

Appendix B

**Swing Bed Assessment Submission
Authority**

And

Correction Procedures

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Swing Bed Assessment Submission Authority

The hospital only has authority to submit SB-MDS assessments to CMS for a patient in a Medicare or Medicaid Certified Swing Bed. Submission of assessments for other patients is a violation of patient privacy rights. The SB_SUB_REQ field in the body record (byte 143) indicates whether submission of the record is authorized.

MDS Records With SB_SUB_REQ = 1 (CMS Authority)

- There is CMS authority to submit an assessment if the patient is in a Medicare or Medicaid certified swing bed. The swing bed MDS event (assessment reference date, discharge date, or reentry date) must occur while the patient was in a Medicare or Medicaid certified swing bed.
- If SB_SUB_REQ is one (1) then submission of the record to the national database IS AUTHORIZED. Submission of the record may be required for patients covered under Medicare or for the Medicaid payment systems.

MDS Records With SB_SUB_REQ = 0 (No Authority)

The following records have SB_SUB_REQ = 0:

- There is no authority to submit an assessment if the patient is not in a Medicare or Medicaid certified swing bed. If the Swing Bed MDS event (assessment reference date, discharge date, or reentry date) did not occur while the patient was in a Medicare or Medicaid certified swing bed, then a record must not be submitted.
- If SB_SUB_REQ is zero (0) then submission of the record to the national database system IS UNAUTHORIZED and PROHIBITED.

NOTE: It is a violation of a patients privacy rights to submit Swing Bed MDS data to the national system when prohibited.

If an unauthorized record is inadvertently submitted with SB_SUB_REQ = 1 (indicating submission authority present) and that record is accepted in the national database, then the hospital must make a written request to have the record deleted. Deletion of unauthorized records is discussed in greater detail in the later sections on "Correction Procedures" and "Swing Bed Unauthorized Record Deletion Process".

Correction Procedures

After an assessment has been completed, data entry has been finalized, and the assessment has been submitted to the national database, no further changes should normally be made to the assessment record. However, corrections are allowed if an assessment, data entry, or software error has been made. The purpose of this section is to describe the proper procedures for making corrections.

Timing of Corrections. All types of corrections (deletion request, correction record, or inactivation record) must be completed within 14 days of detecting the error or errors and then submitted within 14 days after completion.

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Types of Corrections. There are different correction procedures for different types of errors. Records in error that have not been accepted into the National Assessment Collection Database can simply be corrected and submitted without any special correction procedures. This includes records that have been submitted and rejected or records that have not been submitted at all.

Records in error that have been accepted into the National Assessment Collection Database require special correction procedures as follows:

1. If a **"test batch"**¹ of records has been incorrectly submitted and accepted as a **"production batch"**, the hospital must submit a written request to delete the test batch (see later section on "Swing Bed Test File Deletion Process").
2. If an **"unauthorized record"** has been accepted with incorrect **"submission authority"** indicated, the hospital must submit a written request to delete the unauthorized record (see later section on "Swing Bed Unauthorized Record Deletion Process").
3. If an authorized record has been accepted with any errors in **"key fields"**, the hospital must submit an **"inactivation record"** for the record in error and, if appropriate, also submit a new **"original record"** with the correct key fields.
4. If an authorized record with no key field errors has been accepted with errors in **"non-key fields"**, the hospital must only submit a new **"correction record"** with the non-key fields corrected.

DEFINITIONS RELEVANT TO CORRECTION PROCEDURES

- **Test Batch.** The National Assessment Collection Database System allows a hospital to make test submissions to test the submission process and to check that the hospital is submitting valid data. A test batch is indicated by the Test/Production indicator in the header record (TEST_SW field at byte 576). A TEST_SW value of 0 (zero) indicates a test batch. Test batches are edited by the national database system, but the assessment records are not accepted into the database.
- **Production Batch.** A production batch is indicated by the Test/Production indicator in the header record (TEST_SW field at byte 576). A TEST_SW value of 1 (one) indicates a production batch. Production batches are edited by the national database system and assessments without fatal errors are accepted into the database.
- **Unauthorized Record.** If CMS does not have the authority to collect a record and the hospital therefore has no **"submission authority"**, then that record is an unauthorized record.
- **Submission Authority.** The hospital only has authority to submit SB-MDS assessments to CMS for a patient in a Medicare or Medicaid Certified Swing Bed. Submission of assessments for other patients is a violation of patient privacy rights. The SB_SUB_REQ field in the body record (byte 143) indicates whether submission of the record is authorized. Submission authority and the SB_SUB_REQ field have been discussed in greater detail in an earlier section of this document.

