DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-27

DATE: **May 12, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Interim Timeliness Guidelines to Support the Entry of Data into ASPEN Central Office (ACO) and the ASPEN Complaints/Incidents Tracking System (ACTS) and Revisions to Field Definitions in ACTS

Letter Summary

This memorandum sets forth:

- Interim timeliness guidelines for State survey agencies (SAs) for the input of survey visit information into ACO and complaint/incident information into the ACTS for all Medicare- and Medicaid-certified provider/supplier types. These guidelines would not be incorporated into State Performance Reviews until FY 2007, at the earliest.

- Revisions to the Required Fields in ACTS.

I would like to express appreciation to you and your staff for persisting through the various transitions in Federal data systems. For many of you, changes in our systems, especially with the implementation of ACTS and the ASPEN Enforcement Manager (AEM), have required adjustments in your own business processes. Thank you for your patience and assistance.

Interim Timelines

Because the Centers for Medicare & Medicaid Services (CMS) and SAs are moving toward an electronic environment, it is imperative that data be complete and accurate. This letter focuses on two major areas:

- Attachment 1 - The entry of data for both health and life safety code surveys into ACO to ensure the timely processing of enforcement and/or termination action.

- Attachment 2 - The entry of complaint and incident data into ACTS to ensure the completeness of national reports.

These guidelines call for entry into ACO and ACTS to be done within timeframes that take account of program timeframes already in place, or within timeframes that are necessary for the use of the information in the electronic processing environment. They were developed with significant input from standing CMS-SA workgroups which have expertise in the applicable areas.

Discussion with CMS as to Final Timelines, Possible Performance Review in FY 2007
During FY 2005, we will ask the SAs to give us their evaluation of the reasonableness of the interim guidelines. CMS may be able to develop reports that would aid the SAs in observing their progress. The SAs' input to CMS will be via their ongoing communication with ROs, via their participation on national workgroups, and via their association, the Association for Health Facilities Survey Agencies. Our goal is to refine the timeframes so that they contribute to making our electronic tools as effective as they can realistically be. In FY 2006, we hope to set final timeframes, which we can then incorporate into the State Performance Review process for FY 2007.

Revisions to the Required Fields
Based on feedback from the SAs, CMS has revised the definitions of the Required Fields in ACTS. See Attachment 3.

Effective Date: The guidance for ACO and ACTS data entry timeframes will serve as interim policy, effective within 30 days of issuance of this memorandum. For SAs that need more than a brief period to comply with the timeframes, we ask that they first concentrate on data that is related to enforcement activities. The clarifications regarding the Required Fields in ACTS will be effective within 30 days of issuance of this memorandum.

Training: This clarification should be shared with all ASPEN coordinators, all users of ACO and ACTS, staff who manage and investigate complaints and self-reported incidents, their managers, and the state/RO training coordinator.

Please submit any questions, comments, or concerns that you may have by September 30, 2005 to Elaine Lew (Elaine.lew@cms.hhs.gov).

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments

ASPEN Central Office - All Medicare/Medicaid-Certified Provider Types[1] - Data Entry Timelines

For the entry of data for both health and life safety code surveys, there are two sets of timelines, one set applying to visits with an unremoved immediate jeopardy (IJ) situation, and the other set applying to visits for which that is not the case. The key data input to which the timelines refer is the entry of a final Statement of Deficiencies and/or Correction of Deficiencies form into ACO (or ACTS for complaint surveys).

Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Non-Immediate Jeopardy or Removed Immediate Jeopardy Surveys	
	Timeframe in which to enter data
From the last on-site day of a certification survey visit or the last on-site day of a complaint investigation to entry into ACO (or ACTS for complaint surveys) with a final deficiency report (CMS Form-2567)	15 working days
From the last on-site day of a certification survey revisit/follow-up or complaint investigation revisit/follow-up to entry into ACO (or ACTS for complaint surveys) with a final deficiency correction report (CMS Form-2567B)	10 working days
From the in-office "revisit" (follow-up review of a "paper compliance" item) to entry into ACO (or ACTS for complaint surveys) with final deficiency correction report (CMS Form-2567B)	3 working days
From the last on-site day of a certification survey revisit/follow-up or complaint investigation revisit/follow-up to entry into ACO (or ACTS for complaint surveys) if new or continuing deficiencies are found during the revisit/follow-up	15 working days
From the date(s) the SA accepts the plan of correction to input into ACO (or ACTS for complaint surveys)	5 working days
From the date of the IDR decision notice to the provider to IDR Manager input (Nursing homes only)[2]	3 working days

