoding process but before the record has been accepted into the State database. After the 7-day editing period, the facility must correct and submit the record, using the process detailed above, but must also evaluate whether or not an additional Significant Change in Status or Significant Correction of a Prior assessment is required. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered "major" errors and require a new assessment. All other errors related to the coding of clinical items are considered "minor," and can be addressed through the correction process without performing another assessment.

In summary, the facility must then take the following actions:

1.   Correct the original assessment,
2.   Submit the corrected assessment, and
3.   Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment if the error was major, and update the care plan as necessary.

If the MDS (MPAF) is performed for Medicare purposes only (AA8a = 00, AA8b = 1, 2, 3, 4, 5, 7 or 8), no Significant Change in Status or Significant Correction of a Prior assessment is required. RAPs and care planning are not required with Medicare assessments.

5.6   Correcting Errors in MDS Records That Have Been Accepted Into The State MDS Database

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. Two processes have been established to correct MDS records (assessments or tracking forms) that have been accepted into the State MDS database:

- **Modification**

- **Inactivation**

A Modification request moves the inaccurate record into the history file in the State MDS database and replaces it with the corrected record in the active database. An Inactivation request also moves the inaccurate record into the history file in the State MDS database, but does not replace it with a new record. Both the Modification and Inactivation processes require an MDS Correction Request form.

The MDS Correction Request form (Prior Record Section and Section AT) contains the minimum amount of information necessary to enable correction of the erroneous MDS data previously submitted and accepted into the State MDS database. A hard copy of the Correction Request form must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. A hard copy of the Correction Request form should also be kept with an inactivated record. (A copy of the Correction Request form can be found at the end of this chapter.)

Detailed instructions concerning completion of the Correction Request form and examples of the correction process are included in the final Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form (March, 2000), which may be accessed at **http://www.qtso.com/download/mds/prMn1002.pdf**.

MODIFICATION REQUESTS

A Modification request should be used when a **<u>valid</u>** MDS record (assessment or tracking form) is in the State MDS database, but the information in the record contains errors. A record is considered to be valid if it meets all of the following conditions:

1. It is not a test record.
2. The record corresponds to an actual event.
3. The record identifies the correct resident.
4. The record identifies the correct reasons for assessment.
5. The facility has State or Federal authority to submit the record (i.e., the record meets the SUB_REQ submission requirements described in Section 5.1).

When an error is discovered in a tracking form, the facility must complete the following actions to correct the form:

1. Correct the original tracking form,
2. Complete a Correction Request form to modify the tracking form, and
3. Submit the correction record.

When an error is discovered in an assessment, the facility must decide whether or not it is a major error. If it is not a major error, or if this was an assessment completed only for Medicare purposes, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment, and
3. Submit the correction record.

When a major error is discovered in an assessment after the assessment has been accepted into the State MDS database, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment,
3. Submit the correction record, and
4. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment and update the care plan as necessary.

When errors identified in a prior assessment have been corrected in a more current assessment, the facility is not required to perform a new comprehensive assessment. In this situation, the facility has already incorporated the accurate data into the care planning process. However, the facility must use the Modification process to assure that the erroneous assessment residing in the State MDS database is corrected.

Generally, most errors may be corrected through the Modification or Inactivation request submitted with a correction record. Minor errors, such as the misspelling of an occupation in Item AB6, do not need to be corrected; they should be noted and corrected with the next assessment.

INACTIVATION REQUESTS

Records must be inactivated when an incorrect reason for assessment has been submitted in either the Primary Reason for Assessment (AA8a) or Medicare Reason for Assessment (AA8b). The record must then be resubmitted with the correct reason(s) for assessment.

An Inactivation should also be used when an **invalid** record has been accepted into the State MDS database, since it moves the inactive record into the history file in the database. Examples of invalid records include the following situations:

1. It was a test record inadvertently submitted as production.
2. The event did not occur; e.g., 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.
3. The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.
4. The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking form was submitted when the resident was discharged.
5. Inadvertent submission of an inappropriate, non-required record, such as a non-standard assessment performed for "in-house" quality improvement or quality assurance programs.

When inactivating a record, the facility is required to submit an electronic record.

5.7   Inactivation of Submitted Records Lacking State or Federal Authority

Submission of MDS assessment records to the MDS standard database constitutes a release of private information and must conform to privacy laws. The facility indicates the submission authority for a record in a field labeled SUB_REQ. (See Section 5.1)

SUB_REQ may not be modified with a normal MDS modification request. The formal Inactivation process is also insufficient, since the inappropriately submitted record would still remain in the database in the history file. If the SUB_REQ value is incorrect on a record already accepted into the standard MDS database, the facility must make a request to the State help desk to evaluate the problem and, if appropriate, the MDS database will be manually corrected.

CORRECTION POLICY FLOWCHART

Error Found in MDS Assessment or Tracking Form

Data Correction
(Assessments and Tracking Forms)

Record Already ACCEPTED in State DB? Valid?

Yes → Is Record Valid?[2]

No[1] → Is Record Valid?[2]

Is Record Valid?[2] — No → Send Inactive Request to State; Also Create and Submit New Record if Necessary **1**

Is Record Valid?[2] — Yes → Send Modification Request to State **2**

Is Record Valid?[2] (right) — No → Exclude Record From Submission; Also Create and Submit New Record if Necessary **3**

Is Record Valid?[2] (right) — Yes → Correct Record in Facility and Submit **4**

Clinical Correction
(Assessments Only)

For Assmts. Only

Uncorrected Major Error?[3]

Significant Change?

Yes → Significant Change?

8+ Days > Final Completion[4]

For Assmts. Only

Significant Change? — Yes → Perform and Submit Significant Change Assessment and Update Care Plan **8**

Significant Change? — No → Perform and Submit Significant Correction Assessment and Update Care Plan **7**

Uncorrected Major Error?[3] — No → No Additional Action Required **6**

8+ Days > Final Completion[4] — No → No Additional Action Required **5**

Uncorrected Major Error?[3] — Yes (from 8+ Days)

---

[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 assessment are correct*, and *submission is required*.

[3]The assessment in error contains a Major error that has not been corrected by a subsequent assessment.

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

Example MDS SUB_REQ Correction Request Worksheet

The nursing facility must submit the following information to the state MDS Coordinator in writing:

Facility information	
Name	
ID (FAC_ID)	
Requester information	
Name	
Title	
Phone #	
Resident information	
First Name	
Last Name	
SSN	
Birthdate	
Gender	
Record information	
Item AA8a	
Item AA8b	
Target Date[1]	
Submission information	
Date and time	
Batch #	
SUB_REQ values	
Submitted (incorrect)	
Correct	

---

[1]Target date is:

MDS Item A3a (reference date) for an assessment record.
MDS Item R4 (discharge date) for a discharge record.
MDS Item A4a (reentry date) for a reentry record.

Additional information may be found in the MDS Submission Authority instructions available at **http://www.qtso.com/download/mds/SubReqInstructQtso2.pdf**.

This page left intentionally blank for the MDS CORRECTION FORM.