¹ Highlighted terms are defined in the next section.

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- **Key Fields.** Key fields are fields used by the National Assessment Collection Database to uniquely identify an assessment. The table below lists the key fields contained in an assessment record.

Key Field Name	Description
FAC_ID	Unique Hospital ID code
1a (AA1a)	Patient First Name
1c (AA1c)	Patient Last Name
2 (AA2)	Gender
3 (AA3)	Birth Date
7a (AA5a)	Social Security Number
11a (AA8a)	Primary Reasons for Assessment
11b (AA8b)	PPS Scheduled Assessments
10a (A3a)	Assessment Reference Date
15 (R4)	Discharge Date
16 (A4a)	Reentry Date

When a key field is in error, the hospital must (1) submit an **"inactivation record"** to inactivate the record in error and (2) submit a new **"original record"** with correct key fields. When a key field is in error, the hospital cannot simply submit a **"correction record"** with changed key fields.

- **Non-key Fields.** The non-key fields in an SB_MDS record are all fields excluding the **"submission authority"** field (SB_SUB_REQ) and the **"key fields"**.
- **Original Record.** An original record is a body record for the initial version of an assessment submitted to the national database. For an original record the **"correction counter"** field (CORRECTION_NUM) is set to 00 (zero, zero). An original record must have a unique combination of **"key fields"** not already present in an active record in the national database.

An original record will be rejected as a duplicate if there is already an active database record with the same "key fields". In other words, there must be no active version of the record already present in the database. When an original record is accepted, it becomes an active record in the national database.

- **Correction Record.** A correction record is a new version of an existing active assessment record in the national database. A correction record must have the same **"key fields"** as the existing active record in error and must also have a **"correction counter"** field (CORRECTION_NUM) with a value exactly one greater than CORRECTION_NUM in the existing record in error.

A correction record will be rejected if the national database does not already contain an existing active version of the record with exactly the same "key fields", and the correction record has a CORRECTION_NUM value exactly one greater than the CORRECTION_NUM in the existing version of the record. Except for having a CORRECTION_NUM greater than zero, a correction record has the same Record ID (A3 in bytes 1 and 2) and the same pattern of active fields as an **"original record"**.

When a correction record is accepted, the existing active record is moved to an inactive history file as an audit trail and the new corrected record will be placed in the active database. Standard system reports and procedures are limited to active records.

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- **Inactivation Record.** An inactivation record is a special SB-MDS record containing the **"key fields"** needed to identify and inactivate an active record that already exists in the national database. An inactivation record must have key fields exactly matching an existing active database record.

An inactivation record will be rejected if the key fields do not match an existing active record. An inactivation record appears very different from an **"original record"** or **"correction record"**. It has a different Record ID (X3 in bytes 1 and 2) and a very limited number of active items. The only active items in an inactivation record are selected control fields and the key fields. Even the **"correction counter"** (CORRECTION_NUM) field is inactive on an inactivation record.

When an inactivation record is accepted, the existing active record is moved to an inactive history file as an audit trail and no version of the record remains in the active database. After an inactivation, all versions of the record will be inactive.

Once an erroneous assessment has been inactivated, a replacement assessment may be submitted as an **"original record"**, if appropriate. For example, if an assessment was submitted with an incorrect patient birth date (item 3), an inactivation record would be submitted and a replacement assessment with the correct birth date would be submitted. The replacement assessment would be an original record with CORRECTION_NUM equal to 00. Note that both the inactivation record and the replacement assessment record may be included in the same submission batch, if desired.

- **Correction Counter.** The CORRECTION_NUM field is a counter field in the body record (bytes 1781-1782) that is used to track corrections made to an assessment record. This counter field must always be set to 00 (zero, zero) for an **"original record"**. A **"correction record"** is indicated by a CORRECTION_NUM greater than zero. CORRECTION_NUM must be incremented to 01 (zero, one) for the first corrected version accepted in the national database, to 02 (zero, two) for the second corrected version accepted in the national database, etc.