Unremoved Immediate Jeopardy Surveys	
	Timeframe in which to enter data
From the last on-site day of any visit of any type in which an unremoved IJ is found to entry into: • ACO (or ACTS for complaint surveys) of the IJ tag(s) and the same deficiency text that was sent to the provider as the first written notice of IJ (CMS Form-2567 which can be expanded later). • The IJ Situation subtab in AEM (Nursing homes only)	3 working days[3]
From the day that the immediate jeopardy is removed to entering that removal in the AEM IJ Situation subtab (Nursing homes only)	2 working days
From the last on-site day of a certification survey revisit/follow-up or complaint investigation revisit/follow-up to entry into ACO (or ACTS for complaint surveys) of correction of the IJ tag(s) (CMS Form-2567B), or re-citation of the former IJ tag(s) at a lower S/S level for nursing homes, or continuation of noncompliance of the IJ tag(s) (CMS Form-2567, without IJ indication) for other providers.	3 working days
From the last on-site day of a certification survey revisit/follow-up or complaint investigation revisit/follow-up to entry into ACO (or ACTS for complaint surveys) if new or continuing non-IJ deficiencies are found during the revisit/follow-up (CMS Form-2567)	15 working days
From the date of the IDR decision notice to the provider to IDR Manager input (Nursing homes only)[2]	3 working days

[1] Nursing homes, home health agencies, end-stage renal disease facilities, hospitals, suppliers of portable X-ray services, rural health clinics, rehabilitation facilities, hospice, intermediate care facilities for people with mental retardation, psychiatric hospitals

[2] Also, the SA should assure that deficiency data in the CMS National Reporting System (OSCAR/CASPER) is updated according to the results of the IDR process.

[3] This timeframe would not apply to non-IJ deficiencies that are identified at the same survey. Instead, it is expected that non-IJ deficiencies would be entered into ACO within 15 working days from the last on-site day of the survey visit.

ACTS-All Medicare/Medicaid-Certified Provider Types [1,2] - Data Entry Timelines

With respect to complaints and self-reported incidents, SAs are required to enter the following intakes into ACTS:

- Complaints that allege noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), or requirement(s) for participation (RFPs).
- Incidents that lead to an onsite survey of the Federal COPs, CFCs, or RFPs.

Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	*ACTS fields to which the timeframes apply*
Within 5 working days of the date the intake is triaged (Received End date)	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Complaint Priority Investigate within X Days Investigation Due By Allegation Category
If the intake is linked to an onsite survey - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency
If an onsite survey is conducted - Within 30 working days of the survey exit date.	*Intakes linked to an onsite survey* Investigated by Investigation Completed Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed
If an onsite survey is not conducted - Within 30 working days of the date the intake is received (Received End date).	Notifications: Type, Party, Method, Notification Date Proposed Action Proposed Action Date Reason Closed Date Closed

[1] Nursing homes, home health agencies, end-stage renal disease facilities, hospitals, suppliers of portable X-ray services, rural health clinics, rehabilitation facilities, hospice, intermediate care facilities for people with mental retardation, psychiatric hospitals

[2] The SA must receive authorization from the RO prior to conducting a complaint survey for an accredited hospital or other deemed provider.

ACTS-EMTALA Cases - Data Entry Timelines

SAs are required to enter all intakes that allege a violation with EMTALA. Unless there are extenuating circumstances, the following table describes the general timeframes in which SAs must enter data:

Timeframe in which to enter data	*ACTS fields to which the timeframes apply*
Immediately (Within two working days of the Received Start date).	Intake Type Intake Subtype Complainant Name Source Received Start Date Received End Date Allegation Category EMTALA Request for RO Approval Checkbox EMTALA Request for RO Approval Date
If an alleged EMTALA violation is found - Within 10 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable
If no alleged EMTALA violation is found - Within 15 working days of the survey exit date.	Allegation Findings Category Allegation Findings Subcategory Whether the Intake is Linked to a Survey Whether the Allegation is Linked to a Deficiency, if applicable

ACTS REQUIRED FIELDS

TAB	*FIELD(s)*	*DEFINITION*
Intake	**Intake Type**	1) *Complaint* - A *complaint* is a report made to the SA or RO by anyone other than the administrator or authorized official for a provider or supplier that alleges noncompliance with Federal and/or State laws and regulations. 2) *Incident* - An *incident* is an official notification to the SA or RO from a self-reporting provider or supplier (i.e., the administrator or authorized official for the provider or supplier).
	Intake Subtype (for Complaints)	A) *Federal COPs, CFCs, RFPs, EMTALA*: The allegation relates to noncompliance with the Federal condition(s) of participation (COPs), condition(s) for coverage (CFCs), requirement(s) for participation (RFPs), or EMTALA requirement(s). This would include allegations of noncompliance with Federal requirements only or both Federal and State requirements. **(SAs and ROs are required to enter these cases into ACTS.)** B) *State-only, licensure*: The allegation is related to noncompliance with State licensure requirements only. **(SAs have the option to enter these cases into ACTS.)** C) *No State or Federal provider compliance issue involved*: The allegation does not relate to noncompliance with Federal or State survey and certification requirements. **(SAs have the option to enter these cases into ACTS.)**

TAB	*FIELD(s)*	*DEFINITION*
	Intake Subtype (for Incidents)	A) *Federally required, entity-reported*: A provider or supplier is required by Federal law, regulation, or policy to report this type of incident, which includes the following: a. 42 C.F.R. §482.13(f)- *Standard: Seclusion and restraint for behavior management.* The hospital must report to CMS any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion. **(SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)** **b.** 42 C.F.R. §483.13- For skilled nursing facilities (SNFs) and nursing facilities (NFs), the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported …to other officials in accordance with State law through established procedures (including to the State survey and certification agency). **(SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)** B) *State-required, may result in Federal noncompliance, entity-reported*: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident may result in noncompliance with a Federal condition(s) of participation, condition(s) for coverage, requirement(s) for participation, or EMTALA requirement(s). For incidents of this type, the SA must follow CMS policies and procedures to investigate Medicare/Medicaid complaints, no matter the source of information. **(SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)** C) *State-required, all other, entity-reported*: A provider or supplier is required by State law, regulation, or policy to report this type of incident to the SA. This type of incident does not imply noncompliance with Federal conditions or requirements. **(SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)** D) *Reported by other agencies*: As defined by the State. E) *None of the above*: A provider or supplier is not required by Federal or State laws, regulations, or policies to report this type of incident. **(SAs and ROs are required to enter into ACTS all incidents that lead to an onsite survey of Federal requirements or conditions.)**
	Complainant's Name	For an incident the name of the official reporting the information is entered.
	Source	*A selection is made from a predefined list. The user cannot select more than 3.*
	Received Dates: Start/End	*Start Date:* The date of the telephone call or electronic correspondence; or, the date stamped by the SA or RO receiving office of the written correspondence. *End Date:* The date the SA or RO has sufficient information to prioritize the complaint or incident. This is the date in which the SA or RO determines 1) whether an onsite survey to assess Federal compliance or further action is necessary and 2) the appropriate time frame for investigation.