Correction Scenarios

The following 5 scenarios illustrate how different types of corrections should be made.

Scenario 1: Assessment With Any Type of Errors But Not Already Accepted In National Database. If an assessment with any types of errors has *not been submitted* to the national database or has been *submitted and rejected*, the hospital staff can reopen the assessment, make necessary changes, and submit or resubmit it. CORRECTION_NUM should not be incremented in this situation.

A special case of Scenario 1 is when a **"production batch"** has been inadvertently submitted as a **"test batch"**. Assessments from test batches are never accepted into the national database. In this case, the hospital should change the Test/Production indicator to the value of 1 (for production) and resubmit the batch.

Steps required for Scenario 1 are:

- Correct the assessment but do not increment CORRECTION_NUM.
- Submit the assessment with the corrections included.

Scenario 2: Test Batch Accepted as Production Batch. If a **"test batch"** is inadvertently submitted as a **"production batch"**, these assessments must be deleted from the National Assessment Collection Database. When such a deletion is necessary, the hospital must submit a written Test File Deletion Request to the IFMC/QTSO Support office (see later section for details).

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Any test records must be completely deleted from the national database, which should only contain production records.

Steps required for Scenario 2 are:

- Submit a written Test File Deletion Request to IFMC/QTSO.

Scenario 3: Unauthorized Record Accepted into National Database. Only assessments for patients in Medicare or Medicaid certified swing beds are authorized for submission to the national database. Submission authorization is indicated by a value of 1 for the field SB_SUB_REQ. If an **"unauthorized record"** has been accepted into the database, the hospital must submit a written Unauthorized Record Deletion Request to the IFMC/QTSO Support office (see later section for details). Such an unauthorized record must be completely deleted from the database to safeguard patient privacy rights.

Steps required for Scenario 3 are:

- Submit a written Unauthorized Record Deletion Request to IFMC/QTSO.

Scenario 4: Authorized Record Accepted into National Database with Incorrect Key Fields.

An authorized record with incorrect **"key fields"** identifies the wrong hospital, patient, type of assessment, or event date. Such a record must be **"inactivated"**. If appropriate, a new **"original record"** with all information corrected (both key and non-key fields) should also be submitted. The inactivation process moves the record in error from the active part of the database to a history file maintained as an audit trail for corrections. The new original record is accepted into the active database to replace the record in error. Standard database reports and processes only consider active records.

A record with key field errors cannot be corrected with a **"correction record"**. A correction record with different key fields will not be correctly matched up with the prior record in error.

Steps required for Scenario 4 are:

- Submit an "inactivation record" for the database record in error.
- If appropriate, create a new "original record" with key field errors corrected and also any "non-key field" errors corrected. Set CORRECTION_NUM = 00 for this original record.
- If appropriate, submit this new "original record"

Scenario 5: Authorized Record Accepted into National Database with Correct Key Fields But Incorrect Non-Key Fields.

If an authorized assessment has been submitted and *accepted* by the National Assessment Collection Database, and the hospital staff determines that the only corrections required involve **"non-key fields"**, then a **"correction record"** can be used to fix the problems. When a correction record is accepted, the national database keeps only the most recent version of the record (i.e., the version with the greatest CORRECTION_NUM) on its active table. All prior versions of the record are retained in a history table. Standard national system reports and processes use only the active records.

Steps required for Scenario 5 are:

- Make a new copy of the assessment as the corrected assessment.
- Revise any non-key fields necessary in the corrected assessment record.
- Increment CORRECTION_NUM by one digit in the corrected assessment record.
- Submit the corrected assessment.

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Flow Chart. The flow chart on the following page summarizes the SB-MDS correction procedures.

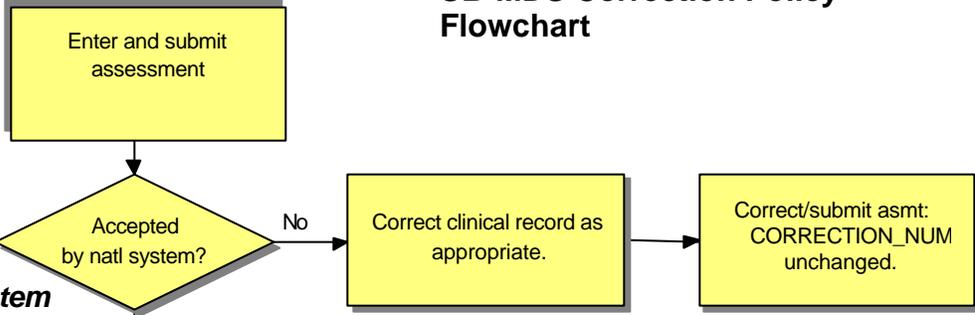
Please note that according to CMS's policy, when an assessment is corrected or inactivated, the facility must maintain the original assessment record as well as all subsequent corrected assessments in the patient's clinical record for five years. If maintained electronically, the facility must be capable of retrieving and reproducing a hard copy of these assessments upon request. It is acceptable to have multiple corrected assessments for an SB-MDS assessment.

SB-MDS Correction Policy Flowchart

of the Correction Policy Scenarios

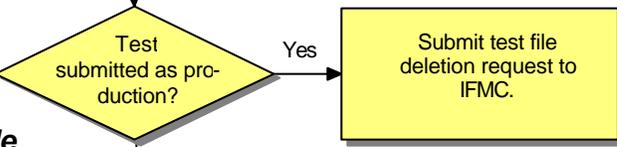
1

Not submitted or rejected by database system

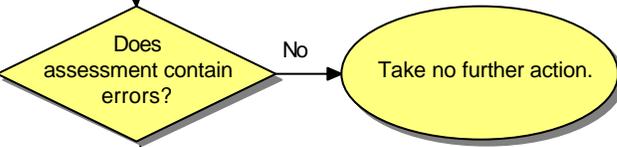


2

Accepted: test batch submitted as production file

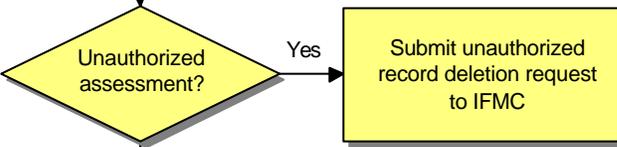


Accepted: no errors



3

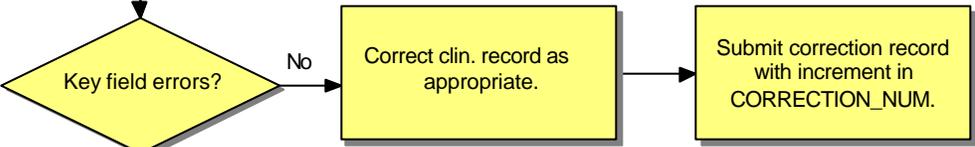
Accepted: unauthorized asmt submitted



**This is caused by an incorrect sb_sub_req value. Please see sb_sub_req instructions.*

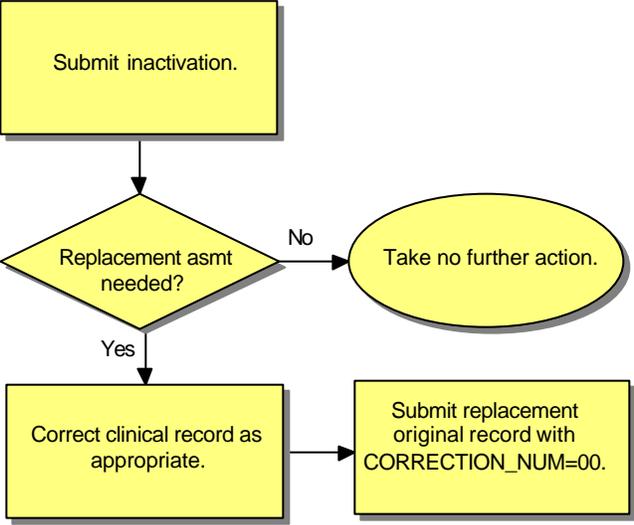
4

Accepted: non-key field errors



5

Accepted: key field errors



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Swing Bed Unauthorized Record Deletion Process

Only records authorized by CMS may be submitted to the National Assessment Collection Database. CMS only authorizes submission of records for patients in Medicare or Medicaid certified swing beds. If an unauthorized record is inadvertently submitted and accepted in the national database, the hospital must request that the unauthorized record be deleted from the database. The record cannot be inactivated, because that action leaves an audit trail with patient information. An unauthorized record must be completely deleted to safeguard patient privacy rights, with no patient information remaining.