TAB	*FIELD(s)*	*DEFINITION*
	Priority	*At least one priority must be selected for each intake. Some combinations are not permitted*. A) *Immediate Jeopardy*: Intakes assigned this priority indicate immediate corrective action is necessary because a provider's or supplier's noncompliance with one or more conditions or requirements may have caused, or is likely to cause, serious injury, harm, impairment or death to a resident, patient or client. B) *Non-Immediate Jeopardy - High*: Intakes are assigned this priority if a provider's or supplier's alleged noncompliance with one or more requirements or conditions may have caused harm negatively impacting on the individual's mental, physical and/or psychosocial status and is of such consequence to the person's well being that a rapid response by the SA is indicated. This level of complaint is represented by specific rather than general information, such as, descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc. C) *Non-Immediate Jeopardy - Medium*: Intakes are assigned this priority if a provider's or supplier's alleged noncompliance with one or more requirements or conditions has caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status to function. D) *Non-Immediate Jeopardy - Low*: Intakes are assigned this priority if a provider's or supplier's alleged noncompliance with one or more requirements or conditions may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage. An onsite investigation may not be scheduled but the allegation would be reviewed at the next scheduled onsite survey, at the latest. E) *Administrative Review/Offsite Investigation*: This priority is used for complaints/incidents that are triaged as not needing an onsite investigation. However, further investigative action (written/verbal communication or documentation) initiated by the SA or RO to the provider may be needed to ensure compliance with the Federal requirements. The additional information is adequate in scope and depth to determine that an onsite investigation is not necessary; however, a SA has the discretion to review the information at the next onsite survey. F) *Referral – Immediate*: Complaints/incidents are assigned this priority if the seriousness of a complaint/incident and/or State procedures requires referral or reporting to another agency, board or network immediately for investigation. G) *Referral - Other*: Complaints/incidents assigned this priority indicate referral to another agency, board, or network for investigation or for informational purposes. H) *No action necessary*: Adequate information has been received about the complaint/incident such that the SA can determine with certainty that no further investigation, analysis, or action is necessary. For all cases except EMTALA, that do not allege immediate jeopardy, and at the SAs discretion an intake may not require a new onsite investigation if, at a previously completed survey, the same events were investigated; the previously completed survey evaluated the appropriate individuals, including those identified in the intake; and the situation did not worsen. These types of intakes should be linked to the appropriate survey that has already reviewed the issue.

TAB	FIELD(s)	DEFINITION
	Investigate Within X Days	*Completion is required if the Priority is Immediate Jeopardy or Non-immediate Jeopardy (Priorities A – D).* *A numerical time frame in calendar days or working days is entered to support the Priority selected. The calendar date of the intake is counted as day zero.*
	Investigation Due By	*Completion is required if the Priority is Immediate Jeopardy or Non-immediate Jeopardy (Priorities A – D).* *A corresponding calendar date is entered.*
Allegations	**Allegation Category**	*At least one allegation category from a predefined list per intake is required unless Priority H - No Action Necessary is selected.*
	Findings (Substantiated)	A *substantiated* allegation is an allegation that is verified by evidence. An allegation is considered substantiated based on the finding about the individual or specific situation named by the complainant in his or her allegation; or, other residents or patients reviewed or similar situations, even if the noncompliance was corrected for the specific individual(s) named by the complainant in the allegation. A. *Federal deficiencies related to the allegation are cited* For nursing homes only, this would include cases of current noncompliance and past noncompliance. B. *State deficiencies related to the allegation are cited* C. *No deficiencies related to the allegation are cited* The SA verified the allegation by evidence. However, at the time of the investigation, the provider had taken action necessary to prevent the deficient practice, and/or the allegation was not serious enough to warrant citing deficiencies. (This is not applicable for EMTALA, for EMTALA see the State Operations Manual at §3410.) D. *Referral to appropriate agency* After investigation, the complaint/incident was forwarded to the appropriate agency.
	Findings (Unsubstantiated)	An *unsubstantiated* allegation is an allegation that cannot be verified by evidence. A. *Allegation did not occur* Evidence indicates that the alleged concern did not occur. *B. Lack of sufficient evidence* There is insufficient evidence to verify the allegation. The evidence is inconclusive. C. *Referral to appropriate agency* After investigation, the complaint/incident was referred to the appropriate agency.
	Link Deficiencies	*Users indicate which Federal deficiencies are related to any of the allegations. Only allegations categorized as "Substantiated" and "Federal deficiencies related to the allegation are cited" may be linked to Federal deficiencies. At least one Federal deficiency must be linked to an allegation if it is categorized as 'Substantiated" and "Federal deficiencies related to the allegation are cited".*
	Priority	*This field is shared with the Intake page and Deemed page (when applicable).*
	Investigate Within X Days	*This field is shared with the Intake page and Deemed page (when applicable).*

TAB	*FIELD(s)*	*DEFINITION*
	Investigation Due By	*This field is shared with the Intake page and Deemed page (when applicable).*
	Death Associated with Restraint/ Seclusion [Grid]	*For Hospitals: When allegation type = Death Associated with Restraint/Seclusion (05), the following must be completed:* Patient Death type Reported Date of death AO Notify To P&A
EMTALA (Fields required only if 'Create EMTALA Allegation' box is checked)	**EMTALA Request for RO Approval Checkbox**	
	EMTALA Request for RO Approval Date	
	EMTALA RO Response Checkbox	*Required when EMTALA Request for RO Approval is checked.*
	EMTALA RO Response Date	*Required when EMTALA Request for RO Approval is checked.*
	Type of Emergency	
	RO EMTALA Determination	*Not required if RO disapproves investigation.*
	Resolution	*Not required if RO disapproves investigation.*
	RO Confirmed Violation Date *or* **RO Confirmed No Violation Date**	*One of these fields should always be completed, unless RO disapproves investigation.*