Steps involved in deleting an unauthorized record are as follows:

1. To request deletion of a specific unauthorized SB-MDS record (assessment, discharge, or reentry), the hospital must send the following information to the QTSO Support staff at the Iowa Foundation for Medical Care:
 - Hospital name
 - Name, title, and phone number of the person making the request
 - The following items from the SB-MDS specific record:
 - Hospital ID (Item FAC_ID)
 - Patient first name and last name (Items 1a and 1c)
 - Patient SSN (Item 7a)
 - Patient birth date (Item 3)
 - Patient gender (Item 2)
 - Primary and secondary reasons for assessment (Items 11a and 11b)
 - Event Date (Item 10a for an assessment, 15 for a discharge, 16 for a reentry)
 - Submission date and time
 - Submission batch ID
 - Assessment internal ID
2. Mail the completed request form to:
Iowa Foundation For Medical Care, QTSO Support
6000 Westown Parkway Suite 350E
West Des Moines, IA 50266-7771
3. The help desk will evaluate the request, obtain CMS approval for the change, make the change, and maintain a log of all changes.

This information MUST NOT be sent via e-mail due to confidentiality of the information

An example worksheet that could be used by the hospital to request deletion of an unauthorized record is provided on the next page.

Example SB-MDS Unauthorized Record Deletion Request Worksheet

Instructions:

1. Complete a copy of this form for each unauthorized record to be deleted.
2. Submit to: Iowa Foundation For Medical Care, QTSO Support
6000 Westown Parkway Suite 350E
West Des Moines, IA 50266-7771
(This information must not be sent via e-mail due to confidentiality of the information)

Facility information	
Name	
ID (FAC_ID)	
Requester information	
Name	
Title	
Phone #	
Resident information	
First Name	
Last Name	
SSN	
Birth date	
Gender	
Record information	
Item 11a	
Item 11b	
Event Date ¹	
Submission information	
Date and time	
Batch #	
Assessment Internal ID	
Reason for Deletion Request	
This record was inadvertently submitted indicating it had submission authority, when it did not have authority. Please delete this record from the national database.	

Assessment Coordinator Name

Assessment Coordinator Signature

Date

¹Event Date:
 SB-MDS Item 10a, reference date, for an assessment record.
 SB-MDS Item 15, discharge date, for a discharge record.
 SB-MDS Item 16, reentry date, for a reentry record.

Swing Bed Test File Deletion Process

When a "Test" File is inadvertently submitted and accepted in the national database as a "Production" File, the hospital must request that the Test File be deleted.

Steps involved in Swing Bed File Deletion Request:

1. To request a deletion for a specific file, the SB Facility must send the following information to the QTSO Support staff at the Iowa Foundation for Medical Care:
 - Hospital Name
 - Name, title, and phone number of the person making the request
 - The following items from the Swing Bed submission file:
 - Hospital ID (FAC_ID)
 - Submission Date/Time
 - Submission Batch ID Number
2. Mail the completed request form to:
 - Iowa Foundation For Medical Care, QTSO Support
 - 6000 Westown Parkway Suite 350E
 - West Des Moines, IA 50266-7771
3. The help desk will evaluate the request, obtain CMS approval for the change, make the change, and maintain a log of all changes.

An example worksheet that could be used by the hospital to request deletion of a Test File is provided on the next page.

Example Swing Bed Test File Deletion Request Worksheet

1. Complete a copy of this form for each Test File to be deleted.
2. Submit to: Iowa Foundation For Medical Care, QTSO Support
 6000 Westown Parkway Suite 350E
 West Des Moines, IA 50266-7771
 (This information must not be sent via e-mail due to confidentiality of the information)

SB Facility information	
Name	
ID (FAC_ID)	
Requester information	
Name	
Title	
Phone #	
Submission information	
Date and time	
Batch #	
Reason For Deletion Request	
This test file was inadvertently submitted as a production file. Please delete all of the assessments from the national database.	

Assessment Coordinator Name

Assessment Coordinator Signature

Date

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