TAB	*FIELD(s)*	*DEFINITION*
	EMTALA Allegation Type	*Entry of EMTALA allegation here ties to an allegation record on the Allegation Page. Once an RO Response is entered, SA users cannot modify the EMTALA page. Also, once an EMTALA RO Response has been entered, EMTALA allegations may no longer be added or deleted by SA users; however, Allegation Findings categories and text may be entered by any user. Once the Determination has been entered, SA users may not add, delete, or modify EMTALA allegations.*
Deemed and Accredited (Fields enabled if 'Deemed for Medicare Participation' or 'Accredited' box is checked. Fields are required if 'Request for RO Approval' box is checked.).	**Priority**	*This field is shared with Intake and Allegation pages.*
	Request for RO Approval	
	Date of Request for RO Approval	
	Condition(s) of Participation	
	RO Response	*There are no edits on these fields at this time.*
	Regional Representative	
	Region	
	Date	
Investigation	**Investigated By**	*Required when Complaint Priority is Immediate Jeopardy or Non-immediate Jeopardy (Priorities A – D)*
	Investigation Completed	*Required when Complaint Priority is Immediate Jeopardy or Non-immediate Jeopardy (Priorities A – D)* The date that the result of the investigation is communicated to the provider or supplier.
Actions/Close	**Forwarded to RO/MSA**	If the intake originates from the CMS RO, the SA should check the "Forwarded to CMS/MSA" box in all complaint/incident scenarios. If the intake originates from the SA, SAs <u>should not</u> check the box or enter a date for all <u>nursing home</u> intakes. For non-long-term care intakes, the SA should check the "Forwarded to RO/MSA" box on the complaint/incident record in the three following scenarios: i. If the complaint/incident survey is on an accredited/deemed provider/supplier. ii. If the complaint results in an EMTALA investigation. iii. If the complaint/incident survey is on an "other than accredited/deemed provider or supplier" and the SA is recommending termination.

TAB	*FIELD(s)*	*DEFINITION*
	Proposed Action	*At least one proposed action per complaint/incident record if a survey is present.*
	Proposed Action Date	Date of the notice sent to the provider/supplier informing the provider/supplier of actions that may be taken as a result of the investigation findings. If the provider/supplier is in compliance, the proposed action date is the date the provider/supplier is notified that it is in compliance. *At least one proposed action date per complaint/incident record if a survey is present.*
	Overall Findings	*Supplied by ACTS (For complaints, uses same rule as Findings: Required when Complaint Priority = Immediate Jeopardy or Non-immediate Jeopardy (Priorities A – D); for incidents, defaults on-screen to Not Applicable).*
	Reason Closed	Field is completed by selecting one or more of the following: A. *Paperwork complete* – All information and documentation related to this complaint or incident has been completed in the SA or RO file. If applicable, this would include the notification of the results of the investigation to the complainant and provider, and the successful upload of the investigation record to the Certification and Survey Provider Enhanced Reports (CASPER) system. For nursing homes, if applicable, the intake may be closed prior to the revisit and imposition of an enforcement action. B. *Withdrawn* – The complainant contacted the entity receiving the allegation and asked that the allegation be removed. C. *Referred* – At the intake, during administrative review, or after the onsite complaint survey, it is determined that the issues involved must be directed to another agency or organization for resolution. D. *No jurisdiction* – The issues identified at intake, during an administrative review or after a survey do not involve Medicare/Medicaid participation requirements. E. *Provider/Supplier Termination* – The provider or supplier has been terminated from participation in the Medicare and/or Medicaid programs.
	Date Closed	*Date associated with the latest reason closed action selected.*
NOTIFICATION: Notices Button (every tab) and the Acknowledgement and Parties Notified section on the Investigation Properties tab		*At least one notification is required, except when Priority is No Action Necessary.* For each notice, enter the Type, Party, Method, and Notification Date.